Oregon Health Authority

Quality and Health Outcomes Committee
AGENDA

MEETING INFORMATION
Meeting Date: June 10, 2019
Location: HSB Room 137 A-D, 500 Summer Street, NE, Salem, OR
Parking: Map Phone: 503-378-5090 x0
Call in information: Toll free dial-in: 888-278-0296 Participant Code: 310477
Webinar: https://attendee.gotowebinar.com/rt/4303958396461018881
All meeting materials are posted on the QHOC website.

Clinical Director Workgroup 10:00 a.m. – 12:30 p.m.			
Time	**Topic**	**Owner**	**Materials**
10:00 a.m.	**Welcome / Announcements**	Holly Jo Hodges	May Meeting Notes (pg. 2-8) Speaker's Contact Sheet (pg. 9)
10:15 a.m.	**Medical Management Updates**		
	HERC (30 minutes)	Ariel Smit Cat Livingston	HERC Update PP (pg. 10-12) HERC Update Documents (pg. 13-33)
	P&T (15 minutes)	Roger Citron	Presentation (pg. 34-38)
10:50 a.m.	Unenrolled Prescribers Update	Jennifer Torkelson	
11:00 a.m.	Legislative Update	Jeannette Taylor	
11:30 a.m.	SUPPORT Act	Dee Weston	Presentation (pg. 39-40) Supporting Documents (pg. 41-60)
12:00 p.m.	Obesity MSI	Cat Livingston	Presentation (pg. 61-66) Supporting Documents (pg. 67-77)
12:25 p.m.	The Oregon Opioid Recommended Practices (OORP) checklist	Erin Stack	
12:30 p.m.	**LUNCH**		
Quality and Performance Improvement Session 1:00 p.m. – 3:00 p.m.			
1:00 p.m.	**Welcome / Announcements**	Jennifer Johnstun	
1:10 p.m.	**Obesity MSI FYI**	Jennifer Johnstun	
1:15 p.m.	**Performance Improvement Project (PIP) Overview Training**	Kris Hartman Christi Melendez	Presentation (pg. 78-81) Supporting Documents (pg. 82-107)
2:00 p.m.	**Dental Opioid Guidelines**	Bruce Austin	Presentation (pg. 108-11)
3:00 p.m.	**Adjourn**	All	

****JULY QHOC CANCELED DUE TO HOLIDAY SCHEDULING****

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QHOC

May 13, 2019

MEETING NOTES

Attendees	
Advanced Health	Anna Warner
AllCare	Laura McKeane, Kelley Burnett, Laura Matola
Cascade Health Alliance	David Shute, Susan Boldt
Columbia Pacific	
Eastern Oregon	Jim Rickards
Health Share	Maggie Bennington-Davis, Barbara Carey
InterCommunity Health Network	Arik Olson, Fritz Darling, Kevin Ewanchyna
Jackson Care Connect	
PacificSource Community Solutions	Alison Little, Sherri Sturko
Primary Health of Josephine County	Andy Luther, Jennifer Johnstun, Ruth McBride
Trillium Community Health Plan	Kristi Seidel
Umpqua Health Alliance	Tanveer Bokhari, Douglass Carr
Willamette Valley Community Health	Carla Munn, Jeanne Savage, Holly Jo Hodges
Yamhill Community Care	Bhavesh Rahjani, Jenna Harms, Tyler Hartman
Capitol Dental Care	
Willamette Dental	Dayna Steringer
CareOregon	Carl Stevens
Providence	Kristin Garrett
Tuality Health Alliance	Kristan Jeannis, Katrina McPherson
Washington County	Andy Wallace
Guests	Laura Brennan, Tracy Muday, Katrina Seipp, Andy Wallace, Ann Ford
OHA	Cat Livingston, Ariel Smits, Dana Hargunani, Roger Citron, Lisa Bui, Alissa Robbins, Jennifer Nones, Tressa Perlichek, Ann Brown, Renae Wentz, Anona Gund, Joell Archibald, Nathan Roberts, Jeannette Taylor, Lisa Krois, Jennifer Valentine, Sarah Wetherson
Attendance via Phone/Webinar	Josue Aguirre, Rob Bauer, Keshia Bigler, Barbara Boardman, Briona Campbell, Lisa Castle, Tiffany Dorsey, Mike Franz, Ashley Green, Kris Hartmann, Heidi Hill, Michelle Jenck, Nicole Japeal, Tanya Kapka, Safina Koreishi, Kristen Lacijan-Drew, Cynthia Lacro, Juliana Landry, Nina Lara, Christy McCallum, Heather Oberst, Yvette Ross, Samantha Shepherd, Tyler Jacob, David Geels, Charmaine Kinney

QHOC MORNING SESSION

WELCOME/ANNOUNCEMENTS:

Role call was done in the room and with those attending by phone.

PUBLIC HEALTH DIVISION UPDATES – MAY 2019

New public education campaign to prevent the use of prescription opioids

OHA will soon be launching a new behavior change campaign to prevent the use of prescription opioids in Oregon. OHA teamed up with Brink Communications and Goodwin Simon Strategic Research to conduct groundbreaking research aimed at uncovering how diverse people think about short-term pain and pain management. OHA is hosting a webinar to give stakeholders an early look at the campaign and the key insights that helped shape OHA's equitable and culturally responsive approach. Join us for a webinar on Tuesday, June 18th from 9am – 10:30am. The webinar will also include an overview of a new narrative that you can leverage to successfully drive change in your own work. Click here to RVSP by June 14th. You will receive a follow up email with a calendar invite and webinar details. For more information, contact Mary Borges at mary.l.borges@state.or.us.

Sustainable Relationships for Community Health (SRCH) RFGP Opportunity

The OHA Public Health Division is getting ready to release a RFGP for the next round of SRCH funding. Sustainable Relationships for Community Health (SRCH) is a facilitated model for collaboration that brings together leaders from Local Public Health Authorities (LPHAs), Oregon Federally Recognized Tribes, Urban Indian Health Programs, Coordinated Care Organizations (CCOs), Regional Health Equity Coalitions (RHECs), clinics, community-based organizational partners delivering self-management programs (SMPs), and others involved with health system transformation to implement evidence-based interventions and services.

SRCH participants create sustainable effective relationships between community partners to improve preventive and chronic care services, improve health outcomes, reduce healthcare costs, and promote equity. The RFGP will be released in early May, and the funding period is from July 2019 – June 2020. For more information, please see the attached document or contact Shira Pope at shira.r.pope@state.or.us.

Upcoming training: Oregon Public Health Assessment Tool

The Oregon Public Health Assessment Tool (OPHAT) is a web-based data query system for community health assessment. It's available at no cost to employees of CCOs or hospitals engaged in community health needs assessment. Oregon Health Authority will hold a training for new users on: Thursday, May 16, 2019 from 1:00-2:00. Register at: https://register.gotowebinar.com/register/8243206196494648323. For more information, contact Nita Heimann at Juanita.a.heimann@state.or.us.

Release of the 2019 Status Report on Oregon's School-Based Health Centers

This report covers a wide variety of topics related to school-based health centers (SBHCs) and adolescent health in Oregon including SBHC utilization in physical health, behavioral health and youth sexual health and youth experience in SBHCs. Link to the Report: https://apps.state.or.us/Forms/Served/le8962_19.pdf If you would like hard copies, please send an email request to sbhc.program@dhsoha.state.or.us.

HERC UPDATE

Upcoming topics of interest:

- Functional MRI and epilepsy surgery
- Injections for plantar fasciitis
- Biologic matrix for breast reconstruction
- Lymphedema issues
- Radiofrequency ablation for knee osteoarthritis
- Chronic Pain Task Force recommendations
- Nonpharmacologic therapy for chronic pain syndrome, fibromyalgia
- Opioid guideline/opioid tapering
- Chronic pain syndrome, fibromyalgia
- Back pain
- Alternative proposals being discussed
- Option to make no changes for chronic pain
- Back opioid guideline will still need to be updated
- Reprioritization of liver transplant for hepatic malignancy
- Moves liver transplant for hepatocellular carcinoma and pediatric malignancies to covered portion of the List
- Leaves angiosarcoma and intrahepatic bile duct carcinoma uncovered

EbGS scheduled for 6/6/2019:

- Planned out-of-hospital birth – Guidelines
- New topic scope statements

HTAS scheduled for 6/20/19:

- Spinal cord stimulators
- New topic scope statements

BHAP:

- Counseling for high risk pregnant women/postpartum women to prevent peripartum mood disorders
- Wrap around services for autism

Future Topics:

- 2020 ICD-10 codes
- Telephone and email consultation

- Massage therapy
- Incontinence procedures
- Lower extremity chronic venous disease
- Repair of varicoceles in children and adolescents
- Vestibular rehabilitation and falls
- Helmets for positional plagiocephaly
- Activity monitors/fitbits?

P&T UPDATE

The March P&T Committee OHA Approved Recommendations are posted online at https://www.oregon.gov/OHA/HSD/OHP/Pages/PT-Committee.aspx. The next meeting scheduled on 5/23/2019 from 1:00 – 5:00pm @ DXC Building

GLP-1 Receptor Agonists Literature Scan:

- Make no changes to the PMPDP based on efficacy and safety and no further review or research needed at this time
- Amend prior authorization (PA) criteria to:
    - ask about concomitant insulin use
    - allow use of basal insulin in combination with a GLP-1
    - auto-PA preferred products for patients with claims for metformin use in the previous 40 days
- After comparative cost consideration in executive session:
    - make exenatide vials (Bydureon®) preferred
    - make liraglutide (Victoza® 2 and 3 Pak) preferred

Calcium/Vitamin D Prior Authorization Update:

- Add a vitamin D solution suitable for infants to the PMPDP
- After comparative cost consideration in executive session:
    - make cholecalciferol (vitamin D3) Baby Ddrops® preferred

Hydroxyprogesterone Prior Authorization Update:

- Update the PA criteria to accommodate new generics for Makena®

Benzodiazepine Prior Authorization Update:

- Update the PA criteria to include:
    - outpatient management of alcohol withdrawal syndrome
    - amend to add “prescribing specialists in mental health”

Cannabidiol Prior Authorization Update:

- Update the PA criteria to include maximum dose limits

Tetracycline Class Update and New Drug Evaluation:

- Make no changes to the PMPDP based on clinical evidence
- After comparative cost consideration in executive session:

- make no changes to the PMPDP

Hereditary Angioedema Agents Class Review:

- Implement the proposed PA criteria after amending to:
  - require laboratory documentation of diagnosis
  - add a dosing table
  - move the question regarding preferred/nonpreferred drugs to later in the PA after all clinical criteria are met
- Make ecallantide non-preferred due to concerns with anaphylaxis
- After comparative cost consideration in executive session:
  - make C1 esterase inhibitors Berinert® and Haegarda® preferred

Endometriosis Class Review:

- Combine the PA criteria for GnRH analogs and antagonists into one criterion entitled GnRH Modifiers after amending to:
  - limit approval to the FDA approved duration
- Retire previous criteria
- Revising the step therapy for elagolix to:
  - remove required trial of acetaminophen or a NSAID
  - add endometriosis diagnosis with step therapy for leuprolide, goserelin, and nafarelin
  - reinforce warnings about bone mineral density loss with use of GnRH modifiers
- After comparative cost consideration in executive session:
  - make no changes to the PMPDP

Antipsychotics for Schizophrenia Drug Use Evaluation:

- Make no changes to the PMPDP for oral or parenteral antipsychotics based on clinical evidence
- Continue to explore opportunities for provider education and Drug Use Review (DUR) initiatives
- After comparative cost consideration in executive session:
  - make no changes to the PMPDP

LEGISLATIVE UPDATE

Update was given by Jeannette Taylor.

LEARNING COLLABORATIVE

Diabetes Prevention Program was discussed during the Learning Collaborative. The session objective was to share strategies from around the state that could support the implementation of the Diabetes Prevention Program (DPP) as outlined in Guideline Note 179 as of January 1, 2019. Session goals were to expand participants understanding of the following:

- The National DPP demonstration pilot project (2016–2018) lessons and opportunities for DPP implementation and scaling among Medicaid populations

- Opportunities for engaging community-based organizations in DPP delivery
- DPP benefit coverage and DPP provider networks, including tribal clinics
- Billing mechanisms for DPP coverage in Medicaid

Resources for health care providers, employers and insurers, and DPP providers are compiled on the Transformation Center website: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Diabetes-Prevention-Program.aspx

Subject matter experts: Professional bios and contact information

Michael Anderson-Nathe is the chief equity and engagement officer for Health Share of Oregon. Michael serves on the executive team of Health Share and is charged with enabling health care transformation by engaging Health Share's members, affiliates and community service providers to cultivate innovative approaches to addressing social determinants of health outcomes, upstream prevention, health equity and member engagement. Prior to joining Health Share in 2014, Michael worked for the Cascade AIDS Project for almost 10 years in a variety of positions including the director of prevention and education services, and interim co-deputy executive director. Michael has over 20 years of experience partnering with marginalized communities on issues of sexual health, health equity and social justice. Michael holds a Master of Public Administration from Portland State University with a focus on organizational development, intercultural communication and leadership and a certificate in diversity and inclusion from Cornell University.

Kevin Ewanchyna is the chief medical officer and vice president of Samaritan Health Plans in Corvallis. He is also a teaching physician at Samaritan Family Medicine and clinical assistant pro fessor of family medicine at Western University of Health Sciences. Kevin is co-chair of the Oregon Health Authority Common Credentialing Advisory Group and serves on the board of trustees for the Oregon Medical Association. He also serves on the board of directors for Court Appointed Special Advocates of Benton County and the Corvallis Sister City Association. Kevin completed his medical degree and family medicine residency at the University of Saskatchewan.

Lavinia Goto is the operations manager for Oregon Wellness Network, a division of the Oregon Association of Area Agencies on Aging and Disability. Since 2008, she has focused on chronic disease management, health prevention and promotion, and developing a network of health coaches and leaders providing evidence-based chronic disease self-management workshops throughout the state. Previously she managed a local home health agency, administered a county public health department, was the chief operational officer for an international managed care organization, ran a large community-based behavioral health organization, and managed a statewide home and community-based waiver. Lavinia has a bachelor's degree in nursing, Master of Public Health, Master of Business Administration, and doctoral degree in health administration. Besides being a registered nurse, she is a certified diabetes educator and an experienced nurse case manager. Lavinia is a master trainer for the suite of self-

management workshops developed by Stanford University, and a master trainer select for the National Diabetes Prevention Program.

Bhavesh Rajani joined Yamhill Community Care as medical director in May 2016. He has many years of experience as a family physician and medical director. He has a deep commitment to low-income, underserved and vulnerable populations, and is passionate about population health initiatives. Bhavesh plays an integral role in ongoing community and clinical best practices and helps with program expansions. Bhavesh also has an interest in working on prevention and wellness efforts and early learning strategies. Bhavesh earned a Master of Business Administration.

QUALITY AND PERFORMANCE IMPROVEMENT SESSION

2019 Statewide PIP update was given.

Reminders:

- CMS PIP protocol is followed for the Statewide PIP
- Metric is calculated by OHA and distributed to CCOs monthly
- Metric is used by External Quality Review Organization (EQRO) for validation of statewide PIP
- The 2019 Statewide PIP report deliverable submitted for EQRO validation on January 31, 2020 will focus on the design phase of the PIP.

2019 Statewide PIP metric/March 2019 QHOC discussion follow-up:

- Questions for OHA Analytics and responses thereof:
    1. Claims data: Can the data be broken out by oral health/BH/PH?
        - Response: No, the prescription claims data cannot be broken out by health domain
    2. Exclusion criteria details relating to cancer
        - Cancer Dx in claims for the measurement year are excluded.
    3. Surgeries included?
        - Surgeries are included but can be excluded if CPT code set list provided
    4. <3 day supply vs. ≤ 3 days supply
        - Received information from Dr. Hedberg on the OHA Acute Prescribing guidelines and alignment will be with the ≤ 3 days supply.

MSHIP survey results:

Presentation was done by Austin Phillips and Sara Hallvik. Purpose of the surveys was to collect consumer input to guide improvement of mental health services for Medicaid-eligible and –enrolled clients.

