

Oregon Health Plan

Section 1115 Quarterly Report



07/1/2019 – 09/30/2019

Demonstration Year (DY): 18 (7/1/2019 – 6/30/2020)

Demonstration Quarter (DQ): 1/2020

Federal Fiscal Quarter (FQ): 4/2019



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I. Introduction

A. Letter from Oregon's State Medicaid Director

During this quarter, OHA continued to make progress toward our waiver goals, while taking significant steps to prepare for the transition to new CCO's and new policies effective in 2020.

OHA completed implementation of an opt-out CCO enrollment for dual-eligible Medicaid/Medicare members who were previously enrolled through an opt-in model. Members enrolled with Medicare Advantage plans were matched with CCOs managing those plans, if possible, and offered choice in plans as available.

OHA partnered with DHS to complete auto enrollment into CCOs for foster children on July 1, 2019. Foster children are automatically enrolled, but child welfare staff can opt youth members out of CCO enrollment or place them at another CCO level that best meets the member's needs. OHA created resources to assist in the communication and collaboration efforts between state agencies and CCOs.

OHA/DHS's system integration effort continues to reduce errors caused by overlapping IDs in multiple systems. This improved claims processing accuracy, protection of member health information, as well as enhanced coordination of benefits.

OHA continued to expand the use of health-related services (HRS) in several ways. OHA partnered with the Oregon Rural Practice-based Research Network (ORPRN) to interview CCOs, clinics and health systems partners. This effort included work group calls and a peer-learning convening about how CCOs are implementing HRS and what services or initiatives CCOs are funding.

OHA staff reviewed CCOs' 2018 HRS policies and shared opportunities with CCOs to update their policies to align with Oregon administrative rules for 2019. The 2019 CCO HRS policies will be reviewed with an eye toward policy requirement changes due to changes in rule and CCO contract. Staff have also reviewed CCO HRS spending data and will give feedback to each CCO on appropriateness of HRS expenditures, as well as share global themes. As a result of this process, OHA plans to give more instruction and support for how to submit documentation of HRS expenditures.

OHA awarded contracts to 15 CCOs during this quarter for services from 2020-2024. Eleven CCOs were awarded five-year contracts and four CCOs were awarded a one- year contract with a remediation plan to assist them to expand their contract to five years if possible. OHA conducted readiness reviews and gave feedback to CCOs, and developed new administrative rules and contract requirements.

Lori Coyner, State Medicaid Director

B. Demonstration description

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

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2017, Oregon sought to demonstrate the effectiveness of delivery system improvements under health system transformation.

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

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

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

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

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

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

- Conversion of the Tribal uncompensated care payments to a Medicaid benefit;
- Clarifying health-related services that meet the requirements as specified in the Code of Federal Regulations;
- Allowing passive enrollment of Medicare and Medicaid dually-eligible individuals into CCOs with the option for each individual to opt-out at any time;
- Specifying the demonstration will not impact American Indian and Alaska Natives rights to exemption from managed care, or the requirements to comply with the Medicaid Managed Care Regulations;

- Offering incentive payments to Patient-Centered Primary Care Homes and Comprehensive Primary Care Plus providers for enhanced fee-for-service delivery of care to Medicaid recipients; and
- Establishing minimum requirements for CCOs to collaborate and communicate in a timely and equitable manner with tribes and Indian Health Care providers.

C. State contacts

Medicaid Director

Lori Coyner, Medicaid Director
503-569-3160 phone
503-945-5872 fax

Demonstration and Quarterly and Annual Reports

Tom Wunderbro, Medicaid Demonstration Waiver Manager
503-510-5437 phone
503-945-5872 fax

State Plan

Jesse Anderson, State Plan Manager
503-945-6958 phone
503-945-5872 fax

Coordinated Care Organizations

David Inbody, CCO Operations Manager
503-756-3893 phone
503-945-5872 fax

Quality Assurance and Improvement

Veronica Guerra
Interim Quality Assurance and Contract Oversight Manager
503-437-5614 phone
503-945-5872 fax

For mail delivery, use the following address

Oregon Health Authority
Health Policy and Analytics
500 Summer Street NE, E54
Salem, OR 97301-1077

II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 07/1/2019 – 09/30/2019
Demonstration Year (DY): 18
Demonstration Quarter (DQ): 1/2020
Federal Fiscal Quarter (FQ): 4/2018

III. Overview of the current quarter

A. Enrollment progress

1. Oregon Health Plan eligibility

There have been no significant issues nor any major system or process changes that would have had any major impacts to Title XIX or Title XXI enrollment levels. Significant work backlogs were caught up earlier in the year, and work continues to be processed within required timeframes. Some recent work has been done to update local work procedures related to the processing of Federal Marketplace referrals in preparation for the upcoming open enrollment period. Staff have also begun initial training activities in preparation for the roll-out of the state's new integrated eligibility system in Spring of 2020. Concurrently, the state is awarding new and different CCO contracts starting in January, and large volumes of phone calls are being received as a result of notifications that have been mailed to explain these changes. An additional temporary call center was stood-up in order to help with these call volumes, specifically.

2. Coordinated care organization enrollment

The Oregon Health Authority (OHA) continues to ensure eligible Oregon Health Plan (OHP) members are appropriately enrolled into CCOs. While new member enrollment is an automatic process in the Medicaid Management Information System (MMIS), OHA's quality control measures verify member demographics to ensure that members are enrolled.

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

B. Benefits

The Pharmacy & Therapeutic (P&T) Committee developed new or revised prior authorization criteria for the following drugs: brexanolone and esketamine; patisiran and inotersen; dupilumab; atopic dermatitis and topical antipsoriatics; solriamfetol; modafinil/armodafinil; remove the PA requirement for preferred insulin pens; hepatitis C, direct-acting antivirals; tobacco smoking cessation; drugs for Duchenne muscular dystrophy; oral cystic fibrosis modulators; short-acting and long-acting opioids; drugs for transthyretin-mediated amyloidosis (ATTR); spinal muscular atrophy; bone metabolism agents; and Fabry disease treatments.

The committee recommended changes to the preferred drug list (PDL): add the drugs for hATTR class to the PDL and to designate inotersen and patisiran non-preferred; make solriamfetol voluntary non-preferred; make sodium oxybate non-preferred; make methocarbamol tablets preferred; make valacyclovir tablets preferred; make insulin glulisine (pens and vials) and insulin regular, human U-500 pens preferred; make Humalog Mix 75/25 and 50/50 KwikPens preferred; make insulin detemir vials preferred; make Zepatier non-preferred; make Vyndaqel and Vyndamax non-preferred; add the spinal-muscular atrophy class to the PDL and make Zolgensma preferred and Spinraza non-preferred; and make Farbyzyme and Galafold non-preferred.

The Health Evidence Review Commission made Prioritized List remained in effect with no changes other than two errata. During this time, the Health Evidence Review Commission approved various changes for implementation 10/1/2019; these were published in the 10/1/2019 Notification of Interim Changes.

C. Access to care (annual reporting)**D. Quality of care (annual reporting)****E. Complaints, grievances, and hearings****E. Complaints, grievances, and hearing****CCO and FFS Complaints**

The information provided is a compilation of data from 15 coordinated care organizations (CCO) and fee-for-service (FFS) data. This quarterly reporting period covers July 1, 2019 through Sept 30, 2019.

Trends

	Oct – Dec 2018	Jan – Mar 2019	Apr – Jun 2019	Jul – Sep 2019
Total complaints received	5,839	5,683	6,875	6776
Total average enrollment	1,180,577	1,190,032	1,131,954	1,203,531
Rate per 1,000 members	4.95	4.78	6.07	5.63

Barriers

CCO complaints showed a slight decrease overall during this quarter over the previous quarter. Access to Care category continues to receive the highest number of complaints, however the data shows a 14.07% decrease from the previous quarter. The Interaction with Provider/Plan category shows an increase of 10.63% this quarter, over the previous quarter and Quality of Care issues increased by 28.4%. FFS data continues to show the highest number of complaints are in the Quality of Service category, with the Client Billing category the next highest.