Public Comment:

None

Adjournment:

Meeting was adjourned at 2:00pm

SPEAKER CONTACT SHEET
QHOC – June 2019

AGENDA TOPIC	SPEAKER	CONTACT INFO
Welcome/Introductions	Holly Jo Hodges	hhodges@wvphealth.org
HERC Update	Ariel Smits, MD, MPH Cat Livingston, MD, MPH	ariel.smits@state.or.us catherine.livingston@state.or.us
Pharmacy Update	Roger Citron	roger.a.citron@state.or.us
Unenrolled Prescribers Update	Jennifer Torkelson	jennifer.torkelson@state.or.us
Legislative Update	Jeanette Taylor	jeannette.t.taylor@state.or.us
SUPPORT Act	Deborah (Dee) Weston	deborah.g.weston@state.or.us
Obesity MSI	Cat Livingston, MD, MPH	catherine.livingston@state.or.us
Oregon Opioid Recommended Practices (OORP) checklist	Erin Stack (Comagine)	estack@comagine.org
Performance Improvement Project (PIP) Overview Training	Kris Hartman (HSAG) Christi Melendez (HSAG)	khartmann@hsag.com CMelendez@hsag.com
Dental opioid guidelines presentation	Bruce Austin, DMD	bruce.w.austin@state.or.us
QHOC CHAIRS		
Medical	Andy Luther, MD	andrew.luther@primaryhealthfamily.com
Behavioral Health	Athena Goldberg, LCSW	athena.goldberg@allcarehealth.com
Oral Health	Laura McKeane	laura.McKeane@allcarehealth.com
Quality	Jennifer Johnstun	jennifer.johnstun@primaryhealthfamily.com
QHOC LEADS		
Medical	K. Renae Wentz, MD	kim.r.wentz@state.or.us
Behavioral Health	TBD	TBD
Oral Health	Bruce Austin, DMD	bruce.w.austin@state.or.us
Quality	Lisa Bui	lisa.t.bui@state.or.us

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QHOC Website: http://www.oregon.gov/oha/HPA/DSI/Pages/Quality-Health-Outcomes-Committee.aspx
Questions: OHA.qualityquestions@state.or.us or call Lisa Bui at 971-673-3397

HERC Update

Ariel Smits, MD, MPH
Cat Livingston, MD, MPH
June 10, 2019

May HERC meeting decision

- Functional MRI and epilepsy surgery
- Injections for plantar fasciitis
- Lymphedema issues
- Radiofrequency ablation for knee osteoarthritis

- 2020 Biennial review
  - Reprioritization of liver transplant for hepatic malignancy
  - Chronic pain reprioritization
- Changes to GN60—opioid tapering for conditions of the back and spine

2

Transitional coverage for patients on long-term opioid therapy:
For patients receiving long-term opioid therapy (>90 days) for conditions of the back and spine, continued coverage of opioid medications requires an individual treatment plan which includes a taper plan where clinically indicated. Opioid tapering should be done on an individualized basis with a shared goal set by the patient and provider based on the patient's overall status. Taper plans should include nonpharmacological treatment strategies for managing the patient's pain. During the taper, behavioral health conditions need to be regularly assessed and appropriately managed. In some situations (e.g., in the setting of active substance use disorder, history of opioid overdose, aberrant behavior), more rapid tapering or transition to medication assisted treatment may be appropriate and should be directed by the prescribing provider. If a patient has developed an opioid use disorder, treatment is included on Line 4 SUBSTANCE USE DISORDER.

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Items for Action or Input

- Genetic testing for siponimod for MS
  - Need to open CPT 81227 (CYP2C9) prior to October 1st
- Lead screening and investigation
  - Any unintended consequences?
  - Need to increase screening rates
- Chronic lower extremity venous disease
  - Input on possible increase in coverage
    - Pain interfering with daily activities
    - Recurrent cellulitis
- Lymphedema provider guideline

4

GUIDELINE NOTE 43, LYMPHEDEMA

Line 421

Lymphedema treatments are included on this line when medically appropriate. These services are to be provided by a licensed practitioner who is

1) Certified by LANA (Lymphology Association of North America; http://www.clt-lana.org), OR
2) A graduate of one of the National Lymphedema Network or North American Lymphedema Education Association (NALEA) accepted training courses

Services should be provided by a LANA certified therapist if available.

~~certified by one of the accepted lymphedema training certifying organizations or a graduate of one of the National Lymphedema Network accepted training courses within the past two years. The only accepted certifying organization at this time is LANA (Lymphology Association of North America; http://www.clt-lana.org).~~ Treatments for lymphedema are not subject to the visit number restrictions found in Guideline Note 6 REHABILITATIVE AND HABILITATIVE THERAPIES.

It is the intent of the HERC that compression dressings/garments and other medical equipment needed for the treatment of lymphedema be covered even in the absence of ulcers or other complications.

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Upcoming topics of interest

- 2019 ICD-10 codes
- Biologic matrix for breast reconstruction
- Repair of varicoceles in children and adolescents
- Incontinence procedures
  - Sacral stimulation
  - Artificial urinary sphincter
  - Sling procedure for male urinary incontinence
  - Urethral bulking injections for urinary incontinence
- Massage therapy
- Helmets for positional plagiocephaly
- Telephone and email visit guidelines
- Vestibular rehabilitation
- CG - Impella devices
- MSI – Community Health Workers

6

EbGS & HTAS

EbGS 6/6/2019

- Planned out-of-hospital birth – Guidelines
- New topic scope statements
  - Multicomponent Interventions to Improve Screening for Breast, Cervical or Colorectal Cancer
  - Non-Invasive Vagus Nerve Stimulation Devices for Cluster and Migraine Headache (e.g., Gammacore)
  - Percutaneous Occlusion of the Left Atrial Appendage in Atrial Fibrillation (e.g. Watchman)

HTAS 6/20/19

- Spinal cord stimulators
- New topic scope statements
  - Patient and Radiologic Factors Influencing Outcomes in Total Knee Arthroplasty

7

BHAP

- Counseling for high risk pregnant women/postpartum women to prevent peripartum mood disorders
- Wrap around services for autism

8

Your feedback or issues

9

Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on May 16. 2019

For specific coding recommendations and guideline wording, please see the text of the 5/16/2019 VbBS minutes.

RECOMMENDED CODE MOVEMENT (effective 10/1/2019)

- Add the procedure code for injections for plantar fasciitis to an uncovered line
- Add the procedure code for radiofrequency ablation for knee osteoarthritis to an uncovered line
- Add the procedure code for pneumatic compression devices for lymphedema therapy to an uncovered line
- Move procedure codes for functional MRI (fMRI) from an unfunded line to the epilepsy surgery line
- Make various straightforward coding changes

ITEMS CONSIDERED BUT NO RECOMMENDATIONS FOR CHANGES MADE

- Reprioritization of the chronic pain syndrome/fibromyalgia line was considered, but not recommended
- Preventive treatment of women at high risk for lymphedema was considered, but not recommended

RECOMMENDED GUIDELINE CHANGES (effective 10/1/2019)

- Edit the guideline for opioids for conditions of the back and spine to remove the requirement for those on long-term opioid therapy to be tapered off completely over a specified period of time *[Note: see the 5/16/19 HERC minutes for further changes made to the guideline]*
- Make various straightforward guideline note changes

2020 BIENNIAL REVIEW (effective January 1, 2020)

- Create a new line for liver transplantation for hepatic malignancies in the funded region

VALUE-BASED BENEFITS SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
May 16, 2019
8:00 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair; Holly Jo Hodges, MD, Vice-Chair; Mark Gibson; Vern Saboe, DC; Gary Allen, DMD; Adriane Irwin, PharmD.

Members Absent: none

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Daphne Peck; Jason Gingerich; Dana Hargunani, MD.

Also Attending: Renae Wentz, MD (Oregon Health Authority); Laura Ocker, LAc; Mary Kelly Rolf; Douglass Carr, MD (Umpqua Health); Jeanne Savage, MD (WVCH); Wendy Gordon; Larry Gordon; Rika Bierek (Oregon Medical Association); Kelly Howard; Len Ramey; Amara M; Kathy Spain; Noel Elliot; Joseph Elliot; Laura Dolph; Jay Hall.

Ø **Roll Call/Minutes Approval/Staff Report**

The meeting was called to order at 8:05 am and roll was called. Minutes from the 3/14/19 VbBS meeting were reviewed and approved unanimously as submitted. Smits reviewed the errata document; there were no questions.

Coffman announced that Kathryn Schabel, MD, was confirmed this week by the Oregon Senate to a HERC position; she already serves on HTAS.

Ø **Topic: Straightforward/Consent Agenda**

Discussion: There was no discussion about the consent agenda items.

Recommended Actions:

1) Add 11971 (Removal of tissue expander(s) without insertion of prosthesis) to lines 191 CANCER OF BREAST; AT HIGH RISK OF BREAST CANCER and 285 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
2) Add 96132 and 96133 (Neuropsychological testing evaluation services) to line 174 GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS Treatment: SINGLE FOCAL SURGERY
3) Remove M54.0 family (Panniculitis affecting regions of neck and back) from line 401 CONDITIONS OF THE BACK AND SPINE
    a. Add M54.0 family to line 519 PANNICULITIS
4) Add 19370 (Open periprosthetic capsulotomy, breast), 19371 (Periprosthetic capsulectomy, breast), and 19380 (Revision of reconstructed breast) to line 191 CANCER OF BREAST; AT HIGH RISK OF BREAST CANCER

5) Add G12.20 (Motor neuron disease, unspecified) to line 292 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS
    a. Advise HSD to remove G12.20 from the Undefined Diagnosis File
6) The coding specification attached to line 292 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS was updated to include one additional CPT code (CPT 63650 Percutaneous implantation of neurostimulator electrode array, epidural):
    a. "Spinal cord stimulation (63650~~63655~~-63688) is not included on this line when paired with ICD-10-CM category G90.5 Complex regional pain syndrome/reflex sympathetic dystrophy…"
7) Add L8690, L8691, L8693, and L8694 (Auditory osseointegrated device) to lines 311 HEARING LOSS - AGE 5 OR UNDER and 444 HEARING LOSS - OVER AGE OF FIVE
8) Add HCPCS L8692 (Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment) to line 311 HEARING LOSS - AGE 5 OR UNDER
9) Modify GN103 as shown in Appendix A
10) Modify GN173 as shown in Appendix A
11) Remove ICD-10 M47.01 family (Anterior spinal artery compression syndromes) and the M47.02 family (Vertebral artery compression syndromes) from lines 346 CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS and 401 CONDITIONS OF THE BACK AND SPINE
12) Add ICD-10 M47.01 family (Anterior spinal artery compression syndromes) and the M47.02 family (Vertebral artery compression syndromes) to line 292 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS
13) Recommend HSD add CPT 97033 (Application of a modality to 1 or more areas; iontophoresis, each 15 minutes) to the Ancillary File

MOTION: To approve the recommendations stated in the consent agenda. CARRIES 6-0.

Ø **Topic: 2020 Biennial Review: Reprioritization of certain chronic pain conditions**

Discussion: Dr. Dana Hargunani thanked the Commission for allowing a pause in their deliberations to allow for the third-party review. She has been pleased by the appraisal assessment by Aggregate Analytics Incorporated (AAI). She said her task to do a complete review of the conflict of interest policies is underway.

Hargunani thanked the staff and the members of the Chronic Pain Task Force (CPTF) who worked on this topic for +18 months. She thanked the public who have had tremendous engagement on this topic from near and far. This input, both from personal accounts and from professionals, has contributed significantly to the Commission's work.

She said the Commission was looking at opening the back-pain guideline, particularly around opioid prescribing. There is forthcoming evidence expected to be published later this year and expect to re-open the topic this coming winter.

Hargunani said OHA, separate from HERC, is developing a task force around opioid prescribing guidelines.

Dr. Andrea Skelly then gave a presentation on AAI's evidence appraisal and clarifying questions from the subcommittee were answered.

Smits gave a brief presentation of the history of the topic and summarized the three options included in the materials on the potential reprioritization of fibromyalgia and four additional chronic pain conditions.

Public testimony
Kelly Rolf, a fibromyalgia patient. Ms. Rolf testified about her various medical conditions, and how they responded well to opioid medications. These medications allowed her to function. She has had her opioid doses reduced, and now is having trouble functioning and is at times suicidal from the pain.

Douglas Carr, the CMO of Umpqua Health Alliance, testified about the sparse evidence to support the interventions being proposed for coverage for certain chronic pain conditions. He noted that high quality evidence will be available this winter on this topic. He noted that the non-pharmacologic interventions have slight or no long-term benefit. He recommended adoption of option 1 (no change from current coverage) and have the HERC review upcoming studies when they become available.

Larry Gordon, the husband of a chronic pain patient, testified about the unintended consequences and misinterpretations of the CDC opioid guidelines. His wife was forced tapered from opioids, and had negative consequences including suicidal ideation. He supports grandfathering in current chronic pain patients who are taking opioids appropriately. He also recommended considering coverage of opioids for patients not currently on them, as the CDC guidelines say that these types of patients can be treated with long-term opioids. He feels there is no evidence for forced tapers. He felt there should be no hard limits on opioid dosing as no evidence exists to support these limits. There are no studies finding that opioids don't work long term—there is just no study of long-term opioids at all. People have committed suicide and experienced other harms due to tapering. He recommended putting a hold on a decision and waiting for coming evidence.

Kelly Howard, a chronic pain patient, testified regarding coverage of additional opioids for pain flares. Breakthrough pain occurs 50-90% of the time for patients on opioids. Flares can increase stress and reduce a patient's medical status. Non-opioid treatments for flares may not be sufficient. She requested access to all tools to deal with breakthrough pain.

Amara M, the cofounder of the Oregon Pain Action Group, testified about being encouraged that the HERC was reopening guidelines on opioids for back conditions. She asked for an emergency halt/pause for opioid tapers for any conditions, including back and spine conditions. She noted that AAI found that evidence was missing for excluding fibromyalgia. She requested consideration of option 3C (allows opioid therapy for chronic pain consistent with national guidelines). She recommended not excluding any diagnosis (such as fibromyalgia) from opioid therapy based on diagnosis code. She also requested that the Commission not remove coverage of additional opioids for flares of chronic pain.

Kathy Spain, a chronic pain patient with fibromyalgia, testified that opioid pain medication was the only therapy that worked for her. Opioid therapy allowed her to function normally in daily life. With opioid therapy, she is able to work part time, do leisure activities and care for family. She has been

treated with opioids for 18 yrs. Without opioids, she would lose function and the ability to do things she enjoys. Pain medications are lifesaving. She feels that there is a stigma currently for being a chronic pain patient.

Laura Dolph, a chronic pain patient due to porphyria, testified in support of option 3c, but not in favor of removing coverage of flare for back pain opioid therapy. She feels that medications help flares, and that no evidence has been shown that treating flares is harmful. She testified against forced tapers. She has tried alternative pain therapies, which helped a bit mentally, but did not affect her pain. She attempted suicide twice due to pain. Pain management should be an exclusive arrangement between patient and provider.

Joseph Elliot, the husband of a chronic pain patient, testified about how opioid therapy has helped her for over 10 yrs. With opioid therapy, his wife is a normally functioning woman with some mobility limitations. If forced to taper off opioids, she would lose function, and has lost cognitive abilities when off opioids in the past. He urged the subcommittee to consider the impact on families and loved ones of removing opioid therapy.

Jeanne Savage, the CMO of Willamette Valley Community Health CCO and a family physician, testified. She noted that many conditions are not currently covered that we want to cover, like asymptomatic hernias, but OHP must balance what is not covered if you choose to cover these particular chronic pain conditions. CCOs have limits on what they can afford to pay for. She stressed the need for the subcommittee to consider fiscal responsibility.

VbBS Discussion:
Saboe requested information on the number of patients on OHP who have one of these 5 diagnoses under consideration. Gingerich replied that there appears to be about 7,000 OHP patients with one of these diagnoses and no other covered diagnosis. Coffman added that patients with only these diagnoses might or might not currently have medications covered, depending on comorbid conditions, lack of PA process in their CCO, etc. Gibson noted that the definition of some of these conditions are so poor that it is difficult to determine what we are treating. He also noted that the proposed interventions have low evidence of effectiveness.

VbBS then reviewed the line scoring for the proposed new line. They determined the most appropriate scores are a "4" for healthy life years, a "3" for suffering, a "0" for tertiary prevention (due to being unsure if treatment of chronic pain prevents development of any condition), a "1" for effectiveness and a "0.8" to need for service. These scores result in a line score of 112, which would keep any new line at about line 528, the current location of these conditions. Based on the fact that the rescoring did not move the line, the VbBS voted 6-0 in favor of option 1, which makes no change to coverage for these 5 specific chronic pain conditions.

The VbBS then discussed the proposed edits to Guideline Note 60, OPIOIDS FOR CONDITIONS OF THE BACK AND SPINE. Hodges asked what evidence was used for the creation of GN60; the reply was expert opinion. Hodges suggested just deleting the dates in the previous taper wording that had already passed, rather than changing the entire taper language. Olson noted that the proposed wording resulted in no consequences for a patient who failed to taper off opioids. Hodges argued that the CCOs are using GN60 and having no issues with the current wording. She suggested waiting to make any changes to the GN60 wording until the global evaluation of the back line planned for this winter. Olson noted that we don't have evidence of how to safely taper patients, or whether

patients need to be tapered down to zero. Irwin was not comfortable leaving GN60 with the current wording. She noted that public comments have shown harms, and that it gives a bad message to leave tapering verbiage in our guideline. Irwin suggested simply deleting GN60. Hodges argued against the staff suggested wording changes, which included nothing about patient safety, harmful doses, or the need to taper patients to safer doses of opioids. Hargunani replied that the CDC guidelines do not actually recommend tapering a patient's opioid dose down if the patient is taking over a certain dose; rather the CDC guidelines just state that caution needs to be taken when considering increasing dose over a certain level. Olson expressed his concern for patient abandonment that might be an unintentional consequence of the current guideline. A recommendation was approved in favor of the staff suggested wording changes to the tapering paragraph in GN60.

Lastly, the VbBS discussed the proposed language regarding removal of additional opioids for treatment of flares of pain, as proposed by the CPTF. Irwin was concerned about the lack of evidence to support this change. Gibson noted that this type of change can be addressed when the VbBS looks at the entire guideline this coming winter. The decision was to make no change to flare language (continue to include in Guideline Note 60).

Note: further changes to Guideline Note 60 were made at the May 2019 HERC meeting. Please see the 5/16/19 HERC minutes for that discussion.

Recommended Actions:

1) No change to the current prioritization of chronic pain syndrome (ICD-10 G89.4), chronic pain due to trauma (ICD-10 G89.21), other chronic postprocedural pain (ICD-10 G89.28), other chronic pain (ICD-10 G89.29), and fibromyalgia (ICD-10 M79.7)
2) Modify guideline note 60 as shown in Appendix A

MOTION: To recommend the changes to Guideline Note 60 as presented. CARRIES 5-1 (Nay: Hodges)

Ø **Topic: 2020 Biennial Review: Reprioritization of liver transplant for hepatic malignancies**

Discussion: Smits reviewed the summary document. There were no questions or discussion.

Recommended Actions:

1) A new line for liver transplantation for hepatic malignancies was created as indicated below with the line scoring shown, effective January 2020

Line: XXX
Condition: CANCER OF LIVER OTHER THAN ANGIOSARCOMA (See Guideline Notes 64,65)
Treatment: LIVER TRANSPLANT
ICD-10: C22.0 [Liver cell carcinoma], C22.2 [Hepatoblastoma], C22.4 [Other sarcomas of liver], C22.7 [Other specified carcinomas of liver], C22.8 [Malignant neoplasm of liver, primary, unspecified as to type],T86.40-T86.49,Z48.23,Z51.11,Z52.6 [transplant rejection codes, post transplant care visit codes]
CPT: 47133-47147,86825-86835,93792,93793,98966-98969,99051,99060,99070,99078,99184, 99201-99239,99281-99285,99291-99404,99408-99449,99451,99452,99468-99480, 99487-99491,99495-99498,99605-99607
HCPCS: G0068,G0071,G0248-G0250,G0396,G0397,G0406-G0408,G0425-G0427,G0463-G0467,G0490,G0508-G0511,G0513,G0514,G2010-G2012

Line Scoring

	Line XXX
Category (Non-Fatal Condition)	6
Healthy Life Years (0-10)	7
Suffering (0-5)	4
Population effects (0-5)	0
Vulnerable population (0-5)	0
Tertiary prevention (0-5)	0
Effectiveness (0-5)	3
Need for service (0-1)	1
Net cost	0
Score	1320
Approximate line	264

2) The original line was modified as shown below, and kept at the current prioritization

Line: 560
Condition: ~~CANCER~~ ANGIOSARCOMA OF LIVER; ~~AND~~ INTRAHEPATIC BILE DUCT~~S~~ CARCINOMA
Treatment: LIVER TRANSPLANT
ICD-10: ~~C22.0 [Liver cell carcinoma],~~ C22.1 [Intrahepatic bile duct carcinoma], ~~C22.2 [Hepatoblastoma],~~ C22.3 [Angiosarcoma of liver], ~~C22.4 [Other sarcomas of liver], C22.7 [Other specified carcinomas of liver], C22.8 [Malignant neoplasm of liver, primary, unspecified as to type],~~T86.40-T86.49,Z48.23,Z51.11,Z52.6 [transplant care visit codes]
CPT: 47133-47147,86825-86835,93792,93793,98966-98969,99051,99060,99070,99078,99184, 99201-99239,99281-99285,99291-99404,99408-99449,99451,99452,99468-99480, 99487-99491,99495-99498,99605-99607
HCPCS: G0068,G0071,G0248-G0250,G0396,G0397,G0406-G0408,G0425-G0427,G0463-G0467,G0490,G0508-G0511,G0513,G0514,G2010-G2012

MOTION: To recommend the new line and line scoring, and modifications of the old line as presented. CARRIES 6-0.

Ø **Topic: Functional MRI (fMRI) and epilepsy surgery**

Discussion: Livingston presented the issue summary.

Dr. David Spencer, from OHSU, was introduced on the phone. He declared no conflict of interest. He shared that the existing test, the Wada test, which is considered the gold standard, has some inherent difficulties. Limitations of the Wada test have also impaired developing a robust evidence base for fMRI. They have seen some adverse effects such as small strokes. fMRI can sometimes provide more specific localizing information than the Wada test.

Olson asked what percentage of time do you use fMRI instead of Wada? Spencer stated it is used to determine whether the language hemisphere is dominant. He is quite confident it does a good job or is equivalent to the Wada test. There is still evolving evidence. The Wada test used to be applied to every patient about to undergo epilepsy surgery, but now it is applied more selectively. There are some cases where neither fMRI or Wada is necessary. Sometimes fMRI is preferred, and other times the Wada test is preferred.

Attention turned to the proposed guideline limiting use to identify the eloquent cortex. Spencer clarified that eloquent cortex is about whichever part of the brain is primarily responsible and is not limited to language. They only have about 10 cases per year. Hodges clarified what exactly would be on the chart notes, whether information about identifying eloquent cortex would be documented and Spencer confirmed it would in the neurologist's notes. Spencer discussed that there is evidence for motor mapping as well. He recommended staying with the more general term of eloquent cortex rather than limiting to language. Subcommittee members debated the need for the guideline.

MOTION: To recommend the code and guideline note addition as presented. FAILED 1-4. (Nay: Allen, Hodges, Irwin, Saboe; Abstained: Olson)

MOTION: To recommend the code changes without the guideline. CARRIES 6-0.

Recommended Actions:

1) Add the following CPT codes to Line 174 GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS Treatment: SINGLE FOCAL SURGERY
    a. CPT 70555 Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing
    b. CPT 96020 Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report
2) Remove the Line 660 entries for CPT codes 70555 and 96020
3) Leave 70554 (Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration) on Line 660, as it is not focused on language and does not involve physician or psychologist involvement

Ø **Topic: Injections for plantar fasciitis**

Discussion: Smits reviewed the summary document and noted that the podiatrists consulted on this topic agreed with the staff recommendation. There was no discussion.

Recommended Actions:

1) Add CPT 20550 (Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")) to line 537 LESION OF PLANTAR NERVE; PLANTAR FASCIAL FIBROMATOSIS, with the coding specification below:
    a. "CPT 20550 only appears on this line for corticosteroid injections."

MOTION: To recommend the code and coding specification changes as presented. CARRIES 6-0.

Ø **Topic: Radiofrequency ablation for knee osteoarthritis**

Discussion: Smits reviewed the summary document. There was no discussion.

Recommended Actions:

1) Add radiofrequency ablation (standard, cooled or cryoablation) for knee arthritis to line 660 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
2) Add an entry to Guideline Note 173 as shown in Appendix A

MOTION: To recommend the code and guideline note changes as presented. CARRIES 6-0.

Ø **Topic: Non-LANA certification for lymphedema therapy**

Discussion: Smits introduced the topic. There was general agreement that the requirement for LANA certification for lymphedema therapists should be broadened to include other certifications if LANA certified providers were not available. However, the manner of the wording of the guideline was debated. The current guideline restricts coverage to providers who are LANA certified, or who have graduated from a certified program in the last 2 years. This second provision is to allow providers who are in the process of getting enough hours to become LANA certified to provide care to OHP patients. However, the wording was felt to be problematic, and various wording revisions were suggested. The decision was to table this topic and have HERC staff work on revising the wording and bring back to the August VbBS meeting.

Recommended Actions:

1) Staff to work on revised language to the lymphedema therapy guideline and bring back to a future VbBS meeting

Ø **Topic: Preventive lymphedema treatment for high risk women**

Discussion: Smits reviewed the summary document; there was no discussion.

Recommended Actions:

1) Make no change to the current coverage of lymphedema and the current limitation to lymphedema therapy to those patients with diagnosed lymphedema

Ø **Topic: Pneumatic compression devices**

Discussion: Smits reviewed the summary document; there was no discussion.

Recommended Actions:

1) Add HCPCS E0650-E0673 and E0676 (Pneumatic compressor; Segmental pneumatic appliance for use with pneumatic compressor) to line 660 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS/GN173 as shown in Appendix A

MOTION: To recommend the code and guideline note changes as presented. CARRIES 6-0.

Ø **Public Comment:**

No additional public comment was received.

Ø **Issues for next meeting:**

- Non-LANA certification for lymphedema therapists

Ø **Next meeting:**

August 8, 2019 at Clackamas Community College, Wilsonville Training Center, Wilsonville Oregon, Rooms 111-112.

Ø **Adjournment:**

The meeting adjourned at 12:30 PM.

Appendix A

Revised Guideline Notes

GUIDELINE NOTE 60, OPIOIDS FOR CONDITIONS OF THE BACK AND SPINE

Lines 346,361,401,527

Opioid medications are only included on these lines under the following criteria:

For acute injury, acute flare of chronic pain, or after surgery:

1) During the first 6 weeks opioid treatment is included on these lines ONLY:
   a) When each prescription is limited to 7 days of treatment, AND
   b) For short acting opioids only, AND
   c) When one or more alternative first line pharmacologic therapies such as NSAIDs, acetaminophen, and muscle relaxers have been tried and found not effective or are contraindicated, AND
   d) When prescribed with a plan to keep active (home or prescribed exercise regime) and with consideration of additional therapies such as spinal manipulation, physical therapy, yoga, or acupuncture, AND
   e) There is documented verification that the patient is not high risk for opioid misuse or abuse.
2) Treatment with opioids after 6 weeks, up to 90 days after the initial injury/flare/surgery is included on these lines ONLY:
   a) With documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tools (e.g. Pain average, interference with Enjoyment of life, and interference with General activity" (PEG) Assessment Scale, Oswestry, Neck Disability Index, SF-MPQ, and MSPQ).
   b) When prescribed in conjunction with therapies such as spinal manipulation, physical therapy, yoga, or acupuncture.
   c) With verification that the patient is not high risk for opioid misuse or abuse. Such verification may involve
      i) Documented verification from the state's prescription monitoring program database that the controlled substance history is consistent with the prescribing record
      ii) Use of a validated screening instrument to verify the absence of a current substance use disorder (excluding nicotine) or a history of prior opioid misuse or abuse
      iii) Administration of a baseline urine drug test to verify the absence of illicit drugs and non-prescribed opioids.
   d) Each prescription must be limited to 7 days of treatment and for short acting opioids only
3) Long-term opioid treatment (>90 days) after the initial injury/flare/surgery is not included on these lines except for the taper process described below.

~~Transitional coverage for patients on long-term opioid therapy as of July 1, 2016:~~
~~For patients on covered chronic opioid therapy as of July 1, 2016, opioid medication is included on these lines only from July 1, 2016 to December 31, 2016. During the period from January 1, 2017 to December 31, 2017, continued coverage of opioid medications requires an individual treatment plan developed by January 1, 2017 which includes a taper with an end to opioid therapy no later than January 1, 2018 and include a taper goal to zero. Tapering should be unidirectional, generally with a 5-10% decrease monthly and can be paused or slowed if the prescriber believes this is medically appropriate. Taper plans must include nonpharmacological treatment strategies for managing the patient's pain based on Guideline Note 56 NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE. If a~~

~~patient has developed dependence and/or addiction related to their opioids, treatment is available on Line 4 SUBSTANCE USE DISORDER.~~

Transitional coverage for patients on long-term opioid therapy:
For patients receiving long-term opioid therapy (>90 days) for conditions of the back and spine, continued coverage of opioid medications requires an individual treatment plan which includes a taper plan *[when clinically indicated]*. Opioid tapering should be done on an individualized basis with a shared goal set by the patient and provider based on the patient's overall status. Taper plans should include nonpharmacological treatment strategies for managing the patient's pain. During the taper, behavioral health conditions need to be regularly assessed and appropriately managed. In some situations (e.g., in the setting of active substance use disorder, history of opioid overdose, aberrant behavior), more rapid tapering or transition to medication assisted treatment may be appropriate and should be directed by the prescribing provider. If a patient has developed *[an]* opioid use disorder, treatment is included on Line 4 SUBSTANCE USE DISORDER.

NOTE: Additional changes made at the May 16, 2019 HERC meeting are noted above in *[italics]*

GUIDELINE NOTE 103, BONE ANCHORED HEARING AIDS

Lines 311,444

Bone anchored hearing aids (BAHA, CPT 69714, 69715; HCPCS L8690-8694) are included on these lines when the following criteria are met:

A) The patient is aged 5-20 years for implanted bone anchored hearing aids; headband mounted BAHA devices may be used for children under age 5
B) Treatment is for unilateral severe to profound hearing loss when the contralateral ear has normal hearing with or without a hearing aid
C) Traditional air amplification hearing aids and contralateral routing of signal (CROS) hearing aid systems are not indicated or have been tried and are found to be not effective
D) Implantation is unilateral.

Use of BAHA for treatment of tinnitus is not covered

GUIDELINE NOTE 172, INTERVENTIONS WITH MARGINAL CLINICAL BENEFIT OR LOW COST-EFFECTIVENESS FOR CERTAIN CONDITIONS

Line 500

The following interventions are prioritized on Line 500 CONDITIONS FOR WHICH INTERVENTIONS RESULT IN MARGINAL CLINICAL BENEFIT OR LOW COST-EFFECTIVENESS:

69710 ~~HCPCS L8690-L8693~~	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone ~~Auditory osseointegrated device~~	Less effective than other therapies	June, 2014, Aug. 2015

Appendix A

GUIDELINE NOTE 173, INTERVENTIONS THAT ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS FOR CERTAIN CONDITIONS

Line 660

The following Interventions are prioritized on Line 660 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS:

Procedure Code	Intervention Description	Rationale	Last Review
E0650-E0673 and E0676	Pneumatic compressor Segmental pneumatic appliance for use with pneumatic compressor	Insufficient evidence of effectiveness	May, 2019
64640	Destruction by neurolytic agent; other peripheral nerve or branch	Insufficient evidence of effectiveness	May, 2019 (knee osteoarthritis)

MINUTES

HEALTH EVIDENCE REVIEW COMMISSION
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
May 16, 2019

Members Present: Kevin Olson, MD, Chair; Holly Jo Hodges, MD, Vice-Chair; Mark Gibson (departed at 3:30 pm); Leda Garside, RN, MBA; Angela Senders, ND; Gary Allen, DMD; Devan Kansagara, MD (arrived at 1:40 pm); Lynnea Lindsey, PhD; Leslie Sutton; Adriane Irwin, PharmD, Kevin Cuccaro, DO (by phone).

Members Absent: Michael Adler, MD.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Jason Gingerich; Daphne Peck.

Also Attending: Renae Wentz, MD, MPH, Dana Hargunani, MD, MPH and Lisa Shields (Oregon Health Authority); Laura Ocker, LAc; Mary Kelly Rolf; Douglas Carr, MD (Umpqua Health); Rika Bierek; Kelly Howard; Amara M and Wendy Sinclair (Oregon Pain Action Group); Kathy Spain; Noel Elliot; Joe Elliot; Jay Hall, Amit Shah, Marine Schmitt and Kali Schweitzer (CareOregon); Kim Blood (WVP Health Authority); Cherry Amabisca; Sue Griffin; Laurel Ramy; Kristian Foden-Vencil (OPB); Julia; Alan Chino, Ph.D.; Jacqueline Conner; Barbara C.; Tina M. Stanfa (Kieser); Jessica Riegel.

Call to Order

Kevin Olson, Chair of the Health Evidence Review Commission (HERC), called the meeting to order; roll was called.

Minutes Approval

MOTION: To approve the minutes of the 3/14/2019 meeting as presented. CARRIES 10-0. *(Absent: Kansagara)*

Director's Report

Staff changes:
Coffman said this meeting will be Wally Shaffer's last. He thanked him for his years or service. He will be missed.

Membership
Coffman said Dr. Kathryn Schabel, who has been serving on the Health Technology Assessment Subcommittee (HTAS), has been appointed to HERC and confirmed by the Senate. She is an orthopedic surgeon.

Legislative Reports
A draft biennial report is being worked on, waiting for the decisions of today's meeting. It will also be finalized and off to the Legislature soon.

The report on Extended Stay Centers is up for review today as part of the HTAS report and will be finalized and formatted for release to the Legislature soon.

Coverage guidance update
A topic, *Sacral Nerve Stimulation for Non-Obstructive Urinary Retention,* was approved in 2017 as a coverage guidance topic. There is good evidence from trusted sources showing that this is a good topic to handle at the Value-based Benefits Subcommittee (VbBS) level.

MOTION: To move the topic of Sacral Nerve Stimulation for Non-Obstructive Urinary Retention from HTAS to VbBS and not conduct a coverage guidance process. CARRIES 12:0.

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes
Meeting materials pages 44-225

Reprioritization of Certain Chronic Pain Conditions
Meeting materials pages 88-225

Dr. Dana Hargunani thanked the Commission for allowing a pause in their deliberations to allow for the third-party review. She has been pleased by the appraisal assessment by Aggregate Analytics Incorporated (AAI). She said her task to do a complete review of the conflict of interest policies is underway.

Hargunani thanked the staff and the members of the Chronic Pain Task Force (CPTF) who worked on this topic for +18 months. She thanked the public who have had tremendous engagement on this topic from near and far. This input, both from personal accounts and from professionals, has contributed significantly to the Commission's work.

She said the Commission was looking at opening the back-pain guideline, particularly around opioid prescribing. There is forthcoming evidence expected to be published later this year and expect to re-open the topic this coming winter.

Hargunani said OHA, separate from HERC, is developing a task force around opioid prescribing guidelines.

Dr. Andrea Skelly then gave a presentation on AAI's evidence appraisal. There were no questions from the Commission.

Smits gave a brief presentation (meeting materials, pages 88-112) of the history of the topic and summarized the options before the Commission. She said VbBS looked at rescoring the line for the 5 conditions under consideration and the prioritization level did not change, therefore they did not recommend moving it into the funded region. VbBS's recommendation is to adopt *OPTION 1: Do not reprioritize chronic pain syndrome, fibromyalgia and related conditions due to lack of evidence of*

effectiveness of available treatment modalities. Consider readdressing the prioritization of these conditions as part of the 2022 or 2024 Biennial Review.

Sutton asked if we wait, when would changes be effective? Smits said the next time we are able to add and move lines would be effective in 2022.