Interventions

CCOs – This quarter, some CCOs report a decrease in call volumes. Some CCOs report they are continuing to work with providers and internal staff to ensure all expressions of dissatisfaction are recorded as complaints. They are continuing to provide training to their customer service representatives, provider offices and clinics and hospital staff to ensure all complaints, including all oral complaints are accurately recorded and reported. Some CCOs have been advised by sub-contractors that upgrades to complaint software has improved reporting. One CCO reports they actively work with providers offices regarding availability to assist members in scheduling timely appointments. They also work with provider offices to reduce issues, such as disconnects between the provider and the front office, which can cause delays in scheduling. CCOs who have implemented Peer Review committees report improvements in provider services which helps to reduce numbers of complaints. Some CCOs are continuing to report staff is being added internally as well at sub-contractor offices. One CCO reports a sub-contractor is now including blank complaint forms with customer satisfaction surveys, which they hope will provide additional insight to where improvements can be made. Rural area CCOs are continuing to report issues with bringing on more providers, which has increased complaints in some areas.

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NEMT continues to be an issue with several CCOs and report they are continuing to work bi-weekly and monthly with NEMT providers to improve transportation services.

Fee-For-Service – The DHS/OHA Member Services data shows complaint calls decreased slightly from the previous quarter for Fee for Service member complaints and complaints from members enrolled in a CCO. The number of complaints from members who were on Fee for Service coverage during the quarter was 645.

Member Services reported an additional 412 records identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 271 calls regarding complaints about Dental Care Organizations. There were 4642 informational calls received asking for a variety of information, such as information about their coverage, CCO enrollment, request ID cards, etc.

Statewide rolling 12-month complaints totals

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

Complaint category	Oct – Dec 2018	Jan – Mar 2019	Apr– Jun 2019	Jul – Sep 2019
Access to care	3,422	2,865	3,127	2687
Client billing issues	373	522	600	586
Consumer rights	207	221	202	248
Interaction with provider or plan	1,082	1,184	1,958	2161
Quality of care	417	443	514	660
Quality of service	338	420	456	434
Other	0	28	18	0
Grand Total	5,839	5,683	6875	6776

Related data

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

CCO Notices of Adverse Benefit Determinations and Appeals

Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs during the quarter. The NOABDs are listed by reason, as per 42 CFR 438.400(b)(1-7) and are the total number of NOABDs issued, regardless of whether or not an appeal was filed. For the current July – September 2019 quarter CCOs report that outpatient care and specialty care continue to be the highest numbers of NOABDs issued. Some CCOs continue to monitor NOABDs to ensure written notices are sent to members in easily understood language and includes the appropriate citations. Tracking for timeliness, as well as reviewing for utilization and appropriateness of care are processes CCOs report they are doing to ensure NOABDs are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	Oct – Dec 2018	Jan-Mar 2019	Apr – Jun 2019	Jul – Sep 2019
a) Denial or limited authorization of a requested service.	33,284	32,590	36,276	33,609
b) Single PHP service area, denial to obtain services outside the PHP panel	90	112	132	149

c) Termination, suspension, or reduction of previously authorized covered services	135	144	149	143
4d) Failure to act within the timeframes provided in § 438.408(b)	48	36	41	26
e) Failure to provide services in a timely manner, as defined by the State	228	288	263	234
f) Denial of payment, at the time of any action affecting the claim.	29000	22,935	18,986	19,823
g) Denial of a member's request to dispute a financial liability.	N/A	N/A	0	0
Total	62,785	56,105	55,847	53,984
Number per 1000 members	72	64	47	45

CCO Appeals

The table below shows the number of appeals the CCOs received during the quarter. There was a 7.43% decrease this quarter over the previous quarter. CCOs reported that specialty care, outpatient care and pharmacy remain the areas with the highest number of appeals. CCOs report they review the overturn rates which leads to more in-depth discussions and reviews, monitoring and process changes. One CCO reports that after review of appeal activity have resulted in activities such as site visits, staff education and process improvements, including improved Website design for providers to improve understanding of the appeal process. CCOs also work with members to assist them in finding services they need or assist them with finding alternative covered options.

CCO Appeals	Oct – Dec 2018	Jan-Mar 2019	Apr – Jun 2019	Jul – Sep 2019
a) Denial or limited authorization of a requested service.	1,203	1,281	1,358	1,236
b) Single PHP service area, denial to obtain services outside the PHP panel.	3	8	2	17
c) Termination, suspension, or reduction of previously authorized covered services.	1	8	2	11
d) Failure to act within the timeframes provided in § 438.408(b).	2	1	1	1
e) Failure to provide services in a timely manner, as defined by the State.	0	0	0	0
f) Denial of payment, at the time of any action affecting the claim.	329	363	387	355
g) Denial of a member's request to dispute a financial liability.	N/A	0	0	0

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Total	1,538	1,661	1,750	1,620
Number per 1000 members	1.76	1.89	1.95	1.35
Number overturned at plan level	481	514	573	495
Appeal decisions pending	11	12	12	8
Overturn rate at plan level	31.27%	30.94%	32.74%	30.56%

CCO and FFS Contested Case Hearings

The following information is a compilation of data from 16 coordinated care organizations (CCO), 7 dental care organizations (DCO) and fee-for-service (FFS). FFS members may be enrolled with a DCO for dental coverage.

The reporting period covers the quarter beginning July 1, 2019 through September 30, 2019. OHA received 398 hearing requests related to the denial of medical services which include NEMT services. In every quarter there is an overlap of processed cases with those received. For instance, cases processed and resolved in July of 2019 may be cases OHA received as far back as May and June of 2019. The number of requests received for CCO-enrolled members was 358 and 40 received for FFS.

The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. There were 18 cases approved prior to hearing. Members withdrew from 37 cases after an informal conference with an OHA hearing representative and OHA dismissed 286 cases that were determined not hearable cases. Of the 56 cases that went to hearing, the administrative law judge upheld the OHA or CCO decision in 34 cases and dismissed 20 cases for the members failure to appear. A total of 2 of the cases that went to hearing had the decision reversed by the administrative law judge and 1 case was dismissed due to a member requesting a hearing after the allowed time frames without good cause for the late request.

Outcomes of Contested Case Hearings Processed

Outcomes	Count	% of Total
Decision overturned prior to contested case hearing	18	5%
Client withdrew request after pre-hearing conference	37	8%
Dismissed by OHA as not hearable	286	75%
Decision affirmed*	34	8%
Client failed to appear*	20	4%
Dismissed as non-timely	1	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	1	0%
Set Aside	1	0%

Total	398	
*Resolution after an administrative hearing		

Related data

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

F. CCO activities**1. New plans**

On September 30, 2019, OHA signed 15 CCO contracts to provide care coordination in 2020. Eleven organizations received 5-year contracts and four received 1-year contracts.

5-Year Contracts:

CCO Name	Service Area	2020 Max Enrollment Capacity
Advanced Health	Coos and Curry	85,790
Columbia Pacific CCO	Clatsop, Columbia, and Tillamook	45,300
Eastern Oregon Coordinated Care Organization	Sherman, Gilliam, Morrow, Umatilla, Union, Wallowa, Wheeler, Grant, Baker, Lake, Harney, and Malheur	55,180
Health Share of Oregon	Clackamas, Multnomah, and Washington	400,100
InterCommunity Health Network	Lincoln, Benton, and Linn	80,000
Jackson County CCO	Jackson	70,000
PacificSource Community Solutions – Central OR	Crook, Deschutes, Jefferson, and partial Klamath	65,842
PacificSource Community Solutions – Columbia Gorge	Hood River and Wasco	17,168
PacificSource Community Solutions – Lane	Lane	85,900
PacificSource Community Solutions – Marion Polk	Marion and Polk	107,260
Trillium Community Health Plan	Lane, Clackamas, Multnomah, and Washington; partial Linn and Douglas	115,000

Total	1,127,540
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1-Year Contracts:

CCO Name	Service Area	2020 Max Enrollment Capacity
AllCare CCO	Josephine, Jackson, Curry, and partial Douglas	65,246
Cascade Health Alliance	Partial Klamath	22,000
Umpqua Health Alliance	Partial Douglas	35,750
Yamhill County Care Organization	Yamhill; partial Polk and Washington	28,778
Total		151,774

Two CCOs were granted expansions to their service area markets:

- PacificSource, expanded into Lane, Marion, and Polk counties
- Trillium Community Health Plan, expanded into Portland Metro counties of Clackamas, Washington, and Multnomah

Three CCOs will expand the levels of coverage offered to members, starting in 2020. CCOE (Behavioral Health only) and CCOG (Behavioral and Dental Health care) will be offered by all CCOs in Oregon.