Public Comment:
Dr. Amit Shah, CareOregon, declared no conflicts of interest. He said he supports the VbBS recommendation of Option 1, to not reprioritize the 5 chronic pain conditions due to weak evidence. Adding coverage would add significant expense in medication costs and harms. His Coordinated Care Organization (CCO) has seen a great number of ICU admissions secondary to opioid prescription use.

Dr. Douglas Carr, CEO of Umpqua Health, the CCO for Douglas County, declared no conflicts of interest. He supports the VbBS recommendation of Option 1, to not reprioritize the 5 chronic pain conditions. He supports the changes to Guideline Note 60, abolishing the mandatory taper as well as allowing for short-term opioid flares. He looks forward to the winter review of the back-pain lines and alignment with the Oregon Opioid Prescribing Guidelines.

Cherry Amabisca, declared no conflicts of interest. She spoke about her brother's struggles with forced tapers. She urged the Commission to retroactively rescind Guideline Note 60 and to eliminate any part of the proposals that endorse mandatory tapers.

Sue Griffin is a chronic pain patient. She has many pain conditions and has needed greater than 90 MME to control her pain. She has been on OHP and had her medication tapered lower. She recommends adding massage to the treatment protocol.

Amara M, co-founder of the Oregon Pain Action Group, a volunteer, declared no conflicts of interest. She said she is encouraged that the Commission is re-opening Guideline Note 60 for conditions of the back and spine. She noted the AAI report found that the evidence studied was found inconclusive to exclude the use of opioids for the treatment of fibromyalgia. She asked that opioids for fibromyalgia be covered. She said she is in favor of Option 3C. She asked the Commission to consider additional opioid prescribing for flares.

Kelly Howard declared no conflicts of interest. She talked about flares leading to a decrease in a patient's quality of life and physiological condition. She said she has tried non-opioid treatments to little success. She said there is no real evidence proving that treating flares with short-term opioids is harmful. The CDC and the FDA have recently come out to say they did not mean to direct force-tapers, nor tapers to zero.

Wendy Sinclair thanked the Commission for agreeing to revisit Guideline Note 60. She questioned why the CPTF proposal went on so long if the conditions didn't warrant being brought above the line. She feels they are valid medical conditions that need medical treatment and that opioids should be allowed. After reading through the AAI report, she asked the Commission to vote in favor of Option 3C.

Laura Ocker, declared conflicts of interest that she works full time at a Federally Qualified Health Center, is past-president of the Association of Acupuncture and Oriental Medicine, and is a part-time advisor to a study that is evaluating the back-pain changes that were implemented under OHP. She was also a member of the Chronic Pain Task Force and a past-VbBS member. She said she submitted a CMS Bulletin

dated February 2019 on opioid prescribing and wanted to make sure the Commission got that. She said that her intent on the CPTF was to open access to effective non-pharmalogical therapies for patients with chronic pain.

Julia said she has been following this topic for the past 18 months. She said she is glad the advocates have been able to prevent the Commission from voting for the past year. She supports Option 3C. She said she does not support tapers or trying to force people under 90 MME. She said she had never heard the Commission discuss the difference between addiction and dependence. She said not everyone who uses opioids is an addict.

Dr. Alan Chino identified himself as a clinical health psychologist who served two terms on the Oregon Pain Management Commission and a pain specialist and declared no conflicts of interest. He believes forced tapers are dangerous. People who are monitored in a multi-disciplinary way tend to do well on long-term opioids. He supports Option 3C and believes fibromyalgia should be above the line.

Jacqueline Conner declared no conflicts of interest. She is a pain patient. She said none of us can escape our own bias; we come at this from a human standpoint. This is a quality of life issue. She said she was force-tapered in 10 days based on her doctor saying she had to do what the CDC recommended. It took the CDC 3-years to come out and clarify their position. She said decisions like the one the Commission faces today cause patients to be abandoned by doctors and causes suicides.

Tina M. Stanfa is a chronic pain patient who has had many medical issues. She has been in chronic pain since 14-years old. She has tried every modality and they have not been effective. She said the CDC guideline started a problem that should never had happened. She said people who are not trained to prescribe pain medication should not make decisions about prescribing pain medications. She has had her medication cut in half which is only enough to just get by. She supports Option 3C.

Jay Hall has a genetic disease causing tumors all over his body and has had multiple surgeries. As a consequence of those surgeries he has been left with chronic pain. He was seen at the Mayo clinic and prescribed high doses opioids; his Oregon doctor tapered him off. He echoed the AAI presentation by saying statistical significance does not equal clinical effectiveness. He mentioned the CDC's recent clarification of their tapering statement.

Jessica Riegel is a chronic pain patient who is being treated with chiropractic and acupuncture. The number of treatments is very limited. She is totally off opioids. She has been granted more visits in the past but in the length of time it took to get the authorization she wound up in the emergency department. She advocated looking at patients on an individual basis.

Olson said public testimony and input has helped shape the conversation around this complicated topic.

Olson reviewed the prioritization methodology. Smits led a discussion about reprioritization of the five conditions. She showed the line scoring that VbBS recommends be used. They thought the best scores were to give a "4" to healthy life years, a "3" to suffering, a "0" to tertiary prevention (due to being unsure if treatment of chronic pain prevents development of any condition), a "1" to effectiveness and a "0.8" to need for service. These scores result in a line score of 112, which would keep any new line at about line 528, the current location of these conditions. Since the rescoring did not move the line, the VbBS voted 6-0 in favor of Option 1, which makes no change to coverage for these five specific chronic pain conditions.

Discussion:
Gibson said we use the prioritization methodology to treat everyone fairly, consistently and equitably. Given that there is high-quality research available to us soon VbBS felt that maintaining stasis was a legitimate conclusion to our deliberation.

Lindsey said this decision is not a hard-stop and the new studies may shift the paradigm of how we have this discussion in the future. She said that "no change" really isn't "no change" – we are going to get there.

Kansagara said he appreciated all the public testimony. He said he struggled with the scoring, particularly around effectiveness, suffering and vulnerable populations. It seems incongruent with the public testimony heard. The numbers seem subjective.

Hodges said VbBS went through the scoring very carefully in the morning meeting, striving for consistency with other conditions that scored similarly. For example, they scored the suffering category the same as the score for rheumatoid arthritis.

Kansagara asked if the Commission voted for Option 1, would there be any forced tapering requirement for these conditions. Hodges and Olson said no, it would just mean that the five unfunded conditions would remain unfunded.

Lindsey said she struggles with the lack of non-pharmalogical treatments for those who have had trauma and vulnerable pain patients. If we put this off another two years we are delaying access to patients who might benefit. She said she struggles with the issue of having lack of evidence for interventions that she has seen be effective in her clinical practice. Olson said there is a similar issue in oncology. There are interventions that work 10% of the time, but for those for whom it is effective it is a great intervention. To determine the 10%, it takes studies.

Allen said testimony heard from medical directors that the costs are not inconsequential.

MOTION: To accept the VbBS recommendation of Option 1, to table the CPTF report and make no changes to the Prioritized List at this time. CARRIES: 12-0.

Guideline Note 60 Discussion:
Smits said this guideline outlines when opioids would be covered for back and neck conditions. There is a section on acute prescribing and a section stating there should be no chronic prescribing. It stated if a patient were on long-term opioids they should be tapered off. The history of this decision is that the Back Pain Reprioritization Task Force found lack of evidence of benefit for long-term opioid use and found evidence of harms. The Task Force wrote a tapering plan so patients would not be cut-off without a taper, giving them an 18-month window. The Chronic Pain Task Force suggested to strike the language allowing for prescribing of opioids for flares. VbBS does not support that suggestion given that the topic will be opened again when the new studies are out this winter.

HERC's staff developed wording for the guideline for consideration. After a brief discussion about tapering, the Commission members edited the language slightly as listed below:

Transitional coverage for patients on long-term opioid therapy:
For patients receiving long-term opioid therapy (>90 days) for conditions of the back and spine, continued coverage of opioid medications requires an individual treatment plan which includes a taper plan when clinically indicated. Opioid tapering should be done on an individualized basis with a shared goal set by the patient and provider based on the patient's overall status. Taper plans should include nonpharmacological treatment strategies for managing the patient's pain. During the taper, behavioral health conditions need to be regularly assessed and appropriately managed. In some situations (e.g., in the setting of active substance use disorder, history of opioid overdose, aberrant behavior), more rapid tapering or transition to medication assisted treatment may be appropriate and should be directed by the prescribing provider. If a patient has developed an opioid use disorder, treatment is included on Line 4 SUBSTANCE USE DISORDER.

Coffman noted, if approved, this change would go into effect with the implementation of the next Prioritized List on October 1, 2019.

MOTION: To approve the amended language in Guideline Note 60 for patients on long-term opioid therapy as stated. CARRIES: 11-0 (*Absent: Gibson)*

Other VbBS Recommendations:
Ariel Smits reported the VbBS met earlier in the day, 5-16-2019. She summarized the subcommittee's recommendations.

RECOMMENDED CODE MOVEMENT (effective 10/1/2019)
- Add the procedure code for injections for plantar fasciitis to an uncovered line
- Add the procedure code for radiofrequency ablation for knee osteoarthritis to an uncovered line
- Add the procedure code for pneumatic compression devices for lymphedema therapy to an uncovered line
- Make various straightforward coding changes

RECOMMENDED GUIDELINE CHANGES (effective 10/1/2019)
- Make various straightforward guideline note changes

2020 BIENNIAL REVIEW (effective January 1, 2020)
- Create a new line for liver transplantation for hepatic malignancies in the funded region

MOTION: To accept the other VbBS recommendations on Prioritized List changes as stated. See the VbBS minutes of 5/16/2019 for a full description. Carries: 11-0. *(Absent: Gibson)*

Evidence-based report on Ambulatory Surgery Centers with Extended Stay Centers: Appropriate Procedures and Patient Characteristics
Meeting materials, pages 226-291

Shaffer gave a history of the report. Shaffer and Obley presented an overview of the evidence. Shaffer then read the proposed guideline from HTAS.

Shaffer reported on HB 2717, which is a bill that would eliminate the requirement for ASCs and ESCs to file ASC discharge abstract records with the Oregon Health Authority (OHA). Reports would still go to the Oregon Patient Safety Commission (OPSC), who would release its data to OHA. The bill has new timelines; HERC is to develop evidence-based guidelines by July 1, 2022 and to update those guidelines by July 1, 2025 based on data collected by the OPSC. The bill has passed through the House Health Care Committee and is in the Ways and Means Committee; it has not yet gone to the Senate. It may be amended along the way or may not be enacted at all.

There was no discussion.

MOTION: To approve the proposed report for Ambulatory Surgery Centers with Extended Stay Centers: Appropriate Procedures and Patient Characteristics as presented. Carries 11-0. *(Absent: Gibson)*

Approved Guideline:

> *Thus we conclude, in the presence of an ESC, the surgical services provided in an ASC should be for patients not requiring hospitalization and for whom the expected duration of services in the ASC would not exceed 24 hours after an admission to the ASC. The presence of an ESC should not expand the surgical risk profile or the procedures permissible in an ASC. ESCs should be utilized for patients who need extra time for managing pain or bodily functions, who do not have a caregiver at home, or who may require extended travel time to return home after a surgical procedure.*

Other topics: Coverage Guidance Topics

Smits said there are a few coverage guidance topics to address:

- Intermittent Pneumatic Compression Devices for the Treatment of Lymphedema
  - This topic was addressed at today's VbBS meeting
- Liposuction for the Treatment of Lymphedema
  - After staff review, no coverage guidance or prioritization change needed
- Extracorporeal Membrane Oxygenation
  - After staff review, evidence is not likely to produce a recommendation that would effectively reduce inappropriate utilization without adversely impacting patients who would need it
- Acellular Dermal Matrix for Post-Mastectomy Breast Reconstruction
  - VbBS would like to address this at the August 2019 meeting
- Interventional Treatments for Lower Extremity Chronic Venous Disease
  - VbBS would like to address this at the August 2019 meeting

MOTION: To remove these topics as potential coverage guidances. Carries 11-0. *(Absent: Gibson)*

Coffman said new potential coverage guidance topics will be presented in August.

Adjournment

Meeting adjourned at 4:30 pm. Next meeting will be from 1:30-4:30 pm on Thursday, August 8, 2019 at Clackamas Community College Wilsonville Training Center, Rooms 111-112, Wilsonville, Oregon.

Coverage Guidance Topics

Health Technology Assessment Subcommittee:

6/20/2019 Spinal Cord Stimulators for Chronic Back Pain
New Topics

9/19/2019 Spinal Cord Stimulators for Chronic Back Pain

Evidence-based Guidelines Subcommittee

6/6/19 Planned Out-of-Hospital Birth
New topics

9/12/2019 Planned Out-of-Hospital Birth
Multisector Interventions to Reduce the Frequency of Asthma Exacerbations

Drug Use Research & Management (DURM) Program

Roger Citron, RPh

May P&T Committee OHA Approved Recommendations

https://www.oregon.gov/OHA/HSD/OHP/Pages/PT-Committee.aspx

Approved May 29, 2019

Gonadotropin-Releasing Hormone (GnRH) Modifiers

- Add the class to the Practitioner-Managed Prescription Drug Plan (PMPDP) and designate all agents as non-preferred

Combination Biologic Therapy Drug Use Evaluation (DUE)

- Update PA criteria to include a maximum dose for patients with rheumatoid arthritis prescribed tofacitinib and to reinforce periodic tuberculosis testing
- Develop a RetroDUR provider education on DMARD adherence

Attention Deficit Hyperactivity Disorder (ADHD) DUE

- Continue to monitor use of ADHD medications
- Consider provider education on importance of diagnosis and assessment for patients with treatment-resistant ADHD symptoms and those at an increased risk of substance misuse
- Develop a RetroDUR to evaluate combination of stimulant and antipsychotic medications

Schizophrenia RetroDUR Proposal

- Implement a retrospective initiative to notify providers when patients on routine therapy for schizophrenia miss a medication refill

Asthma / COPD Class Update and New Drug Evaluation (NDE)

- Update PA criteria to remove references to guideline classifications of COPD
- After comparative cost consideration in executive session:
  - make Dulera, Tudorza, and Asmanex preferred

Migraine Treatment and Prevention DERP Summary

- Make no changes to the PMPDP based on clinical evidence
- After comparative cost consideration in executive session:
  - make sumatriptan succinate syringe and zolmitriptan tablets, rapid tablets and nasal spray preferred

Calcitonin gene-related peptide Inhibitors DERP Summary

- No changes to the PMPDP were recommended based on review of the evidence
- Change duration of approval for renewal criteria to 6 months
- After comparative cost consideration in executive session:
  - maintain all agents in the class as non-preferred

Potassium Exchangers Class Update

- Add sodium zirconium cyclosilicate to patiromer PA criteria to insure appropriate utilization for FDA-approved indications
- Remove requirement for trial and failure of kayexlate because of the acute indication for kayexlate and black box warning
- After comparative cost consideration in executive session:
  - make patiromer non-preferred
  - maintain sodium zirconium cyclosilicate as non-preferred

Other Dyslipidemia Drugs Class Update

- Update PA criteria to be consistent with the new evidence for use of non-statins to prevent ASCVD events
- Retire the PA criteria for lomitapide and mipomersen due to no utilization
- Make gemfibrozil non-preferred due to safety concerns with use in combination with statin therapy
- After comparative cost consideration in executive session:
  - make ezetimibe and evolocumab preferred

July P&T Committee Draft Documents

https://pharmacy.oregonstate.edu/drug-policy/oregon-pharmacy-therapeutics-committee/meetings-agenda

- Draft P&T documents are posted and comments will be accepted until 6/21/2019
- Meeting scheduled on 7/25/2019 from 1:00 – 5:00pm @ DXC Building

Questions?

SUPPORT for Patients and Communities Act of 2018

Deborah ("Dee") Weston
Pharmacy Programs Policy Advisor
June 10, 2019

HEALTH POLICY and ANALYTICS
Office of Delivery System Innovation

SUPPORT Act - background

- **S**ubstance **U**se-disorder **P**revention that **P**romotes **O**pioid **R**ecovery and **T**reatment **for Patients and Communities Act**
- Signed into law October 2018, effective October 1, 2019
- Broad impact, includes Sec. 1004 Medicaid DUR
  (→ **see excerpt in packet**)
- Cut off CMS efforts to develop minimum standards

Impact to Medicaid Pharmacy

- By Oct. 1, 2019 states must set minimum statewide DUR standards that apply program wide (including MCOs) in 3 areas:
  - state-defined limitation for opioid refills
  - maximum daily morphine equivalent
  - concurrent use with a benzodiazepine *or* antipsychotic
- Additional requirements apply to state Medicaid agencies only
- CMS promises guidance "this spring"

OHA progress thus far…

1. Multiple discussions in CCO Pharmacy Directors' meetings, including a May work session
2. Each CCO identified safety edits and claims review processes already in place (or expected by Oct. 1)
   (→ **see packet**)
3. Currently looking for common themes to develop **meaningful** and **achievable** minimum standards
4. Nothing proposed thus far as we wait for CMS guidance

Thank You

Deborah "Dee" Weston
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I. State Medicaid programs must have in place the following, AND must require MCOs to also have in place the following Claims Review Limitations:

(I) opioid refills above a state-defined limitation

	Safety Edits	Claims Review Automated Process
CASCADE HEALTH ALLIANCE	All Rx's over a 7-day supply require a PA. Duration is not currently defined.	Claims in excess of a 7-day supply will reject at the POS and require a PA. Pharmacist will need to contact CHA for an override.