This change primarily impacts dual-eligible Medicare/Medicaid members and child members working with DHS/Child Welfare/Oregon Youth Authority who will have new options for CCO enrollment.

This is expected to result in increased coordination of dental and mental health benefits for these members. Most members will enroll at the highest level of coverage where possible (CCOA – Physical, Dental, and Behavioral Health).

The CCOs that added CCOE and CCOG are:

- Eastern Oregon Coordinated Care Organization
- PacificSource (all areas)
- Umpqua Health Alliance

It was determined that several CCOs will be closing at the end of the year (12/31/2019).

- Willamette Valley Community Health, currently serving Marion and Polk counties, did not apply for a contract in 2020. It will be replaced by PacificSource Marion Polk. Approximately 105,000 members will be impacted by this change, but with minimal disruption.
- PrimaryHealth of Josephine County was not offered a contract for 2020. Members currently enrolled with PrimaryHealth in Josephine and Jackson counties will transition to either AllCare CCO or Jackson Care Connect. Approximately 9,700 members will be affected by this change.
- CareOregon Dental Care Organization will no longer offer services as a standalone DCO (FFS). CareOregon will only be available for enrollment through Health Share of Oregon CCO.

Approximately 2,170 members in the Multnomah, Clackamas, and Washington (Portland Metro) counties will be impacted by this change. Eligible members will have the option to enroll with a CCO (Trillium or Health Share) for dental care; or select a standalone DCO for care (Advantage Dental, Capitol Dental, or ODS Dental).

2. Provider networks

There were no relevant changes in provider networks for physical health, oral health, or behavioral health during this reporting period.

3. Rate certifications

The Oregon Health Authority (OHA) contracts with Coordinated Care Organizations (CCOs) to manage and deliver integrated services that include Physical Health, Behavioral Health, and Dental Services to the majority of Oregon's Medicaid population. OHA pays CCOs with Actuarially Sound capitation rates that are developed on an annual basis. Capitation rates pay an amount per month depending on the individual's age and OHP eligibility category. In addition to CCOs, OHA also retains seven Dental Only (DCO) contracts and a Mental Health Only (MHO) contract where capitation rates are developed separately.

In July 2019, OHA awarded the CCO 2.0 contracts. Once contracts were awarded OHA met with CCOs at an August 8 Rates Workgroup meeting to discuss program changes, trend, and non-medical load, as well as to discuss the impact of member reallocation in areas with multiple CCOs and walk through the cost attribution methodology.

In addition, OHA held an August 28 Rates Workgroup meeting to discuss area factors and risk factors that inform individual CCO rates. OHA delivered the CY2020 rates to individual CCOs during August 28-30, 2019. Each CCO had until September 13, 2019 to review and ask questions in the 2020 contract year. OHA delivered FINAL 2020 rates on September 27, 2019 to ensure final CCO 2.0 contract signing.

OHA submitted final rates to CMS on October 2, 2019, which allows for a 90-day review window, per CMS rule.

4. Enrollment / Disenrollment

During this quarter, OHA completed implementation of an opt-out CCO enrollment for dual-eligible Medicaid/Medicare members who were previously enrolled through an opt-in model. Members enrolled with Medicare Advantage plans were matched with CCOs managing those plans, if possible, and offered choice in plans as available.

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OHA partnered with DHS to complete auto enrollment into CCOs for foster children with specific program eligibility codes on July 1, 2019. Foster children are automatically enrolled at the CCOA level (physical, mental, and dental health benefits), but child welfare staff can opt youth members out of CCO enrollment or place them at another level (CCOB, CCOG, or CCOE) that best meets the member's needs. OHA created resources to assist in the communication and collaboration efforts between state agencies and CCOs.

A new process was developed to address issues in which members are added to another member's Prime ID by error. This was occurring due to multiple systems creating overlapping member IDs. Staff were trained in this process and quality improvement measures implemented to reduce errors. OHA/DHS's system integration effort also continues to reduce these errors. This improved claims processing accuracy, protection of member health information, as well as enhanced coordination of benefits.

Additionally, ongoing monitoring and review of enrollment discrepancies, with attention directed toward analyzing source issues and providing technical assistance as needed, has resulted in a reduction of reported discrepancies from the CCOs.

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

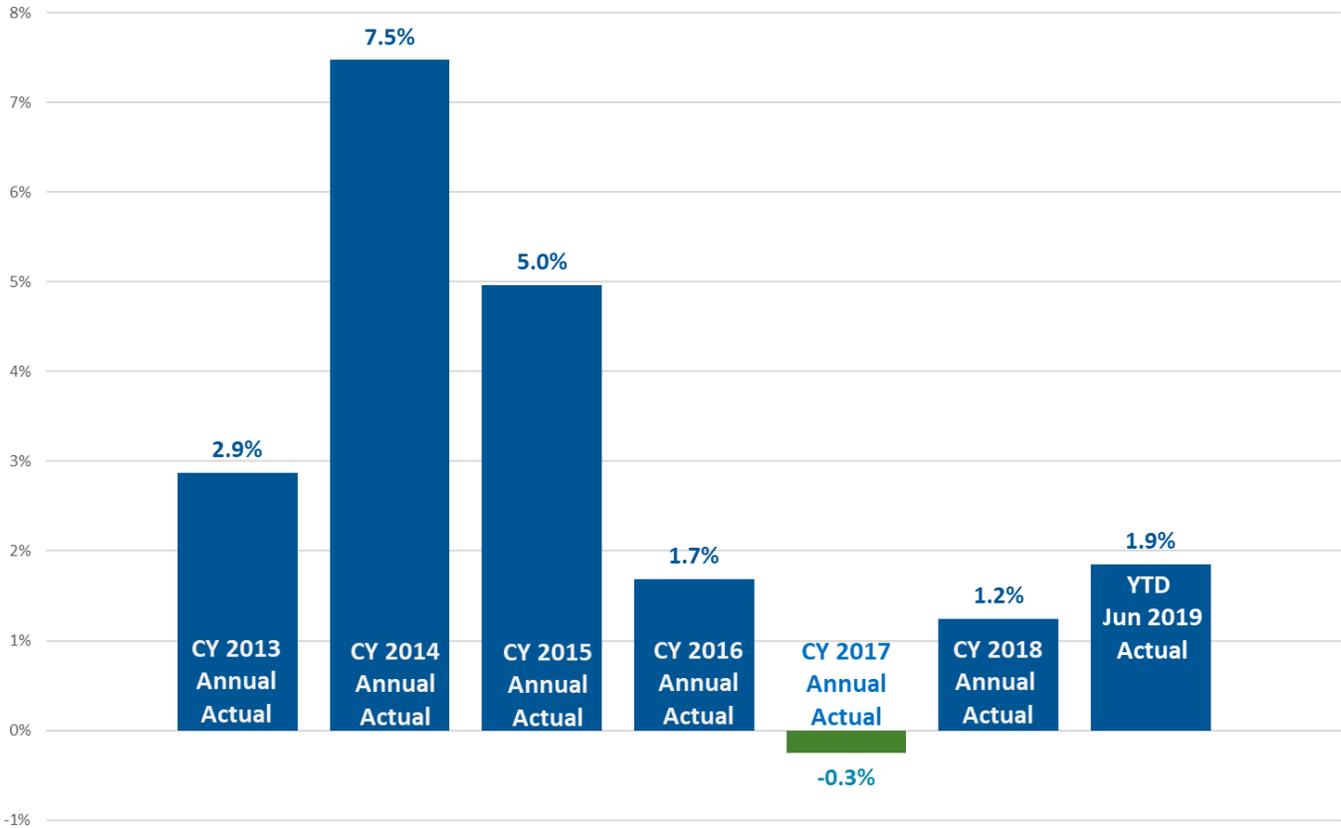
5. Contract compliance

There are no issues with Coordinated Care Organization (CCO) contract compliance.

6. Relevant financial performance

For the 6-months ended June 30, 2019, the statewide CCO operating margin was at 1.9% compared to 1.2% for the year ended December 31, 2018. For reference, the capitation rates include a 1% profit margin. CCO operating margins returned to a slightly profitable status after trending downward during 2015-2017 period.

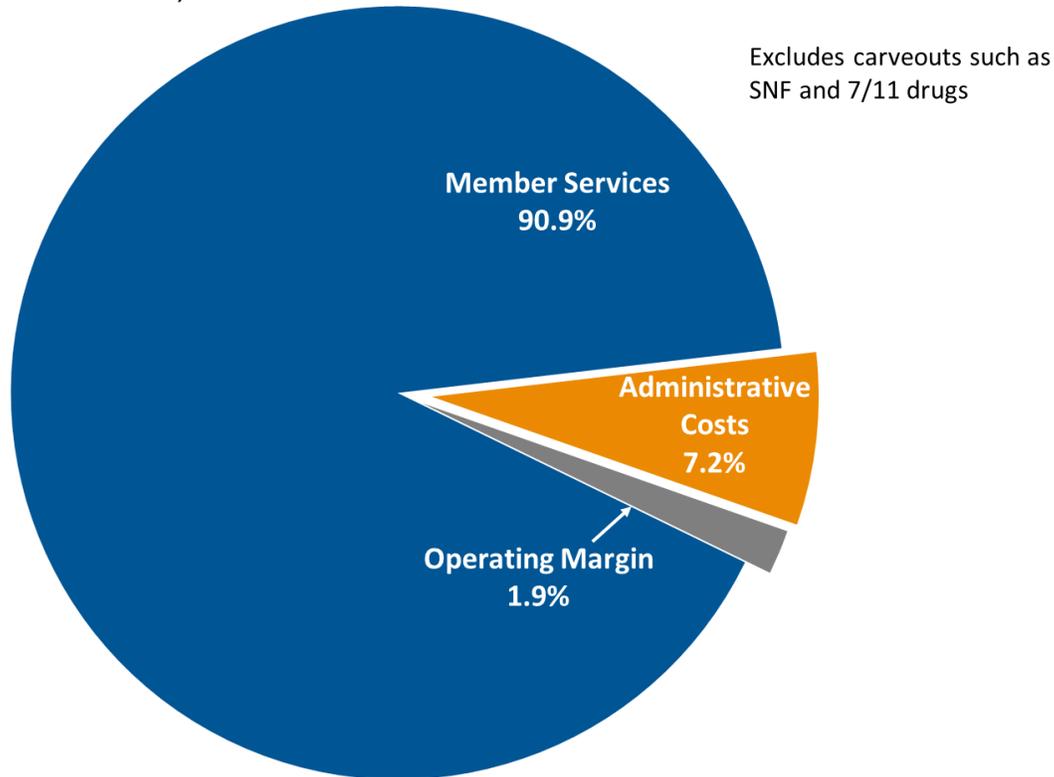
Statewide CCO Operating Margin Percent



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (this includes medical, behavioral, dental and health-related services, reinsurance premiums and recoveries, and other adjustments) as a percentage of total revenue. For the 6-months ended June 30, 2019, the MSR for all CCOs in aggregate was 90.9%. Administrative Services accounted for 7.2% of total CCO revenue, leaving 1.9% as operating margin.

For the 6-months ended June 30, 2019, 12 out of the 15 CCOs met or exceeded the 85% target for MSR, a key indicator for MLR (Six of the CCOs had MSRs above 90%). Three CCOs reported MSR below 85%, Umpqua Health Alliance at 79.9%, Primary Health Josephine County at 80.8% and PacificSource Community Solutions - Central at 83.5%.

CCO Statewide Components YTD June 30, 2019



Note: Excludes Non-Operating Revenues and Expenses and Income Taxes (if applicable).

As of June 30, 2019, all CCOs met their net worth requirement. Net Assets of the CCOs ranged from a low of \$231 per member (Willamette Valley Community Health, LLC) to a high of \$1,255 per member (Intercommunity Health Network), averaging \$480 per member for the state.

Additional CCO financial information and audited financials is available on OHA's Fiscal and Operations Division publicly available webpage.

7. Corrective action plans

For the current quarter, one CCO continues to be on a Corrective Action Plan (CAP):

- Entity name: Cascade Health Alliance (CHA)
- Purpose and type of CAP: Non-compliance with CCO Contract and Hepatitis C Risk Corridor, OAR and CFR. CCO was not timely responding to authorization requests, not determining approvals and denials timely or appropriately, not providing notice to members and providers, and not providing authorized medication timely or at all to members who qualified for treatment for Hepatitis C.
- Start date of CAP: May 20, 2019

- End date of CAP: May 20, 2020
- Action sought:
 - Immediate correction of non-compliance;
 - Development and implementation of a plan for correcting the issues identify by OHA
 - Submission of quarterly reports to OHA for a period of at least one (1) year
- Progress during current quarter:

CHA is compliant with the requirements. Its reports for Q3CY2019 indicate that: all authorization requests were decided within the required timeframe; members and providers were notified about the decisions; and authorized medications were provided timely. No requests were denied.

8. One percent (1%) withhold

During this quarter, the Oregon Health Authority's Health Systems Division analyzed encounter data received for completeness and accuracy for the subject months of July 2019 through September 2019. All coordinated care organizations (CCO) met the administrative performance standard for all subject months and no 1% withholds occurred.

9. Other significant activities

During this reporting period, OHA engaged in a series of meetings with CCOs on their contracts for the 2020-2024 period and led a Rule Advisory Committee process on the Medicaid Managed Care chapter of the Oregon Administrative Rules. The contract meetings allowed CCOs to communicate concerns with early drafts of the contracts and ensured that CCOs understood the requirements that will be new in 2020.

The rulemaking process included tribes, stakeholders from CCOs, providers, and a variety of community-based organizations. The updates to the state's administrative rules reinforce the requirements in the new CCO 5-year contracts and represent the implementation of the CCO 2.0 policy development process that took place throughout 2018 and 2019.

G. Health Information Technology

Medicaid Electronic Health Records Incentive Program

Through the Medicaid EHR Incentive Programs (also known as the Promoting Interoperability Programs), eligible Oregon providers and hospitals can receive federally-funded financial incentives for adopting, implementing, upgrading, or meaningfully using certified electronic health records technology (CEHRT). Since the Medicaid EHR Incentive Program's inception in 2011, 3,830 Oregon providers and 60 hospitals have received over \$204 million in federal incentive payments (as of September 30, 2019). Between July and September 2019, 330 Oregon providers received \$2.7 million in Medicaid EHR incentive payments. To promote continued participation and success in the program, Medicaid EHR Incentive Program staff hosted an informational webinar to present updates and requirements to 86 attendees. The program sunsets at the end of 2021.

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Behavioral Health and HIT

The Behavioral Health HIT Workgroup was formed in August 2018 under the direction of HITOC to review the draft Behavioral Health HIT Scan and provide recommendations and priorities. The BH HIT Work Group met again in July 2019 to review the draft OHA work plan based on the Workgroup recommendations on how to expand and enhance HIT adoption and use among behavioral health providers. The work plan was then presented to HITOC at a meeting in August 2019. HITOC approved this work to move forward.

OHA drafted a request for grant funds through the SAMHSA Block Grant application to support behavioral health providers working with patients with substance use disorders to receive technical assistance on the adoption and use of EHRs. This application was submitted as part of a larger Block Grant application in September 2019.

A portion of the SUPPORT Act referred to as the “Improving Access to Behavioral Health Information Technology Act” authorized CMMI to create a demonstration project to incentivize the adoption and use of CEHRT for behavioral health care providers. The goals are to decrease the gap in behavioral health EHR adoption and improve the coordination and quality of care for Americans with mental health, Substance Use Disorder, and other behavioral health care needs. There has been no public information about this effort moving forward. OHA submitted a letter of interest to CMMI on July 10, 2019 expressing Oregon’s interest and highlighting our commitment to improving behavioral health as well as the technology gap that exists for Oregon behavioral health providers. OHA is in strong support of this demonstration project moving forward and hopes to see CMMI movement on this in the near future.

HIT Commons

The HIT Commons is a public-private partnership to coordinate investments in HIT, leverage funding opportunities, and advance HIE across the state. HIT Commons is co-sponsored by the Oregon Health Leadership Council (OHLIC) and OHA, and is jointly funded by OHA, hospitals, and health plans.