(II) maximum daily morphine equivalent for treatment of chronic pain

	Safety Edits	Claims Review Automated Process
CASCADE HEALTH ALLIANCE	Opioid dose limit of 90MEDD currently in effect.	Claims for opioid prescriptions exceeding the 90MEDD threshold will require a PA.

(III) monitor when a client is concurrently prescribed opioids + benzodiazepines

	Claims Review Automated Process
CASCADE HEALTH ALLIANCE	All first fills for clonazepam in excess of 30 days require a PA. No edits currently in place for concurrent prescribing with opioids.

(III) monitor when a client is concurrently prescribed opioids + antipsychotics

	Claims Review Automated Process
CASCADE HEALTH ALLIANCE	Antipsychotics are carved out; no current edits in place for concurrent prescribing with opioids.

II. Additional requirements for states that are **not explicitly applied to MCOs**:

(B) Program to monitor and manage the appropriate use of **antipsychotic medications by Medicaid children**. Applied to Medicaid kids in general age 18 or below, and specifically to children in foster care.

	Claims Review Automated Process
CASCADE HEALTH ALLIANCE	No edits currently in place due to carve out of antipsychotics.

(C) Process that "identifies **potential fraud or abuse of controlled substances**" by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies.

	Claims Review Automated Process
CASCADE HEALTH ALLIANCE	Currently have a "lock-in" program for patients receiving controlled substances from multiple providers and /or using multiple pharmacies.

One Hundred Fifteenth Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Wednesday, the third day of January, two thousand and eighteen

An Act

To provide for opioid use disorder prevention, recovery, and treatment, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act" or the "SUPPORT for Patients and Communities Act".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

under this subsection after the submission of such interim report; and

"(III) evaluating such demonstration project.

"(C) AHRQ REPORT.—Not later than 3 years after the date of the enactment of this subsection, the Director of the Agency for Healthcare Research and Quality, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall submit to Congress a summary on the experiences of States awarded planning grants under paragraph (3) and States selected under paragraph (4).

"(7) DATA SHARING AND BEST PRACTICES.—During the period of the demonstration project under this subsection, the Secretary shall, in collaboration with States selected under paragraph (4), facilitate data sharing and the development of best practices between such States and States that were not so selected.

"(8) CMS FUNDING.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $5,000,000 to the Centers for Medicare & Medicaid Services for purposes of implementing this subsection. Such amount shall remain available until expended.".

SEC. 1004. MEDICAID DRUG REVIEW AND UTILIZATION.

(a) MEDICAID DRUG UTILIZATION REVIEW.—

(1) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 1001, is further amended—

(A) in paragraph (83), at the end, by striking "and";

(B) in paragraph (84), at the end, by striking the period and inserting "; and"; and

(C) by inserting after paragraph (84) the following new paragraph:

"(85) provide that the State is in compliance with the drug review and utilization requirements under subsection (oo)(1).".

(2) DRUG REVIEW AND UTILIZATION REQUIREMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 1001, is further amended by adding at the end the following new subsection:

"(oo) DRUG REVIEW AND UTILIZATION REQUIREMENTS.—

"(1) IN GENERAL.—For purposes of subsection (a)(85), the drug review and utilization requirements under this subsection are, subject to paragraph (3) and beginning October 1, 2019, the following:

"(A) CLAIMS REVIEW LIMITATIONS.—

"(i) IN GENERAL.—The State has in place—

"(I) safety edits (as specified by the State) for subsequent fills for opioids and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the State plan (or under a waiver of the State plan) is prescribed a subsequent fill of opioids in excess of any limitation that may be identified by the State;

"(II) safety edits (as specified by the State) on the maximum daily morphine equivalent that

can be prescribed to an individual enrolled under the State plan (or under a waiver of the State plan) for treatment of chronic pain and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the plan (or waiver) is prescribed the morphine equivalent for such treatment in excess of any limitation that may be identified by the State; and

"(III) a claims review automated process (as designed and implemented by the State) that monitors when an individual enrolled under the State plan (or under a waiver of the State plan) is concurrently prescribed opioids and—

"(aa) benzodiazepines; or

"(bb) antipsychotics.

"(ii) MANAGED CARE ENTITIES.—The State requires each managed care entity (as defined in section 1932(a)(1)(B)) with respect to which the State has a contract under section 1903(m) or under section 1905(t)(3) to have in place, subject to paragraph (3), with respect to individuals who are eligible for medical assistance under the State plan (or under a waiver of the State plan) and who are enrolled with the entity, the limitations described in subclauses (I) and (II) of clause (i) and a claims review automated process described in subclause (III) of such clause.

"(iii) RULES OF CONSTRUCTION.—Nothing in this subparagraph may be construed as prohibiting a State or managed care entity from designing and implementing a claims review automated process under this subparagraph that provides for prospective or retrospective reviews of claims. Nothing in this subparagraph shall be understood as prohibiting the exercise of clinical judgment from a provider enrolled as a participating provider in a State plan (or waiver of the State plan) or contracting with a managed care entity regarding the best items and services for an individual enrolled under such State plan (or waiver).

"(B) PROGRAM TO MONITOR ANTIPSYCHOTIC MEDICATIONS BY CHILDREN.—The State has in place a program (as designed and implemented by the State) to monitor and manage the appropriate use of antipsychotic medications by children enrolled under the State plan (or under a waiver of the State plan) and submits annually to the Secretary such information as the Secretary may require on activities carried out under such program for individuals not more than the age of 18 years generally and children in foster care specifically.

"(C) FRAUD AND ABUSE IDENTIFICATION.—The State has in place a process (as designed and implemented by the State) that identifies potential fraud or abuse of controlled substances by individuals enrolled under the State plan (or under a waiver of the State plan), health care providers prescribing drugs to individuals so enrolled, and pharmacies dispensing drugs to individuals so enrolled.

"(D) REPORTS.—The State shall include in the annual report submitted to the Secretary under section 1927(g)(3)(D) information on the limitations, requirement, program, and processes applied by the State under subparagraphs (A) through (C) in accordance with such manner and time as specified by the Secretary.

"(E) CLARIFICATION.—Nothing shall prevent a State from satisfying the requirement—

"(i) described in subparagraph (A) by having safety edits or a claims review automated process described in such subparagraph that was in place before October 1, 2019;

"(ii) described in subparagraph (B) by having a program described in such subparagraph that was in place before such date; or

"(iii) described in subparagraph (C) by having a process described in such subparagraph that was in place before such date.

"(2) ANNUAL REPORT BY SECRETARY.—For each fiscal year beginning with fiscal year 2020, the Secretary shall submit to Congress a report on the most recent information submitted by States under paragraph (1)(D).

"(3) EXCEPTIONS.—

"(A) CERTAIN INDIVIDUALS EXEMPTED.—The drug review and utilization requirements under this subsection shall not apply with respect to an individual who—

"(i) is receiving—

"(I) hospice or palliative care; or

"(II) treatment for cancer;

"(ii) is a resident of a long-term care facility, of a facility described in section 1905(d), or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

"(iii) the State elects to treat as exempted from such requirements.

"(B) EXCEPTION RELATING TO ENSURING ACCESS.—In order to ensure reasonable access to health care, the Secretary shall waive the drug review and utilization requirements under this subsection, with respect to a State, in the case of natural disasters and similar situations, and in the case of the provision of emergency services (as defined for purposes of section 1860D–4(c)(5)(D)(ii)(II)).".

(3) MANAGED CARE ENTITIES.—Section 1932 of the Social Security Act (42 U.S.C. 1396u–2) is amended by adding at the end the following new subsection:

"(i) DRUG UTILIZATION REVIEW ACTIVITIES AND REQUIREMENTS.—Beginning not later than October 1, 2019, each contract under a State plan with a managed care entity (other than a primary care case manager) under section 1903(m) shall provide that the entity is in compliance with the applicable provisions of section 438.3(s)(2) of title 42, Code of Federal Regulations, section 483.3(s)(4)) of such title, and section 483.3(s)(5) of such title, as such provisions were in effect on March 31, 2018.".

(b) IDENTIFYING AND ADDRESSING INAPPROPRIATE PRESCRIBING AND BILLING PRACTICES UNDER MEDICAID.—

(1) IN GENERAL.—Section 1927(g) of the Social Security Act (42 U.S.C. 1396r–8(g)) is amended—

(A) in paragraph (1)(A)—

(i) by striking "of section 1903(i)(10)(B)" and inserting "of section 1902(a)(54)";

(ii) by striking ", by not later than January 1, 1993,";

(iii) by inserting after "gross overuse," the following: "excessive utilization,"; and

(iv) by striking "or inappropriate or medically unnecessary care" and inserting "inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization"; and

(B) in paragraph (2)(B)—

(i) by inserting after "gross overuse," the following: "excessive utilization,"; and

(ii) by striking "or inappropriate or medically unnecessary care" and inserting "inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect with respect to retrospective drug use reviews conducted on or after October 1, 2020.

SEC. 1005. GUIDANCE TO IMPROVE CARE FOR INFANTS WITH NEONATAL ABSTINENCE SYNDROME AND THEIR MOTHERS; GAO STUDY ON GAPS IN MEDICAID COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN WITH SUBSTANCE USE DISORDER.

(a) GUIDANCE.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidance to improve care for infants with neonatal abstinence syndrome and their families. Such guidance shall include—

(1) best practices from States with respect to innovative or evidenced-based payment models that focus on prevention, screening, treatment, plans of safe care, and postdischarge services for mothers and fathers with substance use disorders and babies with neonatal abstinence syndrome that improve care and clinical outcomes;

(2) recommendations for States on available financing options under the Medicaid program under title XIX of such Act and under the Children's Health Insurance Program under title XXI of such Act for Children's Health Insurance Program Health Services Initiative funds for parents with substance use disorders, infants with neonatal abstinence syndrome, and home-visiting services;

(3) guidance and technical assistance to State Medicaid agencies regarding additional flexibilities and incentives related to screening, prevention, and postdischarge services, including parenting supports, and infant-caregiver bonding, including breastfeeding when it is appropriate; and

(4) guidance regarding suggested terminology and ICD codes to identify infants with neonatal abstinence syndrome and neonatal opioid withdrawal syndrome, which could include opioid-exposure, opioid withdrawal not requiring

I. State Medicaid programs must have in place the following, AND must require MCOs to also have in place the following Claims Review Limitations:

(I) opioid refills above a state-defined limitation

	Safety Edits	Claims Review Automated Process
ADVANCED HEALTH	Advanced Health has implemented a prior authorization requirement for use of any opioid greater than #60 tablets within a 180 day period A prior authorization is required for initial fill of any long acting opioid	A prior authorization is automatically required for any opioid prescription that exceeds #60 tablets within a 180 day period. This is a cumulative total of tablets within a 180 day period.
ALLCARE HEALTH PLAN	Limit of 1 short-acting opioid rx [up to plan QL (≤90MME/d) and ≤7 day supply] every 60 days without prior authorization.	All claims for short-acting opioids beyond plan limit and all formulary long-acting opioids are automatically flagged to require prior authorization.
CASCADE HEALTH ALLIANCE	[forthcoming]	[forthcoming]
COLUMBIA PACIFIC	All preferred long-acting opioids require Prior Authorization (PA). The duration of treatment is reviewed and determined based on established criteria. CO does not have fill limits in place for opioids naïve patients. CO evaluated restricting number of fills for opioids naïve patients. The complex coding and rejections at Point of Service (POS) may create unintended barrier to access opioids for safe and appropriate use. Will have max 7 day first fill limit for opioid naïve.	Preferred long-acting opioids are rejected at POS unless there is previous approval in place. Soft claim reject for first opioid (in 120 days) prescription if greater than 7 - day supply per fill.
EASTERN OREGON	EOCCO has a 30 day limit on fills at point of sale pharmacy. There are no limits on opioid refills that are within MME, quantity, or do not flag for other UM.	Review of MME and UM against FDA prescribing guidelines, Prioritized List, and clinical criteria.
FFS	FFS has implemented a max duration of opioid therapy at 150 days for short-acting opioids. No defined duration of therapy limit set for preferred long-acting opioids. Considering feasibility and implementation of a soft pharmacy edit which would send a message to the pharmacy/pharmacist	Opioid claims for FFS patients beyond 150 days of therapy are automatically flagged to require prior authorization. No defined duration of therapy limit set for preferred long-acting opioids.

(I) opioid refills above a state-defined limitation

	when a patient is prescribed more than 7-30 days of opioid therapy.	
HEALTH SHARE - Care Oregon	All preferred long-acting opioids require Prior Authorization (PA). The duration of treatment is reviewed and determined based on established criteria. CO does not have fill limits in place for opioids naïve patients. CO evaluated restricting number of fills for opioids naïve patients. The complex coding and rejections at Point of Service (POS) may create unintended barrier to access opioids for safe and appropriate use. Will have max 7 day first fill limit for opioid naïve.	Preferred long-acting opioids are rejected at POS unless there is previous approval in place. Soft claim reject for first opioid (in 120 days) prescription if greater than 7 - day supply per fill.
HEALTH SHARE – Kaiser	Refill threshold is currently set at 95% for all Schedule II-IV controlled substances. Claims submitted before 95% of previous fill would be exhausted, as prescribed, will deny at the point of sale as “refill too soon”.	Refill threshold is currently set at 95% for all Schedule II-IV controlled substances. Claims submitted before 95% of previous fill would be exhausted, as prescribed, will deny at the point of sale as “refill too soon”.
HEALTH SHARE – Providence	Providence Health Assurance (PHA) has a 7-day initial fill limit for opioid naïve members based on CDC recommendations (in place since 1/1/19). Dispensing pharmacists can override if patient is not opioid naïve, in cancer, palliative or hospice related pain. Patients are not limited to a 7-day supply on subsequent fills. We do not currently have a max duration of opioid therapy for preferred short or long acting opioids.	The 7-day opioid limit is automated at point of sale. Dispensing pharmacist has ability to override with PPS/DUR codes if appropriate. Exploring max duration of short acting opioids for future- to align with state recommendations.
HEALTH SHARE – Tuality	THA currently has a 7 day limit per prescription of short acting opiates for up to 4 prescriptions per month. THA will implement a max duration of opioid therapy at 150 days for short-acting opioids by 10/1/19. Preferred long-acting opioids are restricted to prior authorization.	Opioid claims for THA patients beyond 150 days of therapy will reject and the automatic edit will require a prior authorization as of 10/1/19.
INTERCOMMUNITY HEALTH NETWORK	[forthcoming]	[forthcoming]

(I) opioid refills above a state-defined limitation

JACKSON CARE CONNECT	All preferred long-acting opioids require Prior Authorization (PA). The duration of treatment is reviewed and determined based on established criteria. CO does not have fill limits in place for opioids naïve patients. CO evaluated restricting number of fills for opioids naïve patients. The complex coding and rejections at Point of Service (POS) may create unintended barrier to access opioids for safe and appropriate use. Will have max 7 day first fill limit for opioid naïve.	Preferred long-acting opioids are rejected at POS unless there is previous approval in place. Soft claim reject for first opioid (in 120 days) prescription if greater than 7 - day supply per fill.
PACIFICSOURCE - CENTRAL OREGON - COLUMBIA GORGE	Chronic use of opioids with a Morphine Milligram Equivalents (MME) per day greater than 100 MME is not funded by PacificSource. Safety edits are in place to prevent early refills. Members are reviewed on a continual basis to confirm subsequent fills do not exceed quantity limits, CDC guidelines, or FDA limits.	Claims reject and require a prior authorization for coverage if a member has a fill history exceeding 100 MME in the last 60 days.
PRIMARYHEALTH OF JOSEPHINE COUNTY	By 10/1/2019 plan on having 7-day restriction on initial prescriptions of opioids. Currently have quantity restrictions (59 per 30 days requires a PA).	Currently review all opioid claims that are deemed chronic (59 per 30 day supply).
TRILLIUM COMMUNITY HEALTH	TCHP implemented an edit of max duration of 120 tablets per day of opioid therapy per 120 days at the end of 2017. After the 1st fill of 120 tablets, or multiple fills equaling 120 tablets in fewer than 120 days, the subsequent prescriptions are flagged for PA.	Trillium is in consideration of changing point of sale (POS) edits to MED from # of tablets. We receive monthly and quarterly reports of DUR edits from CVS which can include both the soft or hard edits. We are currently in discussion of the ideal MED level to implement with soft/hard edits to encourage safety, while minimizing member disruption.
UMPQUA HEALTH ALLIANCE	UHA has implemented a max duration of opioid therapy of 30 days every 180 days without prior authorization.	Opioid claims for UHA patients beyond 30 days of therapy are automatically flagged to require prior authorization.
WILLAMETTE VALLEY COMMUNITY HEALTH	There are currently quantity limits, duration limits and age limits on opioid analgesic medications.	Pharmacy claims for opioids for members without prior claims will allow to process for up to two 7day fills every 6 months. There are also 30 day limit QL for all opioids. If a member exceeds the monthly QL or a total of 14 days of opioid therapy, it will prompt for a prior authorization. All extended release formulations and high dose immediate release formulations of opioid therapy require prior authorization for claims processing.

(I) opioid refills above a state-defined limitation

		There are age edits on most opioid therapies.
YAMHILL COMMUNITY CARE	Yamhill Community Care (YCC) has a 7-day initial fill limit for opioid naïve members based on CDC recommendations (in place since 1/1/19). Dispensing pharmacists can override if patient is not opioid naïve, in cancer, palliative or hospice related pain. Patients are not limited to a 7-day supply on subsequent fills. We do not currently have a max duration of opioid therapy for preferred short or long acting opioids.	The 7-day opioid limit is automated at point of sale. Dispensing pharmacist has ability to override with PPS/DUR codes if appropriate. Exploring max duration of short acting opioids for future- to align with state recommendations.