The HIT Commons Governance Board has met twice in 2019. The Board approved two new board members, including one community-at-large member, and directed staff to begin exploration and conceptual development of a statewide social determinants of health (SDoH) “Community Information Exchange” effort (see below for more information).

Social Determinants of Health (SDOH) and HIT: Community Information Exchange

In the first half of 2019, the HIT Commons started to explore the concept of a statewide social determinants of health (SDOH) resource directory and referral network, currently referred to as the Oregon Community Information Exchange (CIE). The goal is to make it easier for health care providers and the social services sector to refer patients to an up-to-date social services resource directory, and to receive information about the outcome of the referral. In spring of 2019, the HIT Commons conducted 20 meetings/interviews with stakeholders to understand the existing SDOH landscape in Oregon. Interviews were summarized in an Oregon CIE environmental scan and shared with stakeholder groups throughout the summer. Initial recommendations were discussed at the May HIT Commons Board meeting, including a plan to develop a statewide roadmap for a CIE network or coordinated efforts. The HIT Commons Board agreed in July to stand up a statewide advisory group to develop this roadmap. The group is expected to begin meeting in Winter 2019.

Emergency Department Information Exchange and PreManage

The Emergency Department Information Exchange (EDie) allows Emergency Departments (EDs) in real-time to identify patients with complex care needs who frequently use the emergency room for their care. In addition to utilization alerting, EDie also provides succinct and critical information to ED physicians, such as: security alerts, care guidelines entered by the patient primary care home, and contact information for case managers.

PreManage is a companion software tool to EDie. PreManage brings the same real-time hospital event notifications (ED and Inpatient Admit, Discharge, and Transfer [ADT] data) to those outside of the hospital system, such as health plans, Coordinated Care Organizations (CCOs), providers, and care coordinators. EDie and PreManage are in use statewide and adoption for PreManage continues to grow.

A 2019 Technical Assistance calendar has been created for the year, and four sessions of a six-part series have been held. The series supports basic, intermediate, and advanced use of the platform for primary care, behavioral health clinic use and work flows, and technical work flows. As of February, hospitals who receive EDie notifications via fax now receive a Physician Order for Life Saving Treatment (POLST) as a print out along with the EDie notification and PreManage users may request POLST delivered within their web platform for their panel of patients.

Oregon Prescription Drug Monitoring Program Integration Initiative

The Oregon's Prescription Drug Monitoring Program (PDMP) Integration initiative connects EDie, HIEs, EHRs, and pharmacy management systems to Oregon's PDMP, which includes prescription fill information on controlled substances, and is administered by OHA's Public Health Division. HIT Commons oversees the PDMP Integration work with guidance from the Oregon PDMP Integration Steering Committee and in coordination with OHA's Public Health PDMP program.

PDMP Integration capabilities went live in summer of 2017 and the statewide subscription funding officially launched through the HIT Commons in Spring 2018. As of the September PDMP Integration report:

- 9,609 prescribers across 135 organizations have integrated access to Oregon's PDMP data—either through their EDie alerts, or through one-click access at the point of care.
- Six retail pharmacy chains (across 243 sites) are also live.
- Interstate data sharing is established with PDMPs in Idaho, Kansas, Nevada, Texas, North Dakota, and Washington (WA for web portal only). Alaska, Wyoming and California are in progress.

A streamlined process to initiate PDMP Integration is now available through the HIT Commons.

Oregon Provider Directory (OPD)

The OPD will serve as Oregon's directory of accurate, trusted provider data. It will support care coordination, HIE, administrative efficiencies, and serve as a resource for health analytics. Authoritative data sources that feed the OPD will be matched and aggregated and data stewards will oversee management of the data to ensure the OPD maintains initial and long-term quality information. The Provider Directory Advisory Committee provides stakeholder input and oversight to OHA's development of this program.

The OPD will benefit CCOs by supporting care coordination/HIE, administrative efficiencies, and serve as a resource for health analytics in the following ways:

Oregon Health Authority

- 1) Having one place to go for accurate and complete provider data
- 2) Reducing burden on providers and staff time spent on data maintenance activities
- 3) Enabling better care coordination for patients and ability to meet certain meaningful use objectives by supplying complete information on providers and how to contact them
- 4) Improving the ability to calculate quality metrics that require detailed provider and practice information

The Oregon Provider Directory successfully completed user acceptance testing in August 2019. It went live on September 23, 2019 in a soft launch and is onboarding a small set of users in Central Oregon. Soft launch users include a CCO, health system, independent practice association, dental care organization, and a federally qualified health center. HIT Commons is working with OHA staff and stakeholder volunteers to develop initial use case testing for the soft launch. Additional users will be added in later phases as data become more robust.

Clinical Quality Metrics Registry

Oregon's CQMR collects, aggregates, and provides clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting. The CQMR went live in early 2019 for Medicaid EHR Incentive Program/Promoting Interoperability electronic clinical quality measure (eCQM) reporting and the option for reporting eCQMs to CMS for the Merit-based Incentive Payment System (MIPS) and Comprehensive Primary Care Plus (CPC+). Starting with the 2019 measurement year, the CQMR will support eCQMs and some state-specific measures for the CCO incentive measure program.

OHA continues to engage with stakeholders through a subject matter expert workgroup and other outreach. In the summer of 2019, OHA engaged stakeholders in testing new CQMR functionality, and system enhancements were planned in response to stakeholder feedback. The enhancements will be in place for 2019 data to be reported in early 2020. In addition, ongoing technical assistance is offered through a contract with Oregon Health & Science University (OHSU), to help clinics prepare for patient-level eCQM reporting.

Health IT Stakeholder Groups

Health IT Oversight Council (HITOC)

The HITOC HIT 2017-2020 Strategic Plan was approved by the Oregon Health Policy Board in October 2017 and provides a roadmap for Oregon's HIT work ahead, including strategies for a "network of networks" approach to statewide health information exchange and the HIT Commons public/private partnership model of governance. The plan is available on OHA's Office of Health Information Technology webpage.

In February 2019, OHPB approved HITOC's major 2019 priorities (under the approved Strategic Plan): exploratory work in SDOH/health equity and patient engagement, next steps for statewide health information sharing ("network of networks") efforts (includes physical, behavioral, oral, and other information), wrapping up planning for behavioral health and HIT work, showing Oregon's HIT progress via dashboards and milestones, and potentially updating the Strategic Plan in fall 2019. Ongoing priorities include continued oversight work on partnerships/programs and new landscape assessment as appropriate.

HITOC meets six times a year. Highlights from HITOC's August 2019 meeting include:

- Receiving reports on the development of the HIT Commons as an organization and clarifying HITOC and HIT Commons roles
- Providing feedback on the Oregon Health Leadership Council's social determinants of health and health IT environmental scan and recommended next steps
- Finalizing a work plan for improving behavioral health provider access to health IT, created in collaboration with behavioral health representatives from across Oregon

The work to update the Strategic Plan will begin in 2020.

CCO Health IT Advisory Group (HITAG)

HITAG met in September 2019 as a joint meeting with HITOC's Health IT & Health Information Exchange Community and Organizational Panel (HCOP). The groups learned about current HIE strategies and new opportunities on the horizon. Then both groups collaborated in a discussion about their perspectives on HIE opportunities and challenges over the next five years. They also received updates on the work plan for improving behavioral health provider access to health IT, the HIT Commons social determinants of health and health IT environmental scan and recommended next steps, and the Clinical Quality Metrics Registry.

Health IT & Health Information Exchange Community and Organizational Panel (HCOP)

HCOP met in September 2019, as a joint meeting with HITAG (see meeting description above).

Network of Networks Technical Definitions Workgroup

The planned Network of Networks is a critical part of HITOC's strategy for statewide HIE to support care coordination, population health, patient engagement, and value-based payment models. In its mature form, the Network of Networks may include: coordinating and convening key stakeholders; identifying and implementing needed infrastructure to facilitate exchange; ensuring interoperability; ensuring privacy and security practices; providing neutral issue resolution; and monitoring environmental, technical, and regulatory changes and adapting as needed. It will not include a state-run HIE.