(I) opioid refills above a state-defined limitation

	Safety Edits	Claims Review Automated Process
ADVANCED HEALTH	A maximum MED of 50 is currently in place, however, exceptions may be requested to this limit through the PA process and medical review	MED is calculated during the prior authorization review process (it is not automated at the point of sale pharmacy benefit level)
ALLCARE HEALTH PLAN	All requests for chronic pain require PA review and are limited to 90 mg morphine equivalent per day for all opioids combined (IR/ER).	Claims that exceed plan limit reject at pharmacy point-of-sale.
CASCADE HEALTH ALLIANCE		
COLUMBIA PACIFIC	There is a current soft reject at 90 MED cross-claim for opioid experienced users. There will be a soft reject at 50 MED for first opioid fill. There is a hard rejection at 120 MED for IR individual strengths.	Soft rejection if cross claim total is >90mg daily Morphine Equivalent Dose (MED). Soft rejection if first opioid fill (in 120 days) is >50mg MED. Each IR strength is coded to limit the number of tablets equivalent to 120mg MED. PA is required when MED is exceeded.
EASTERN OREGON	EOCCO has a 120 MME soft POS edit, 200 MME hard POS edit in place.	Soft edit can be overridden at POS by the dispensing pharmacist. Both can be reviewed against clinical criteria for approval.
FFS	Currently in effect; FFS has set an opioid dose limit at 90 daily morphine equivalents for each opioid prescription. Currently there are no cumulative edits which evaluate dose limits for multiple prescriptions.	Currently in effect; FFS opioid claims greater than 90 daily morphine equivalents are automatically flagged to require prior authorization.
HEALTH SHARE - Care Oregon	There is a current soft reject at 90 MED cross-claim for opioid experienced users. There will be a soft reject at 50 MED for first opioid fill. There is a hard rejection at 120 MED for IR individual strengths.	Soft rejection if cross claim total is >90mg daily Morphine Equivalent Dose (MED). Soft rejection if first opioid fill (in 120 days) is >50mg MED. Each IR strength is coded to limit the number of tablets equivalent to 120mg MED. PA is required when MED is exceeded.
HEALTH SHARE – Kaiser	Goal to reduce daily morphine equivalent to lowest effective dose if appropriate to continue to for	Cumulative Morphine Milligram Equivalent (MME) >90 mg edit currently set at the PBM. Opioid claims for
HEALTH SHARE – Providence	Currently quantity limits on individual opioids are set at a MME of 120.	Claims will hard block and require PA when individual quantity limits are exceeded.

	Cumulative point of sale (POS) safety limits set at MME 90. Dispensing pharmacists can override at point of sale if dose has been confirmed to be appropriate.	Plan to change the cumulative MME 90 POS edit to a hard block with PA review and will eliminate individual drug quantity limits to avoid duplicative review. Goal for 10/1/19 go live -working on implementation plan and feasibility.
HEALTH SHARE – Tuality	Currently in effect; THA has set an opioid dose limit at 90 daily morphine equivalents for each opioid prescription.	Currently in effect; THA has set an automated edit to limit opioid doses to 90 daily morphine equivalents for each opioid prescription Currently THA has cumulative edits which evaluate dose limits for multiple prescriptions.
INTERCOMMUNITY HEALTH NETWORK		
JACKSON CARE CONNECT	There is a current soft reject at 90 MED cross-claim for opioid experienced users. There will be a soft reject at 50 MED for first opioid fill. There is a hard rejection at 120 MED for IR individual strengths.	Soft rejection if cross claim total is >90mg daily Morphine Equivalent Dose (MED). Soft rejection if first opioid fill (in 120 days) is >50mg MED. Each IR strength is coded to limit the number of tablets equivalent to 120mg MED. PA is required when MED is exceeded.
PACIFICSOURCE - CENTRAL OREGON - COLUMBIA GORGE	Chronic use of opioids with a Morphine Milligram Equivalents (MME) per day greater than 100 MME is not funded by PacificSource. Safety edits are in place to prevent early refills. Members are reviewed on a continual basis to confirm subsequent fills do not exceed quantity limits, CDC guidelines, or FDA limits.	Claims reject and require a prior authorization for coverage if a member has a fill history exceeding 100 MME in the last 60 days.
PRIMARYHEALTH OF JOSEPHINE COUNTY	90 MED	Currently review all opioid claims that are above 90MED.
TRILLIUM COMMUNITY HEALTH	All Long Acting opioid prescriptions require PA. All patients using opioids for chronic pain were pre-approved by PA, or tapering plan. Safety edits are in consideration for members not approved by PA.	Trillium contracts with Envolve pharmacy solutions to utilize an electronic claim adjudication process incorporating 'edits' from Medispan. They then provide automated reports to Trillium for review. Trillium is in the process of modifying selection of edits and RetroDur activities with go live date set prior to 10/1/19. Goal date 7/1/19.
UMPQUA HEALTH ALLIANCE	Currently in effect; UHA has set an cumulative opioid dose limit at 90 daily morphine equivalents.	Currently in effect;

(II) maximum daily morphine equivalent for treatment of chronic pain

		UHA opioid claims greater than 90 daily morphine equivalents, cumulatively across any opiate, are automatically flagged to require prior authorization.
WILLAMETTE VALLEY COMMUNITY HEALTH	MED edits are managed through quantity limits on the formulary. Currently there is an edit in place to prevent members being able to hop from dose to dose or drug to drug to bypass the quantity limits.	There are quantity limits in place on all opioid analgesics. High dose immediate release opioids require prior authorization (hydromorphone 8mg, oxycodone 20mg, 30mg, etc.)
YAMHILL COMMUNITY CARE	Currently quantity limits on individual opioids are set at a MME of 120. Cumulative point of sale (POS) safety limits set at MME 90. Dispensing pharmacists can override at point of sale if dose has been confirmed to be appropriate.	Claims will hard block and require PA when individual quantity limits are exceeded. Plan to change the cumulative MME 90 POS edit to a hard block with PA review and will eliminate individual drug quantity limits to avoid duplicative review. Goal for 10/1/19 go live -working on implementation plan and feasibility

(II) maximum daily morphine equivalent for treatment of chronic pain

	Claims Review Automated Process
ADVANCED HEALTH	This is reviewed through the prior authorization process and medication lists included in submitted chart notes. As benzodiazepines (with the exception of clonazepam) are covered through the FFS mental health carve-out, there is not currently an automated process for identifying concurrent use of opioids and benzodiazepines
ALLCARE HEALTH PLAN	RetroDUR program is currently under development; will be in effect by 10/1/19.
CASCADE HEALTH ALLIANCE	
COLUMBIA PACIFIC	[Safety edit: A soft Drug Utilization Review (DUR) rejection occurs if the following medications are detected along with the opioid claim: clonazepam.] Soft DUR reject if identified. Retrospectively CPCCO uses internal quarterly opioid report to identify patients with concurrent opioids and benzodiazepines use. These patients are flagged in Premanage.
EASTERN OREGON	No current edits in place for Medicaid. Can be captured as part of targeted MUE.
FFS	RetroDUR program is currently under development; will be in effect by 10/1/19. Patients who are prescribed concurrent opioids and benzodiazepines who are also at higher risk for sedative overdose will be identified weekly via an automated retrospective data pull and a patient-specific letter will be sent to the prescriber to notify and educate them on the risk of sedative overdose. Program is not currently designed to apply to ALL patients prescribed concurrent opioids and benzodiazepines, only those identified as having a higher risk for sedative overdose. An automated quarterly report will track the number of providers notified and the number of Medicaid patients prescribed concurrent opioids and benzodiazepines. Any new start benzodiazepine prescribed longer than 30 days requires a PA. An evaluation of concurrent opioid prescribing is required for every PA. Currently evaluating system requirements needed to implement point-of-sale edits and pharmacy messaging when opioids/benzodiazepines or opioids/antipsychotics are prescribed concurrently. Ongoing conversations with CCOs to evaluate and identify opportunities for coordination and collaboration. CCOs are currently sent a daily list of paid FFS claims for their members to facilitate coordination of care for member with claims paid for by both FFS and a CCO.
HEALTH SHARE - Care Oregon	[Safety Edit: A soft Drug Utilization Review (DUR) rejection occurs if the following medications are detected along with the opioid claim: clonazepam.] Soft DUR reject if identified. Retrospectively CO uses internal quarterly opioid report to identify members with concurrent opioids and benzodiazepines use. The information are shared with major network partners through an opioids dashboard. The dashboard includes both rate of co-prescribing per clinic as well as a member list that flags co-prescribing.

HEALTH SHARE – Kaiser	[Safety edit: The rate of members >90 MED and the rate of members >50 MED with benzodiazepines are tracked. PMG uses a multidisciplinary team to review patients on >90 MED or on >50 MED with benzodiazepines.] Exploring ways to utilize FFS data with our PHA data as safety tool. Rely on our pharmacy networks to monitor safety and drug interactions when MCO physical medicine plan is separate from FFS mental health plan for benefit administration. A retrospective DUR program is being explored.
HEALTH SHARE – Providence	[Safety edit: The rate of members >90 MED and the rate of members >50 MED with benzodiazepines are tracked. PMG uses a multidisciplinary team to review patients on >90 MED or on >50 MED with benzodiazepines.] Exploring ways to utilize FFS data with our PHA data as safety tool. Rely on our pharmacy networks to monitor safety and drug interactions when MCO physical medicine plan is separate from FFS mental health plan for benefit administration. A retrospective DUR program is being explored.
HEALTH SHARE – Tuality	THA regularly receives a raw data file from Health Share which lists all members who are prescribed benzodiazepines. We are incorporating that data with our own opioid data to monitor members who are concurrently prescribed opioids and benzodiazepines and notify their PCPs
INTERCOMMUNITY HEALTH NETWORK	
JACKSON CARE CONNECT	[Safety edit: A soft Drug Utilization Review (DUR) rejection occurs if the following medications are detected along with the opioid claim: clonazepam.] Soft DUR reject if identified.
PACIFICSOURCE - CENTRAL OREGON - COLUMBIA GORGE	--
PRIMARYHEALTH OF JOSEPHINE COUNTY	By 10/1/2019 will monitor and restrict concurrent use of clonazepam with opioids. Other benzodiazepines fall under 7/11 carve out and need to go to FFS for monitoring.
TRILLIUM COMMUNITY HEALTH	CDUR and RetroDur activities will extend to review of opioids and benzodiazepines as described above. 7/1/19 goal implementation date.
UMPQUA HEALTH ALLIANCE	Opioid and benzodiazepine prior authorization criteria does not allow payment for concurrent opioid and benzodiazepine use. Pharmacy staff look at both UHA and FFS claims for benzodiazepines since some are covered by each entity.
WILLAMETTE VALLEY COMMUNITY HEALTH	Currently this is not performed as the DMAP file of claims is not incorporated into the workflow for processing prior authorization for claims. In looking at the file format that is received by the CCO, there are many data elements included that are not useful and missing data elements that would be useful. There are no headers on the columns for the data that are sent to the CCOs for review. By best guess, the following information missing from the file: • Medication strength • MD full name • MD NPI number

(III) monitor when a client is concurrently prescribed opioids + benzodiazepines

	• MD DEA number (if has one) In addition, the format of the file is not easily compatible with our workflow processes. We are able to convert it to excel. Is it possible for the state to send the information in the excel format or for the CCOs to send their claims data to the state (which is already occurring) to monitor for these groups? Other questions that will need to be answered: Concurrent use of antipsychotics and BZD is found, who will need to be notified, will there be requirements for follow-up if no change is made? Both state to monitor…to whom will it fall to monitor the therapy.
YAMHILL COMMUNITY CARE	Exploring ways to utilize FFS data with our YCC data as safety tool. Rely on our pharmacy networks to monitor safety and drug interactions when MCO physical medicine plan is separate from FFS mental health plan for benefit administration. A retrospective DUR program is being explored.

(III) monitor when a client is concurrently prescribed opioids + benzodiazepines

	Claims Review Automated Process
ADVANCED HEALTH	We do not currently have a process for monitoring concurrently prescribed opioids and antipsychotics, as all antipsychotics are covered through the FFS mental health carve out
ALLCARE HEALTH PLAN	RetroDUR program is currently under development; will be in effect by 10/1/19.
CASCADE HEALTH ALLIANCE	
COLUMBIA PACIFIC	NA
EASTERN OREGON	EOCCO does not process claims for antipsychotics and has no edits in place.
FFS	Program is currently under development; will be in effect by 10/1/19. Similar program as described for opioids and benzodiazepines. Patients at high risk for sedative overdose who are prescribed concurrent opioids and sedating antipsychotics will be identified weekly via an automated retrospective data pull and a patient-specific letter will be automatically sent to the prescriber to notify them about the risk of sedative overdose. An automated quarterly report will track the number of providers notified and the number of Medicaid patients prescribed concurrent opioids and antipsychotics. Similar to above, CCOs are sent a weekly list of paid FFS claims for their members to facilitate coordination of care for member with claims paid for by both FFS and a CCO.
HEALTH SHARE - Care Oregon	NA
HEALTH SHARE – Kaiser	PHP unable to monitor, as antipsychotics are covered under DMAP.
HEALTH SHARE – Providence	PHP unable to monitor, as antipsychotics are covered under DMAP.
HEALTH SHARE – Tuality	THA regularly receives a raw data file from Health Share which lists all members who are prescribed antipsychotics. While this has not been an area of focus related to opioid prescribing, we will work to incorporate this data with our own opioid data so that we can monitor members who are concurrently prescribed opioids and antipsychotics and notify their PCPs. This will be complete well before 10/1/19.
INTERCOMMUNITY HEALTH NETWORK	
JACKSON CARE CONNECT	NA
PACIFICSOURCE - CENTRAL OREGON - COLUMBIA GORGE	--
PRIMARYHEALTH OF JOSEPHINE COUNTY	Falls under 7/11 carve out and need to go to FFS for monitoring.

TRILLIUM COMMUNITY HEALTH	Accurate automated reporting for antipsychotics may provide to be more challenging –due to medications being provided by FFS and opioids by Trillium. –meeting to discuss with PBM set 5/28/19; alternatively- internal reporting is available and RetroDur Policy will be followed for this metric prior to 10/1/19
UMPQUA HEALTH ALLIANCE	Not applicable- antipsychotics are covered under FFS (DMAP).
WILLAMETTE VALLEY COMMUNITY HEALTH	See response for opioids + benzos
YAMHILL COMMUNITY CARE	YCC unable to monitor, as antipsychotics are covered under DMAP

(III) monitor when a client is concurrently prescribed opioids + antipsychotics

II. Additional requirements for states that are **not explicitly applied to MCOs**:

(B) Program to monitor and manage the appropriate use of **antipsychotic medications by Medicaid children**. Applied to Medicaid kids in general age 18 or below, and specifically to children in foster care.

	Claims Review Automated Process
EASTERN OREGON	Not applicable to EOCCO as all fills are through Open Card.
FFS	Program is currently in effect for foster care children and under development for other Medicaid children less than 10 years of age; will be in effect by 10/1/19. As currently designed, this program will not apply to children 11-18 years of age or children prescribed less than 6 months of an antipsychotic. Program will refer children on long-term antipsychotics (>6 months of therapy) to specialists for expert review. Patient profiles will be sent to Oregon's free psychiatric access line (OPAL-K) and their staff will reach out to prescribers to discuss optimal therapy for the patient. An automated quarterly report will evaluate the overall number of children prescribed antipsychotics, number of patients referred for expert review, and the number of children with changes in therapy after referral. CCOs are currently sent a weekly list of paid FFS claims for their members to improve coordination of care for children receiving antipsychotics.
PACIFICSOURCE - CENTRAL OREGON - COLUMBIA GORGE	PacificSource's programs ensure psychotropic medications that are covered through the CCO are used for medically accepted indications. These programs include managing a closed prescription formulary, point of sale DUR edits, active review of FWA, and prior authorization requirements for drugs that have a high-risk for being used in non-medically accepted ways. In addition, PacificSource manages a DUR committee that reviews trends for outlier prescribers and medication use. Children (including those in the custody of DHS) that are identified as potentially benefiting from coordination and provision of other mental health services are prioritized for case management.
TRILLIUM COMMUNITY HEALTH	Program is in development for PMUR- with initial reporting to determine scope (all children vs focus on foster children). The date of an automated report of medical, pharmacy and other clinical histories including laboratory work will be screened for need to referral for follow up. Provider outreach will be conducted via fax. Members will be offered assistance with barriers (such as laboratory work) via case management). Implementation target is prior to 10/1/19.

(B) Program to monitor and manage the appropriate use of **antipsychotic medications by Medicaid children**.

(C) Process that "identifies **potential fraud or abuse of controlled substances**" by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies.

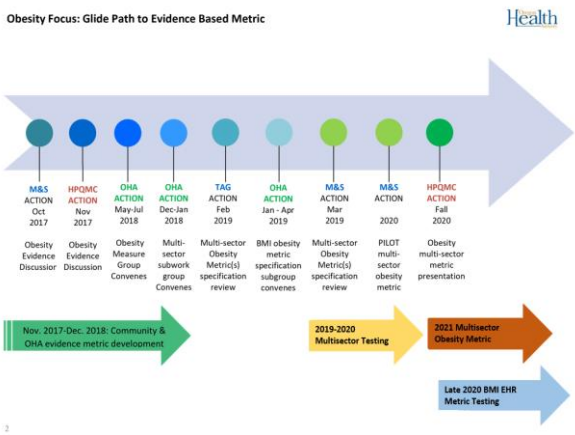
	Claims Review Automated Process
EASTERN OREGON	EOCCO has enhanced FWA monitoring through our PBM, not specific to controlled substances.
FFS	Program currently in effect to identify fraud or abuse by Medicaid clients; No specific FFS programs evaluate fraud or abuse specifically for enrolled prescribers or pharmacies. The pharmacy lock-in program retrospectively identifies patients who receive controlled substances from multiple pharmacies and providers. Patients are prioritized according to the number of pharmacies visited and patient profiles of those with the highest number are reviewed quarterly by a pharmacist. If fraud or abuse is suspected based on claims data, the patient is "locked in" and required to fill prescriptions at a single pharmacy. Oregon has a statewide prescription drug monitoring program (PDMP). Pharmacies in the state are required to report any dispensed controlled substance (schedules II, III, and IV) to the PDMP within 72 hours of dispensing. Pharmacists and Oregon-licensed healthcare providers may be authorized for an account to access information from the PDMP and can evaluate controlled substances dispensed to their patients. Currently FFS does not have access to PDMP data, but several PA criteria (opioid and benzodiazepine) require that the provider attests to review of the PDMP for their member.
PACIFICSOURCE - CENTRAL OREGON - COLUMBIA GORGE	PacificSource in combination with CVS Caremark oversite FWA through an enhanced safety and monitoring system that triggers based on outlier filling patterns.
PRIMARYHEALTH OF JOSEPHINE COUNTY	We currently use Medimpact to monitory FWA of controlled and non-controlled medications.
TRILLIUM COMMUNITY HEALTH	POS drug edits: "Apparent Drug Misuse" will be implemented. Review of monthly report will be reviewed and trended by plan pharmacists in addition to the "Opioid Profiling" report which identifies the top opioid providers to verify medical appropriateness of recent therapy.

Obesity Metric:
Multisector Intervention for Obesity Prevention and Treatment

Cat Livingston, MD, MPH

Quality Health Outcomes Committee
June 10, 2019

Oregon Health Authority



Obesity Glidepath Workgroup: Recommended Obesity Metric

Child and adult obesity
- Ages 3 and up

Two part measure

- Part 1: Investments in multisector interventions
- Part 2: Document BMI and referral to intervention; follow-up on referral

Multisector Interventions for Obesity: Technical Specification Workgroup Members

Name	Affiliation
Tom Jeanne, MD, MPH	Deputy State Health Officer Oregon Health Authority, Public Health Division
Lisa Bui, MBA	Quality Improvement Director Oregon Health Authority, Health Policy and Analytics
Miriam D. McDonell, MD	Health Officer North Central Public Health District Wasco Childhood Obesity Reduction Community Action Plan
Cat Livingston, MD, MPH	Associate Medical Director Health Evidence Review Commission
Jen Johnstun	Primary Health of Josephine County
Staff	Lena Teplitsky, Public Health Division Shira Pope, Public Health Division Todd Beran, Public Health Division Kristin Tehrani, Health Policy and Analytics Valerie Stewart, Health Policy and Analytics

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Support for this metric

✓Presentations to **TAG:**

- **August 2018**
  - TAG supports one bundled measure with two parts that are rolled out separately over three years.
  - Glide path to introduce Part 1/ multisector interventions in 2021 (year 1) and add BMI measurement change to the measure in 2023 (year 3)
- **February 2019 and May 2019**
  - Presented draft technical specifications
  - Support for direction of multisector intervention part of metric
  - Suggestions on metric attestation method
  - Pilot proposal review

✓Presentations to **Metrics and Scoring Committee**

- **November 2018:** supports moving forward with two-part measure
- **March 2019**
  - Presented draft technical specifications,
  - Suggestions on metric attestation method

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Attestation Model Proposal

❖ **Attestation Model based upon a point system across five areas:**

- Coverage and promotion to adult and pediatric intensive supports
- Root cause analysis and actions plans
- Community engagement
- Multisector interventions
- Foundational criteria

❖ **Model based upon HERC evidence review guidance.**

❖ **Escalating point system across multiple years.**

❖ **Model proposed as result of TAG feedback.**

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Attestation Point System Proposal

Area	Specific interventions	Point value
Clinical attestations	Adult intensive intervention covered and available (e.g., National Diabetes Prevention Program)	4
	Pediatric intensive intervention covered and available	4
	Adult benefit is promoted to providers and to CCO members (families, patients). Promotions to CCO members should incorporate health literacy strategies.	2
	Pediatric benefit is promoted to providers and to CCO members (families, patients). Promotions to CCO members should incorporate health literacy strategies	2
Root cause analysis and action plans	Root cause analysis completed	1
	Action plan developed and/or integrated into Community Health Improvement Plan (CHIP) related to obesity	2
	Engaging Community Advisory Councils in soliciting feedback on obesity interventions	1

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Attestation Point System Proposal

Community Engagement – broader structure by which to address obesity and offer sustainability of interventions	Significant community engagement that involves active participation and investment in regional community mobilization around obesity (e.g. coalitions on obesity prevention) ○ Name at least 2 community organizations with whom you have partnered on obesity work ○ How is this sustainable? ○ Financial support ○ Staffing support	5
Multisector Interventions		
	School and childcare setting intervention (choose 2) • In order to get 10 points, interventions collectively must address physical activity and nutrition	5 per MSI intervention
	Community/policy level intervention (choose 2) • In order to get 10 points, interventions collectively must address physical activity and nutrition	5 per MSI intervention

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Attestation Point System Proposal

Annual point requirements

Year	Minimum required points
Year 1	**11**
Year 2	**19**
Year 3	**27** (Must have 12 points from clinical)
Year 4	**35** (Must have 12 points from clinical)
Year 5	**40** (Must have 12 points from clinical)

Total available points is 41

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MSI Foundational Criteria

Foundational Criteria	Requirement
Multisector interventions must **reach ≥ 10%** of the CCO member population	Must pass by end of Year 4
At least one Multisector Intervention must specifically **address disparities**	Must pass by end of Year 4
Interventions must separately, or in combination, address both children and adults, **across the lifespan** (including pre-pregnancy and prenatal periods)	Must pass by end of Year 4

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Multisector interventions to slow the increase of obesity

1: School and childcare-based interventions

- School and childcare-based interventions to reduce BMI and prevent obesity
- School nutrition policy and day care meal standards
- Family-based group education programs
- Obesity prevention interventions in childcare settings (nutrition education, healthy cooking classes for children ages 2–6, physical activity and playful games)

Example MSIs:

- CATCH (Coordinated Approach to Child Health)
- Youth Fit 4 Life
- Safe Routes to Schools

11 https://www.oregon.gov/oha/HPA/DSI-HERC/EvidenceBasedReports/Evidence-review-Multisector-Interventions.pdf

Multisector interventions to slow the increase of obesity

2: Community-level/policy interventions

- Environmental interventions in the workplace
- Community-based health education and counseling interventions
- Interventions to reduce sedentary screen time (in some studies, also to increase physical activity and nutrition)

Example MSIs:

- Benefit coverage of evidence-based self-management programs (Diabetes Self-Management Program, Diabetes Self-Management Education, Walk with Ease, etc.)
- Complete Streets policies
- Sugar sweetened beverage price increases

12 https://www.oregon.gov/oha/HPA/DSI-HERC/EvidenceBasedReports/Evidence-review-Multisector-Interventions.pdf

Community-based individual interventions to slow the increase of obesity

3: Adult and pediatric intensive supports *(3-part attestation)*

1. Covering both adult and pediatric intensive supports listed below, and
2. Outreach/promotion of the benefits to providers and members, and
3. Referral to and follow-through to adult and pediatric supports.

Example adult intensive supports:
- National Diabetes Prevention Program
- Weight Watchers

Example pediatric intensive supports:
- MEND (Mind, Exercise, Nutrition, Do It)
- Bright Bodies/Smart Moves

[13] https://www.oregon.gov/oha/HPA/DSI-HERC/EvidenceBasedReports/Evidence-review-Multisector-Interventions.pdf

What's Next

CCO Survey

GOAL: to collect data from CCOs about what they are currently doing related to Obesity Prevention and Treatment for their members, the barriers/challenges related to this work, and what resources are needed for technical assistance.

Data collected from the survey:
- will inform and help to refine the attestation process.
- will contribute to a menu of strategies that CCOs can choose from to implement as part of the metric.

Survey logistics:
- This survey will take place between June 14 – July 19, 2019.
- This survey can be completed by multiple CCO staff.
- Survey will be distributed via QHOC and TAG members.

Proposed Obesity MSI Metric Pilot

GOAL: OHA would like to gather the following information from CCOs to inform the MSI component of the obesity metric.

This pilot will focus on the attestation process for the metric:

- Current CCO engagement in obesity prevention and treatment initiatives/strategies.
- Barriers/challenges with collecting data and attesting to metric criteria
- What kind of support will be needed for CCOs that are currently doing this work and CCOs not yet doing this work?

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Obesity Metric: Multisector Interventions
Attestation Point System Proposal

Area	Specific interventions	Point value
Clinical attestations	Adult intensive intervention covered and available (e.g., National Diabetes Prevention Program)	4
	Pediatric intensive intervention covered and available	4
	Adult benefit is promoted to providers and to CCO members (families, patients). Promotions to CCO members should incorporate health literacy strategies.	2
	Pediatric benefit is promoted to providers and to CCO members (families, patients). Promotions to CCO members should incorporate health literacy strategies	2
Root cause analysis and action plans	Root cause analysis completed	1
	Action plan developed and/or integrated into Community Health Improvement Plan (CHIP) related to obesity	2
	Engaging Community Advisory Councils in soliciting feedback on obesity interventions	1
Community Engagement – broader structure by which to address obesity and offer sustainability of interventions	Significant community engagement that involves active participation and investment in regional community mobilization around obesity (e.g. coalitions on obesity prevention) o Name at least 2 community organizations with whom you have partnered on obesity work o How is this sustainable? o Financial support o Staffing support	5
Multisector Interventions	School and childcare setting intervention (choose 2) • In order to get 10 points, interventions collectively must address physical activity and nutrition	5 per MSI intervention
	Community/policy level intervention (choose 2) • In order to get 10 points, interventions collectively must address physical activity and nutrition	5 per MSI intervention
Foundational criteria	Multisector interventions must reach ≥ 10% of the CCO member population	Must pass by end of Year 4
	At least one Multisector Intervention must specifically address disparities	Must pass by end of Year 4
	Interventions must separately, or in combination, address both children and adults, across the lifespan (including pre-pregnancy and prenatal periods)	Must pass by end of Year 4

Year	Minimum required points
Year 1	**11**
Year 2	**19**
Year 3	**27** (Must have 12 points from clinical)
Year 4	**35** (Must have 12 points from clinical)
Year 5	**40** (Must have 12 points from clinical)

Total available points: 41

DRAFT Obesity Multisector Interventions survey for CCOs

The goal of this survey is to collect baseline data from CCOs about current efforts related to Obesity Prevention and Treatment for Medicaid members, the barriers/challenges related to this work, and what resources may be needed for technical assistance.

This data will help inform:

- Development of the potential evidence-based obesity multisector intervention metric
- Refinement of the proposed attestation process for the obesity MSI metric
- Development of a menu of interventions/strategies CCOs can choose from to support metric implementation, as based on the HERC's Prioritized List Multisector Interventions for Obesity guidance

A few notes:

- Multiple staff from a CCO can respond to this survey. There is no limit to the number of responses per CCO. CCO staff expertise and knowledge will determine how many questions they will respond to. There is not an expectation that every respondent will answer every question.
- Please provide as much or as little detail as appropriate.
- Survey responses will be aggregated so that no individual CCO will be identified. We are asking for CCO names so we can link multiple responses from the same CCO.

---

1. What CCO do you represent? (**required**) _____

Clinical Interventions:

Adults – Coverage and Access:

2. Is your CCO currently **covering and providing access** to adult intensive interventions for obesity prevention and treatment? If yes, please check all that apply in the table below. If no, please check the box in the last row.

	Program/Initiative for prevention or treatment of obesity
	Traditional clinical interventions (e.g. dietician or nurse with intensive clinic-based appointments)
	National Diabetes Prevention Program
	Weight Watchers
	Obesity Treatment through Behavioral Coaching
	PILI Lifestyle Program (PLP)
	Weight Loss for Life
	Coach Approach

	Other:
	Our CCO is not currently covering and providing access to adult intensive interventions for obesity prevention and treatment.

IF 2="Yes"

2a. Please list which CPT codes are used by your CCO for the adult intensive counseling benefit.

Resume asking all

3. What are the current barriers/challenges with **providing coverage and access** to adult intensive interventions for obesity prevention and treatment?

4. What technical assistance resources would be helpful to address intervention **coverage and access** for adult obesity prevention and treatment strategies for your CCO?

Adults – Promotion:

5. Is your CCO currently **promoting** adult intensive interventions for obesity prevention and treatment?
    a. Yes
    b. No

If 5="Yes"

5a. Please provide detail on how your CCO is **promoting** adult intensive interventions for obesity prevention and treatment:

Resume asking all

6. What are the current barriers/challenges with **promoting** to adult intensive interventions for obesity prevention and treatment?

7. What technical assistance resources would be helpful to address intervention **promotion** for adult obesity prevention and treatment strategies for your CCO?

Children – Coverage and Access:

8. Is your CCO currently **covering and providing access** to pediatric intensive interventions for obesity prevention and treatment? If yes, please check all that apply in the table below. If no, please check the box in the last row.

	Program/Initiative for prevention or treatment of obesity
	Traditional clinical interventions (e.g. dietician or nurse with intensive clinic-based appointments)
	MEND (Mind, Exercise, Nutrition, Do it)
	Bienestar Health Program
	Bright Bodies/Smart Moves
	Strong Fast Fit at YWCA
	Other:
	Our CCO is not currently covering and providing access to pediatric intensive interventions for obesity prevention and treatment.

IF 8="Yes"

8a. Please list which CPT codes are used by your CCO for the adult intensive counseling benefit.

Resume asking all

9. What are the current barriers/challenges with **providing coverage and access** to pediatric intensive interventions for obesity prevention and treatment?

10. What technical assistance resources would be helpful to address pediatric obesity prevention and treatment strategies for your CCO?

11. Is your CCO currently **promoting** child intensive interventions for obesity prevention and treatment?
    a. Yes
    b. No

If 11="Yes"

11a. Please provide detail on how your CCO is **promoting** child intensive interventions for obesity prevention and treatment:

Resume asking all

12. What are the current barriers/challenges with **promoting** to child intensive interventions for obesity prevention and treatment?

13. What technical assistance resources would be helpful to address intervention **promotion** for child obesity prevention and treatment strategies for your CCO?

Multi-Sector Interventions (MSIs):

School and childcare settings:

14. Is your CCO currently engaged in any MSIs in a school or childcare setting? If yes, please check all that apply in the table below. If no, please check the box in the last row.

	Program/Initiative	Issue addressed	Setting
	CATCH (Coordinated Approach to Child Health)	Physical activity, nutrition	School
	Youth Fit 4 Life	Physical activity, nutrition	School
	MEND (Mind, Exercise, Nutrition, Do it)	Physical activity, nutrition, self-esteem	School, community
	Bienestar Health Program	Physical activity, nutrition, diabetes prevention	School, community
	BOKS	Physical activity, nutrition	School
	PHIT Kids	physical activity; nutrition	community/schools
	Start For Life	Physical activity	Pre-school
	Behavioral interventions to reduce sedentary screen time	Physical activity	School/community
	Safe Routes to School	Physical activity	School, community
	Strengthen Nutrition Standards/School Health Guidelines	Physical activity, nutrition	School, child care
	Strengthen Food and Beverage Marketing and Promotion Policies	Nutrition	School, child care
	Other:		
	Our CCO is not currently engaged in MSIs in a school or childcare setting		

15. What are the current barriers/challenges to conducting MSIs in school or childcare settings?

16. What technical assistance resources for MSIs in school or childcare settings would be helpful to address obesity prevention and treatment?

Community/policy level:

17. Is your CCO currently engaged in any MSIs at the community or policy level? If yes, please check all that apply in the table below. If no, please check the box in the last row.

	Program/Initiative	**Issue addressed**	**Setting**
	Blue Zones	Physical activity; nutrition	Transportation; workplace; retail; parks and recreation
	HEAL Cities	Physical activity; nutrition	Transportation; workplace; parks and recreation
	Bright Bodies/Smart Moves	Physical activity; nutrition	Community; clinic
	MEND (Mind, Exercise, Nutrition, Do it)	Physical activity; nutrition; self-esteem	Transportation; community; faith based; clinics
	Bienestar Health Program	Physical activity; nutrition; diabetes prevention	community; faith based
	PHIT Kids	physical activity; nutrition	Community; schools
	ShapeUp Somerville	physical activity; nutrition	community
	Safe Routes to Schools	Physical activity	Transportation

	Coverage of evidence-based self-management programs not currently covered by Medicaid (e.g. Diabetes Self-Management Program, Walk with Ease, Chronic Disease Self-Management Program, Chronic Pain Self-Management Program, etc.)	Physical activity; nutrition	CCO/clinic/CBO
	Complete Streets policies	Physical Activity	
	Access to lactation accommodation in workplaces and public places	Nutrition	Workplace; public places
	Behavioral interventions to reduce sedentary screen time among children	Physical activity	School and community
	Increasing access to healthy food and beverages through nutrition standards and food service guidelines	Nutrition	Workplace; college/university
	Healthy procurement/healthy vending policies for food purchasing and contracting	Nutrition	Workplace; college and university; retail; parks and recreation
	Financial incentives to change health habits for physical activity and healthy eating (ex. Health Engagement Model)	Physical activity; nutrition	Workplace; college and university
	Sugar sweetened beverage price increases	Nutrition	Retail
	Other:		
	Our CCO is not currently engaged in MSIs in a school or childcare setting		

18. What are the current barriers/challenges to conducting MSIs at the community or policy level?

19. What technical assistance resources for MSIs at the community or policy level would be helpful to address obesity prevention and treatment?