In June 2018, after further study of the current Oregon HIE environment, HITOC chartered two workgroups to develop the Network of Networks concept: a technical definitions group to draft working definitions, and an advisory group to make recommendations to HITOC about key next steps after analyzing approaches and their relative merits in terms of effort, impact, and cost. After meeting with the technical definitions group several times, coordinating with the HIT Commons, and assessing major shifts at the federal level, including the planned Trusted Exchange Framework (TEFCA) and Common Agreement and draft rules promulgated by CMS and ONC, HITOC decided to pause on network of networks efforts until the federal shifts are more clear, in order to avoid conflicting with national efforts. HITOC will continue to monitor the situation and will take action when appropriate.

The Network of Networks Technical Definitions Workgroup did not meet during July-October 2019.

Kindergarten Readiness

As a reminder, this developmental work comprises a four-part, multi-year measurement strategy:

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

During this quarter, the Metrics & Scoring Committee implemented the first part of the strategy by voting to include the both Well-child visits for children ages 3-6 and Preventive dental visits for children ages 1-5 in the 2020 Quality Incentive Program.

During this same time, OHA continued its partnership with Children's Institute, to develop the other components of the multi-year-multi-measure strategy. The workgroup developing the second component of the strategy (a CCO-level measure to improve the social-emotional health of young children) held bimonthly working sessions in this quarter. These meetings will through October 2020, with the goal of developing a measure that the Metrics & Scoring Committee could choose to include in the CCO quality incentive program in 2022.

Oregon is one of only eight states selected to participate in the Aligning Early Childhood and Medicaid (AECM) initiative, supported by the Robert Wood Johnson Foundation, and which aims to improve the health and social outcomes of low-income infants, young children, and families through cross-agency collaboration. This national program is led by the Center for Health Care Strategies in partnership with the National Association of Medicaid Directors and ZERO TO THREE. During this quarter OHA participated in monthly technical assistance meetings as a part of this initiative, focusing on how to engage stakeholders in the development of the measure on social-emotional health. In addition, we planned for an AECM site visit to occur in October, to which thought leaders in health and early learning will be invited to strategize about how to move our work forward.

SDOH / Health-related Social Needs Measure

At its August 2019 meeting the Metrics & Scoring Committee clarified that while long-term aims are to address the social determinants of health, initial measure development should focus on addressing individual health-related social needs. After these decisions, OHA formed an internal planning team to conduct research and staff the to-be-formed public workgroup which will make recommendations on the measure. Discussions in this quarter focused on the role of health IT in this work, and how to coordinate measure development IT efforts related to the social determinants of health that are occurring in Oregon.

The next step will be to form a public workgroup to consider and develop recommendations back to the Metrics & Scoring and Health Plan Quality Metrics Committees. OHA plans to solicit applications for workgroup membership in the next quarter, with the aim of forming the workgroup in early 2020.

Evidence-based Obesity Measure Workgroup (Developmental measure workgroup)

Since May 2018, the Oregon Health Authority has been working on the development of an evidence-based obesity measure for use in the state of Oregon. Workgroup membership includes Oregon Health Authority staff from the Public Health Division and the Health Policy and Analytics Division, and CCO and Local Public Health representatives.

The measure proposal is for a two-part measure. Part 1 focuses on investments in multisector interventions, and part 2 measures the documentation of BMI and referral to intensive interventions to treat obesity diagnosed individuals. Part 1 is planned for roll out in 2021 and part 2 in 2023, depending on acceptance by the Metrics and Scoring Committee. The measure aligns with CCO 2.0 goals because it will increase a focus on issues outside the doctor's office that impact health and build stronger relationships with community partners.

Part 1 of the measure (Multi-sector Interventions) utilizes an attestation model with a point system across five areas. The areas are based on Oregon's Health Evidence Review Commission (HERC) evidence-review guidance document on obesity. The five areas are:

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

During the period of July 1 to September 30, 2019, the workgroup for Part 1 began a pilot test for the attestation point system of the measure. Ten of fifteen CCOs are participating in this pilot project. The purpose of the pilot is to:

- Test the attestation process for the Obesity Multisector Interventions component of the metric.
- Test the capability of CCOs to assess current obesity prevention and treatment work.

The pilot runs from August 5 to December 31, 2019. The results of the pilot will be presented to the Metrics and Scoring Committee in January 2020 and the Health Plan Quality Metrics Committee in February 2020.

During the period of July 1, 2019 to September 30, 2019, the workgroup for Part 2 (documentation of BMI) was on pause while a sub-group conducted a feasibility review with consultation from partner measurement experts. Results of the findings will be presented in October with the goal of finalizing measure specifications by December 31, 2019.

Health Equity Measurement Workgroup (Development measure workgroup)

Oregon Health Authority

In early 2018, the Oregon Health Policy Board tasked the Oregon Health Authority with developing recommendations for measuring health equity in Oregon's healthcare system. The Health Equity Measurement Workgroup convened in October 2018. The workgroup is co-chaired by the Director of OHA's Equity and Inclusion Division, and the Director of the OHA Office of Health Analytics.

The proposed metric measures the proportion of visits with spoken and sign language interpreter needs that are provided by OHA qualified and certified interpreters. The goal of the measure is to ensure meaningful access to health care services for all CCO members through quality communication and language access services, and the delivery of culturally responsive care.

In May 2019 the measure proposal was presented to HPQMC for final decision to include in the 2020 menu set. The committee did not vote to include the measure for 2020. However, in June 2019, a requirement to report the total number of interpreters and type of interpreters provided per quarter was included in CCO 2.0 contracts.

For the period of July 1 to September 30, 2019, an internal OHA workgroup continues to work on measure development for 2021 implementation

I. Budget neutrality

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

Reports are attached separately as Appendix D – Neutrality Reports.

J. Legislative activities

Oregon's 80th Legislative Assembly completed its work on July 30th, after a six-month long legislation session. Highlights of key legislation passed that impacts the Oregon Health plan are as follows:

Legislation to close the funding gap in the state health budget and put Medicaid on a sustainable funding path

Oregon's Medicaid funding gap posed a challenge to Oregon's rate of health coverage, the state's cost-saving health reform efforts, and the strength of its economy. OHA supported the Governor's Medicaid Financing Work Group to develop long-term mechanisms to sustainably fund Oregon's share of Medicaid, which resulted in three bills to provide sustained funding. Two of the three measures passed, significantly closing the funding gap for years to come. OHA will continue to evaluate the third measure – an assessment on large employers who do not cover some portion of employees' health care costs – for possible consideration in a future session.

- HB 2010 updates existing assessments on health plan premiums and hospitals, and extends them for another 6 years, to ensure long-term funding.
- HB 2270 increases the cigarette tax by \$2 per pack and extends the tax on other tobacco products to inhalant delivery systems (e-cigarettes). Of these revenues, 90% will fund OHP and 10% will fund culturally-responsive tobacco cessation and prevention services. This measure goes to a public vote in November 2020.

Legislation to support the transformation of health care delivery and reduce the cost of care through CCO 2.0

Oregon has pioneered innovative cost-saving transformations in health care delivery through Coordinated Care Organizations (CCOs). Based on lessons learned in our first round of contracts, the Oregon Health Policy Board recommended new components of the CCO delivery system in the next round of contracts, known as CCO 2.0.

- HB 2267 puts the Oregon Health Policy Board recommendations into state law, including requiring CCOs to have at least two community representatives on their governing board, requiring CCOs, local public health authorities, and hospitals to partner to develop shared community health assessments and improvement strategies, and establishing tribal liaisons and a tribal advisory council for CCOs. OHA's budget also includes 15 new positions to implement CCO 2.0, many of them focused on complaints and enforcement.
- SB 1041 increases accountability and transparency in CCO finances based on best practices established by the National Association of Insurance Commissioners, and provides OHA with tools to identify when a CCO's financial condition deteriorates – and to intervene if it does – to protect CCO enrollees from losing their access to health care.

Other bills that strengthen the overall health care system in several ways include:

- HB 23 authorizes the collection of abstracted patient discharge records from emergency departments at Oregon's 60 acute care hospitals, filling a critical data gap.
- SB 770 establishes the Task Force on Universal Health Care, which is charged with recommending the design of a Health Care for All Oregon Plan.
- SB 889 establishes the Health Care Cost Growth Benchmark program to control growth of health care expenditures across the entire health care market in Oregon.
- HB 2040 adds new members to the Traditional Health Worker Commission, to help it better identify and address root causes of health problems.

K. Litigation status

Lawsuits and legal actions

There are no significant changes in lawsuits or legal actions to report this quarter.

L. Public forums

Health Evidence Review Commission

August 8, 2019

This testimony concerned the Coverage Guidance on Temporary Mechanical Circulatory Support with Impella Devices being recommended by the Evidence-based Guidelines Subcommittee and corresponding changes to the Prioritized List discussed by the Value-based Benefits Subcommittee (VbBS).

Oregon Health Authority

Erik Schulwolf, an attorney representing Abiomed, spoke about coverage by other payers, including the fact that payers cover Impella for elective high-risk PCI and recommendations of clinical society guidelines include the use of Impella. He expressed concern that OHP would be an outlier. He also raised concern about the procedural validity of the EbGS coverage guidance review. He quoted rules and stated that because Dr. Crispin Davies was designated as an ad hoc expert and did not attend the April EbGS meeting, the draft coverage guidance was not properly approved and argued it could not be considered by VbBS and the full HERC.

Stacey Bunk, Director of Reimbursement at Abiomed, referred the commission to the submitted letters. She stated only 25 Impella devices were used in Oregon Medicaid patients in 2018. She also stated that there were previous EbGS discussions around payment regarding these devices which are misinformed, and because they are built into the DRG, no additional payment would be made. She also mentioned that the FDA letter, which was included in the packet, addressed a right heart device (Impella RP), and was not in the scope of the review. Also, salvage patients were not excluded from the post-approval study (which could explain the lack of a difference in mortality rates).

Erin Hanussak, a patient with no affiliation with Abiomed, shared her story. She became sick in Roseberg, had her gallbladder removed, and woke up 1 week later, learning that an Impella had been implanted at St. Vincent. They were exploring a potential heart transplant, which in the end she did not need. She is now healthy.

Carolyn Bonnin, a retired nurse, shared her story. She described an extensive family history of heart disease. In 2014 she was admitted with chronic cardiomyopathy, scheduled to be transferred to Stanford, then her blood pressure dropped, and she required an Impella.

Kurt Klinger, a patient, shared his story. He started feeling indigestion 4 years ago and went into cardiac arrest with a massive blockage of a coronary artery. He needed an Impella to allow his heart to rest and recover.

Rocky Dallum, from Tonkon Torp, represented the Oregon Bioscience Association. He described challenges in the process and expressed general concerns about different data points used, reliance on experts, and the timing of the coverage guidance development. He stated a concern about how Impella is the standard of care and widely covered, yet Oregon Medicaid can come up with a different coverage recommendation. He shared it was challenging to digest recommendations within the time frame they were given and recommended slowing down the process.

Jason Wollmuth, an interventional cardiologist at Providence, testified about his experience providing Impella. He specializes in complex revascularization and complex coronary artery disease and has used 32 Impella devices out of 350 interventions. He shared he may be an outlier in his low rate of utilization. He described three things that have changed his practice in a major way, with Impella being one of those for high-risk PCI. He described two patient cases.

HERC Value-based Benefits Subcommittee

August 8, 2019

This testimony concerned Lower Extremity Chronic Venous Disease (LECV) interventions that could be used for cosmetic varicose veins, an unfunded condition, or to prevent leg ulcers, a funded condition.

The seven individuals who testified at the August Commission meeting also provided similar testimony at this meeting regarding the Coverage Guidance and corresponding Prioritized List changes regarding Temporary Mechanical Circulatory Support with Impella Devices. Please see the text of the 8/8/2019 HERC meeting for a summary of their testimony.

Monty Madison from Medtronic testified. Madison noted that CLEVD has a 4% annual progression rate, and early treatment results in decreased risk of progression, increased quality of life in patients and reduced cost for treating complications. Treatment has shifted from inpatient surgery to outpatient endovascular procedures.

HERC Evidence-based Guidelines Subcommittee

September 12, 2019

The committee heard more testimony related to updating the 2015 Coverage Guidance on Planned Out-of-hospital Births with committee discussion of the topic planned to continue through at least December.

Sharron Fuchs, a Doctor of Chiropractic, spoke from the audience. She had submitted late written public comment with testimony that appointed expert Melissa Cheyney had presented at another meeting. She asked the group to listen to the testimony and consider her discussion of nulliparity before making a decision.

Silke Akerson, a licensed direct-entry midwife and director of the Oregon Midwifery Council, testified. She said she mostly believes things are going in a good direction but there are still some things that don't belong in an evidence-based coverage guidance for payment. She believes EbGS is still drifting into practice standards in a way you wouldn't for any other group the HERC makes coverage guidance for. She cautioned the group to step back from those places. Fundal height or size discrepancies should not be included; intrauterine growth restriction, gestational diabetes and macrosomia are already included and are clear evidence-based guidance. She is concerned about suspected macrosomia being too vague. Maternal confusion and disorientation are too vague as categories; sometimes there would be clear explanations of what was happening, and no transfer would be required. All history of seizures should not require transfer, such as people who have had mild seizures as children but none for years. The broad endocrine conditions category has been addressed. In hematologic disorders, the consult for history of postpartum hemorrhage requiring intervention is not evidence-based or clear. There are many neurologic disorders that should be a consult but not a transfer, as the range is vast. She expressed concerns about grand multiparas being required to consult, as midwives aren't stupid and can discuss it with their clients and prepare for management of hemorrhage; there is nothing gained by seeing another provider. In fetal monitoring or movement, abnormal heart rate is too vague. The duration and rate need to be specified.

Debbie Cowart, a CPM and LDEM and vice president of the Oregon Midwifery Council and owner of Growing Family Birth Center, testified. She has three small concerns. One is parity of five or more. She has a number of clients with more than five children. As midwives they are always prepared if anyone hemorrhages. When the 2015 HERC coverage guidance was implemented, advanced maternal age was originally a criterion, then it was removed. She asked whether there have been issues in covering these women without consultation. In addition, she suggested the BMI > 35 consult requirement be moved to 40. It is putting a strain on the providers they ask to do consultations; they feel it is ridiculous as the patients are already screened for blood sugar issues or high blood pressure. She added that she has been impressed with the way these meetings are going. She expressed appreciation for the process.

Oregon Health Authority Medicaid Advisory Committee

September 25, 2019

There was no public comment during this meeting

Metrics and Scoring Committee

July 19, 2019

Nine people submitted written comment, which can be found in the July meeting materials on the Metrics and Scoring Committee's webpage.

Oral public testimony provided at the meeting is below:

- Julie Harris, Children's Health Alliance & Foundation, spoke regarding the childhood and adolescent immunization measures, and the challenge of incentivizing adolescent care.
- Heidi Beaubriand, OHA, spoke in support of the Assessments for children in DHS custody measure.

Chandra Elser, Health Share, spoke regarding several topics related to CCO Metrics selection and design, and endorsed the Diabetes: HbA1c poor control; Childhood immunization; Initiation, engagement, and treatment for drug and alcohol use; and Children in DHS custody measures.

September 20, 2019

Public testimony heard at the meeting:

- Chandra Elser of Health Share testified in person, providing brief clarification of the point from their July testimony regarding the Initiation and Engagement of Drug Treatment measure.
- Julie Harris of the Children's Health Alliance (CHA) spoke on metrics related to immunization rates and pediatrics, speaking to the written public testimony from CHA, which is available on the Metrics and Scoring Committee's webpage.

Health Plan Quality Metrics Committee

No public comment in July, August or September.

IV. Progress toward demonstration goals

A. Improvement strategies

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

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

- Lever 2: Implementing value-based payment models to focus on value and pay for improved outcomes.
- Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care.
- Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources.
- Lever 5: Implementation of health-related services aimed at improving care delivery, enrollee health, and lowering costs.
- Lever 6: Testing, accelerating and spreading effective delivery system and payment innovations through peer-to-peer learning, the spread of best practices, and innovation through the Oregon Health Authority's Transformation Center

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

Certified Community Behavioral Health Clinics

The Oregon Health Authority (OHA) Certified Community Behavioral Health Clinic (CCBHC) demonstration program is currently on hold. There is no information to report for the July 1 through September 30, 2019 quarter.