Foundational criteria

20. Multisector Interventions (MSI) should reach a certain percent of your CCO member population (e.g. 10%). How will you collect data to report/attest to the reach of the MSIs?

21. What barriers/challenges do you foresee in reporting/attesting to this reach requirement?

22. Do any of the MSIs your CCO is currently working on specifically address health disparities?

    By health disparities we mean preventable, inequitable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. These populations can be defined by factors such as race/ethnicity, gender, education, disability, geographic location, sexual orientation, etc.

    a. Yes
    b. No

IF 22="Yes"

22a. Please describe the populations targeted by your CCO's MSIs to address health disparities:

Resume asking all

23. Do any of the MSIs your CCO is currently working on specifically address health for populations across the lifespan (from pre-pregnancy and prenatal periods to children to adults and aging population)?
    a. Yes
    b. No

IF 23="Yes"

24. Please describe how your CCO's MSIs are reaching populations across the lifespan:

Community Engagement:

25. Are you currently engaging with community organizations around obesity prevention and treatment? Community engagement may include active participation and investment in regional community mobilization around obesity (e.g. coalitions on obesity prevention).
    a. Yes
    b. No

If 25= "Yes"

25a. Please describe how your CCO is currently engaging community organizations for obesity prevention and treatment:

25b. How is your CCO sustaining this community engagement? *Choose all that apply.*
    a. Financial support
    b. Staffing support
    c. Other: _____

Resume asking all

26. What barriers/challenges to community engagement is your CCO facing?

27. What technical assistance resources for community engagement would be helpful to address obesity prevention and treatment strategies for your CCO?

Root cause analysis and action plans:

28. Has your CCO engaged in root cause analysis or action planning around obesity prevention and treatment?
    a. Yes
    b. No

IF 28="Yes"

28a. Please provide a high-level summary of the process your CCO uses to determine the priorities of a Community Health Improvement Plan or Community Health Assessment.

Resume asking all

29. What barriers/challenges to conducting root cause analysis or action planning is your CCO facing?

30. What technical assistance resources for root cause analysis/action planning would be helpful to address obesity prevention and treatment strategies for your CCO?

CCO Performance Improvement Project (PIP) Validation Training
June 10, 2019

Kris Hartmann, MS
Project Manager II, Performance Improvement Projects

Christi Melendez, RN, CPHQ
Associate Executive Director, Performance Improvement Projects

Presentation Objectives

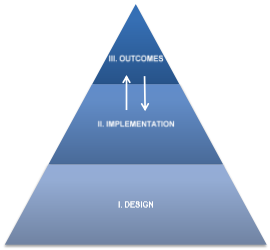
- Describe the HSAG PIP validation process
- Review PIP documentation requirements

What is a Performance Improvement Project (PIP)?

A process of:

- Identifying and measuring a targeted area (clinical or nonclinical)
- Implementing interventions for improvement
- Analyzing the results

PIP Stages



PIP Submission Form

PIP Submission Form

- Aligns with Centers for Medicare & Medicaid Services (CMS) protocol
- CMS reviewed and approved

HSAG's PIP Validation Process

7

PIP Validation Tool

- Aligns with Centers for Medicare & Medicaid Services (CMS) protocols
- Follows 10 Steps in CMS protocols
- 29 Evaluation Elements
- 14 Critical Evaluation Elements

8

Evaluation Element Scoring

Each evaluation element will be given a score of

Not Met

Partially Met

Met

9

Overall Validation Status

HSAG will report a level of confidence as one of the following:

Met	**High confidence/confidence** in reported PIP results. All critical evaluation elements were Met, and 80 percent to 100 percent of all evaluation elements were Met across all activities.
Partially Met	**Low confidence** in reported PIP results. All critical evaluation elements were Met, and 60 percent to 79 percent of all evaluation elements were Met across all activities; or one or more critical evaluation elements were Partially Met.
Not Met	All critical evaluation elements were Met, and less than 60 percent of all evaluation elements were Met across all activities; or one or more critical evaluation elements were Not Met.

10

Questions and Discussion

11

HSAG HEALTH SERVICES ADVISORY GROUP

Performance Improvement Projects

Thank you!

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Performance Improvement Projects
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State of Oregon 2019 PIP Submission Form
<PIP Topic>
for <Plan Name>

Demographic Information	
Plan Name: _____	
Project Leader Name: _____	Title: _____
Telephone Number: _____	Email Address: _____
PIP Title: ***<PIP Topic>***	
Submission Date: _____	

Step I: Select the Study Topic. The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State.
Topic: **Provide plan-specific data:** **Describe how the PIP topic has the potential to improve member health, functional status, or satisfaction:**

Step II: Define the Study Question(s). Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The Question(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- State the question in clear and simple terms.
- Be answerable based on the data collection methodology and study indicator(s).

Question(s):

Step III: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify members in the population, if applicable. Codes identifying numerator compliance should not be provided in Step III.
- Capture all members to whom the question(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion

Population definition:

Enrollment requirements (if applicable):

Member age criteria (if applicable):

Inclusion, exclusion, and diagnosis criteria:

Diagnosis/procedure/pharmacy/billing codes used to identify population (if applicable):

Step IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the study Indicator(s) should:

- Include the complete title of each study indicator.
- Include a narrative description of each numerator and denominator.
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Study Indicator 1: [Enter title]	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was developed, if internally developed.**
Numerator Description:	
Denominator Description:	
Baseline Measurement Period	MM/DD/YYYY to MM/DD/YYYY
Remeasurement 1 Period	MM/DD/YYYY to MM/DD/YYYY
Remeasurement 2 Period	MM/DD/YYYY to MM/DD/YYYY
Mandated Goal/Target, if applicable	
Study Indicator 2: [Enter title]	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was developed, if internally developed.**
Numerator Description:	
Denominator Description:	
Baseline Measurement Period	MM/DD/YYYY to MM/DD/YYYY

Step IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. **The description of the study Indicator(s) should:** • Include the complete title of each study indicator. • Include a narrative description of each numerator and denominator. • Include the rationale for selecting the study indicator(s). • If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually. • Include complete dates for all measurement periods (with the month, day, and year). • Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."	
Remeasurement 1 Period	MM/DD/YYYY to MM/DD/YYYY
Remeasurement 2 Period	MM/DD/YYYY to MM/DD/YYYY
Mandated Goal/Target, if applicable	
Use this area to provide additional information.	

Step V: Use Sound Sampling Techniques. If sampling is used to select members of the population (denominator), proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling techniques should be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods should:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each study indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling techniques support generalizable results.

Measurement Period	Study Indicator Title	Population Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample:

Step VI: Reliably Collect Data. The data collection process must ensure that data collected for each study indicator are valid and reliable.

The data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the study indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ] Hybrid—Both medical/treatment record review (manual data collection) and administrative data.

Medical/Treatment Record [ ] Medical record abstraction tool [ ] Electronic health record abstraction/query Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached	[ ] Administrative Data Data Source [ ] Programmed pull from claims/encounters [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [ ] Codes used to identify data elements (e.g., ICD-9/ICD-10, CPT codes)- please attach separately [ ] Data completeness assessment attached [ ] Coding verification process attached Estimated percentage of administrative data completeness: _____ percentage. Description of the process used to calculate the reported data completeness percentage:	[ ] Survey Data Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

In the space below, describe the step-by-step data collection process used in the production of the study indicator outcomes:

Step VII: Study Indicator Results. Enter the results of the study indicator(s) in the table below. For HEDIS-based PIPs, the data reported in the PIP Summary Form should match the validated performance measure rate(s).

Enter results for each study indicator by completing the table below. The study indicator percentage should be reported to one decimal place with rounding rules applied. *P* values should be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Study Indicator 1 Title: Enter title of study indicator

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
MM/DD/YYYY–MM/DD/YYYY	Baseline					NA for baseline
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 1					
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 2					

Study Indicator 2 Title: Enter title of study indicator

Time Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target , if applicable	Statistical Test, Statistical Significance, and *p* Value
MM/DD/YYYY–MM/DD/YYYY	Baseline					NA for baseline
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 1					
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 2					

Step VII: Data Analysis and Interpretation of Study Results. Clearly document the results for each study indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

Baseline Narrative:

Baseline to Remeasurement 1 Narrative:

Baseline to Remeasurement 2 Narrative:

Step VIII: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Description of the quality improvement team members.
- Description of the processes and tools used to conduct causal/barrier analysis.
- Description of the processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Description of the processes/methods used to evaluate the effectiveness of each individual intervention and the evaluation results (data).
- Description on how evaluation and data analyses guided continuation, revision, or discontinuation of an intervention.

Describe the causal/barrier analysis processes, quality improvement team members, and quality improvement tools:

Describe the processes, tools, and/or data analysis results used to prioritize barriers:

Barriers/Interventions Table:

Use the table below to list barriers, corresponding interventions, intervention type, and implementation date. For each intervention, select if the intervention was (1) new, continued, or revised, and (2) member, provider, or system. Update the table as interventions are added, discontinued, or revised.

Date Implemented (MM/YY)	Select if Continued, New, or Revised	Select if Member, Provider, or System Intervention	Priority Ranking	Barrier Description	Intervention Description
		Click to select status			
		Click to select status			

Step VIII: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Description of the quality improvement team members.
- Description of the processes and tools used to conduct causal/barrier analysis.
- Description of the processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Description of the processes/methods used to evaluate the effectiveness of each individual intervention and the evaluation results (data).
- Description on how evaluation and data analyses guided continuation, revision, or discontinuation of an intervention.

		Click to select status			
		Click to select status			

Intervention Evaluation Table:

In the table below, list each intervention that was listed in the Barriers/Interventions Table above. For each intervention, document the processes and measures used to evaluate effectiveness, the evaluation results, and next steps taken in response to the evaluation results. Additional documentation of evaluation processes and results may be attached as separate documents. Attachments should be clearly labeled and referenced in the table below.

Measurement Period	Intervention Description	Evaluation Process	Evaluation Results	Next Steps

Demographic Information	
Plan Name: **<Plan Name>**	
Project Leader Name: _____	Title: _____
Telephone Number: _____	Email Address: _____
PIP Title: ***<PIP Topic>***	
Submission Date: _____	

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
I.	**Select the Study Topic(s): The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State. The study topic:**		
C*	1. Was selected following collection and analysis of data. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Has the potential to affect member health, functional status, or satisfaction. The scoring for this element will be ***Met*** or ***Not Met.***	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step I

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0	1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
II.	**Define the Study Question(s): Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The study question:**		
C*	1. Was stated in simple terms and in the recommended X/Y format. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step II

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0	1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
III.	**Define the Study Population: The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding members with special healthcare needs. The study population:**		
C*	1. Was accurately and completely defined and captured all members to whom the study question(s) applied. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step III

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0	1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
IV.	**Select the Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The study indicator(s):**		
C*	1. Was well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Included the basis on which the indicator(s) was developed, if internally developed.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step IV

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
V.	**Use Sound Sampling Techniques: (If sampling was not used, each evaluation element will be scored Not Applicable [NA]). If sampling was used to select members in the population, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling methods:**		
	1. Included the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1).	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Included the title of each study indicator.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	3. Included the population size for each study indicator.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	4. Included the sample size for each study indicator.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	5. Included the margin of error and confidence level for each study indicator.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	6. Described the method used to select the sample.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	7. Allowed for the generalization of results to the study population.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step V

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
7	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
VI.	**Reliably Collect Data: The data collection process must ensure that the data collected on the study indicator(s) was valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:**		
	1. Clearly defined sources of data and data elements collected for the study indicator(s). ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	2. A clearly defined and systematic process for collecting baseline and remeasurement data for the study indicator(s). ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	4. The percentage of administrative data completeness following allowable claims lag and the process used to calculate the percentage.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VI

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
4	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
VII.	**Analyze Data and Interpretation of Study Indicator Results: Clearly present the results for each study indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each study indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the study indicator outcomes:**		
C*	1. Included accurate, clear, consistent, and easily understood information in the data table.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Included a narrative interpretation of results that addressed all requirements.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VII

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
3	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
VIII.	**Improvement Strategies and Interventions: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:**		
C*	1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Barriers that were identified and prioritized based on results of data analysis and/or other quality improvement processes.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	3. Interventions that were logically linked to identified barriers and have the potential to impact study indicator outcomes.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	4. Interventions that were implemented in a timely manner to allow for impact of study indicator outcomes.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	5. An evaluation of effectiveness for each individual intervention.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	6. Interventions that were continued, revised, or discontinued based on evaluation data.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VIII

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
6	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
3	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
IX.	**Assess for Real Improvement: Real improvement or meaningful change in performance is evaluated based on study indicator(s) results.**		
	1. The remeasurement methodology was the same as the baseline methodology.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	2. There was statistically significant improvement over the baseline across all study indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step IX

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
X.	**Assess for Sustained Improvement: Sustained improvement is demonstrated through repeated measurements over comparable time periods.**		
C*	1. Repeated measurements over comparable time periods demonstrated sustained improvement over the baseline across all study indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step X

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0	1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Table B-1—2019 PIP Validation Tool Scores for <PIP Topic> for <Plan Name>										
Review Step	**Total Possible Evaluation Elements** (Including Critical Elements)	**Total *Met***	**Total *Partially Met***	**Total *Not Met***	**Total *NA***	**Total Possible Critical Elements**	**Total Critical Elements *Met***	**Total Critical Elements *Partially Met***	**Total Critical Elements *Not Met***	**Total Critical Elements *NA***
I. Select the Study Topic(s)	2					1				
II. Define the Study Question(s)	1					1				
III. Define the Study Population	1					1				
IV. Select the Study Indicator(s)	2					1				
V. Use Sound Sampling Techniques	7					2				
VI. Reliably Collect Data	4					2				
VII. Analyze Data and Interpret Study Results	3					1				
VIII. Improvement Strategies	6					3				
IX. Assess for Real Improvement	2					1				
X. Assess for Sustained Improvement	1					1				
Totals for All Steps	**29**					**14**				

Table B-2 PIP Validation Overall Score for <PIP Topic> for <Plan Name>	
Percentage Score of Evaluation Elements *Met**	**%**
Percentage Score of Critical Elements *Met***	**%**
Validation Status***	***<Met, Partially Met, or Not Met>***

* The percentage score for all evaluation elements *Met* is calculated by dividing the total *Met* by the sum of all evaluation elements *Met*, *Partially Met*, and *Not Met*. The Not Assessed and Not Applicable scores have been removed from the scoring calculations.

** The percentage score for critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** Validation Status: See confidence level definitions below.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS
HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:
Met:* High confidence/confidence in reported PIP results. All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.** ***Partially Met:* Low confidence in reported PIP results. All critical evaluation elements were *Met,* and 60 to 79 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Partially Met. ***Not Met:* All critical evaluation elements were *Met,* and less than 60 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Not Met.***
Validation Status ☐ ***Met*** ☐ ***Partially Met*** ☐ ***Not Met***

Dental Opioid Guidelines

Bruce Austin, DMD

1

Dentists DO play an important role in this issue!

- Dentists are the leading prescribers to young people. (ages 10 – 19)
- Opioid addiction commonly begins with wisdom teeth extractions.
- Less than one half of opioids prescribed after surgical extractions are used, leaving one half for misuse. Journal of the American Dental Association (JADA) 12/16.
- Many dental opioid prescriptions come from patient expectations and traditions
- Dental patients should be encouraged to seek emergency care in dental offices, not emergency rooms (EDs)
- Multiple studies, including a recent review in the (JADA Moore, 2013) show that NSAIDs can be as effective as opioid combinations, with fewer side effects

2

Oregon Opioid Prescribing Guidelines for Dentists

- Created in 2016 by a multidisciplinary work group (DCOs, Board of Dentistry, general dentists, oral surgeons, OHSU Dental School)

- Examples came from the following:
  - Oregon Pain Guidance Opioid Policy for Dentists
  - ADA House of Delegates
  - Oregon chapter of the American College of Emergency Physicians
  - Pennsylvania Dental Association

Oregon Health Authority

Sharing Guidelines Roll-Out (2017-2018)

- Internal OHA presentation
- CCO Quality Health Outcomes Committee *morning session
- CCO Op's Bench
- Intercommunity Health Network CCO Quality Team
- Oregon College of Emergency Physicians
- Board of Dentistry
- Board of Pharmacy
- OHSU Dental School
- Oregon Dental Association and ADA president

Oregon Health Authority

Support for broader implementation

Ongoing:

- Opioid State Targeted Response (STR) grant will collaborate with OHSU Dental School to incorporate dental prescribing of opioids into curriculum
- Statewide PIP: acute prescribing * beginning in 2019

Potential:

- Local presentation to communities
- Connecting oral health provider communities with CCOs

Links to Publications

- Dental Prescribing Guidelines for Dentists: http://www.oregon.gov/dentistry/docs/2017.08%20Oregon%20opioid%20guidelines%20for%20dentists-Flyer.pdf
- "Prescribing Opioids Safely as a Dentist" brochure: http://www.oregon.gov/dentistry/docs/2017.08%20Oregon%20Opioid%20Prescribing%20for%20Dentists%20Brochure.pdf