Patient-Centered Primary Care Homes

PCPCH program staff conducted 27 site visits to primary care clinics this quarter. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address barriers.

As of September 30, 2019, 629 clinics were recognized as PCPCHs (eight more than the prior quarter). This is approximately three-quarters of all primary care practices in Oregon. Sixty-five PCPCHs (18 more than the prior quarter) have been designated as 5 STAR, the highest tier in the PCPCH model.

The PCPCH Standards Advisory Committee is a multi-stakeholder body that provides OHA with policy and technical expertise for the PCPCH model of care. The committee will convene monthly from July to December 2019 to review PCPCH implementation progress and advise on refining the model to further guide primary care delivery transformation.

Tribal Care Coordination

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

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The claiming of 100% federal match is made possible by updated CMS guidance contained in State Health Official Letter SHO #16-002 (February 26, 2016). The disbursement of these savings to the tribes is allowed per Governor Brown's letter to the tribes on September 7, 2016.

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

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

OHA has been working with tribal health representatives from Oregon's nine Federally-recognized Tribes to support efforts to establish one or more Indian Managed Care Entities. OHA has been hosting weekly meetings since April 2019 to move this proposal forward. This work is expected to continue into 2020.

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

Comprehensive Primary Care Plus

The Transformation Center manages the Medicaid fee-for-service implementation of CPC+. Per-member, per-month care management fees are a key component of the CPC+ payment model.

The Oregon CPC+ payers had monthly facilitated meetings to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers:

- Documented key aspects of payer implementation of alternative payments, including attribution, calculation and timing of care management fees and performance-based incentives, and payment administration, in a central resource to identify promising practices and areas of alignment/opportunities to streamline non-visit-based financial support for practices;
- Collaborated with CPC+ technical assistance leads to streamline payer/practice communication and interactions and promote information and knowledge sharing; and
- Conducted outreach to CPC+ practices to increase engagement with data aggregation solution.

Value-Based Payment Innovations and Technical Assistance

The CCO VBP Roadmap and VBP technical guide for CCOs were developed and released by the Transformation Center. These reports detail VBP requirements and processes for the next five-year CCO contracts.

Beginning 2021, the center will provide targeted technical assistance to support the CCOs' development of VBP models that consider health equity; are in the five care delivery areas of hospital care, maternity health care, children's health care, behavioral health care, and oral health care; and advance in their level of sophistication.

By 2024, CCOs are required to achieve the five-year VBP targets of 70% for CCOs and their contracted providers.

Primary Care Payment Reform Collaborative

OHA convenes the Primary Care Payment Reform Collaborative, a multi-stakeholder advisory group tasked with assisting OHA with the development and implementation of a Primary Care Transformation Initiative. In 2019 the collaborative formed four work groups to support the work: metrics, evaluation, implementation and technical assistance.

At the July meeting members reviewed and provided feedback on a 2020–2024 workplan drafted by OHA staff, a draft of an aligned metrics set, and an attribution framework. The technical assistance work group provided an update on an environmental scan of TA resources in Oregon.

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

Behavioral Health Collaborative Implementation

The Transformation Center staffs the Regional Behavioral Health Collaborative (RBHC), which is a partnership with behavioral health leaders and stakeholders in the Portland area to improve behavioral health outcomes through collective action across organizations responsible for behavioral health. The initial focus of the RBHC is peer-delivered services and substance use disorder activities that can make an impact in 12–24 months. Three topic-specific work groups are developing implementation plans and measures of success:

- The medical work group is developing a resource document for medical settings engaging peers in caring for patients struggling with substance use disorder.
- The project proposed by the communities of color work group will increase culturally specific peer-run emergency housing and culturally specific trainings for peers.
- The project proposed by the youth and families work group will provide peer-delivered services to youth in foster care.

Additionally, the center is planning a one-day event offering peer-to-peer learning on how CCOs, primary care practices and specialty behavioral health organizations are integrating behavioral health. Topics will include the benefit of integration in reducing emergency department use amongst those with mental illness, effective use of data, and substance use disorder strategies. Registration for the event is full.

Oregon Health Authority Roadmap to Oral Health

Oregon Medicaid has taken several important steps forward regarding oral health integration this quarter.

OHA has embarked on an effort to draft oral health integration performance indicators for coordinated care organizations (CCOs) starting in 2021. The authority anticipates completing this process in March 2020.

OHA has also submitted rules under the state Medicaid program allowing dentists to perform HbA1c tests to aid in the diagnosis and treatment of people with diabetes and to administer vaccines.

Finally, the Metrics and Scoring Committee, which recommends outcomes and quality measures for CCOs, adopted a set of incentive metrics that includes two which directly encourage integration of oral health care. One measures the rate of preventive dental care for children ages 1-14, with a special emphasis on the 1-5 age group. The other measures the rate of oral exams for adults with diabetes.

Statewide Performance Improvement Project

The current statewide PIP, based upon calendar year (CY) 2019-2021, is in the design phase. OHA and CCOs selected the topic of opioid prescribing in acute situations. The measure is currently defined as:

Percent of patients with at least one opioid prescription in one year, who have no opioids prescribed in the prior six months, among patients in the population by days' supply (i.e., ≤ 3 , 4–7, 8–13, and ≥ 14).

Discussion on the baseline measurement period for the PIP is underway with multiple contributing factors. Factors include but not limited to: rebalance of OHP enrollees to CCO 2.0 contractors, timing of reporting to CCOs, and timing of reporting due to OHA from CCOs.

Performance Improvement Projects

As part of the CMS 1115 OHP waiver, attachment E, CCOs are expected to develop and implement three additional PIPs and/or focus study; outside the statewide integration PIP focus.

Figure 4 (below) illustrates the current breakdown by focus area for these additional PIPs. The CCO PIP Quarterly Summary is also publicly available on OHA's Quality Improvement Program webpage.

For the coming calendar year, 2020, OHA will be working with the external quality review organization, HSAG, on the review summary provided to OHA to better support rapid cycle improvement implementation. Prioritizing the areas of opportunities for CCOs to receive technical assistance will further move the CCOs to continuous quality improvement methods in ensuring health transformation and quality of care for OHP enrollees.

Oregon Health Authority

Oregon Health Authority is using a portion of funds to modernize statewide population health surveillance systems and to make upgrades to the Oregon State Public Health Laboratory. Improvements to statewide health data and the public health lab ensure health care providers and others have the information they need to understand and respond to health threats.

Sustainable Relationships for Community Health program

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

The Sustainable Relationships for Community Health (SRCH) grant was awarded to four teams for 2019-2020:

- Hood River County Public Health
- Tillamook County Community Health Centers
- Intercommunity Health Network CCO
- Public Employee Benefit Board (PEBB)

Hood River County Public Health, Tillamook County Community Health Centers, and Intercommunity Health Network CCO teams include partners from local public health authorities (LPHAs), Oregon federally recognized tribes, urban Indian health programs, coordinated care organizations (CCOs), regional health equity coalitions (RHECs), clinics, and community-based organizational partners delivering self-management programs (SMPs).

The Public Employee Benefit Board is comprised of PEBB leadership, the PEBB Board and its three health plans: Kaiser Permanente, Moda Health, and Providence Health Plan.

Over the grant year, these teams will develop and strengthen relationships, co-design strategies to formalize infrastructure and/or arrangements between health system partners and community-based organizational partners (e.g., closed loop referrals, memorandums of understanding), implement quality improvement processes, and collect, analyze and share data in order to reduce some of the leading causes of death and disability in Oregon. There are three in-person SRCH Institutes, each lasting two days: SRCH Institute 1 in October, SRCH Institute 2 in February, and SRCH Institute 3 in May. During this quarter, the SRCH teams began their work with team kickoffs and planning sessions in July and August and gathered baseline data to determine priority populations and pilot projects for SRCH grant year. Each team receives technical assistance from their OHA team liaison, who provides support during the Institutes as well as between Institutes with monthly technical assistance calls.

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

Health-related services

CCOs receive a global payment for each member, which provides CCOs the flexibility to offer health-related services (HRS) to improve the health of Oregon's Medicaid population. To answer questions CCOs have about housing-related services and supports can qualify as HRS, the OHA published a Health-Related Services and Housing Guide available on the Transformation Center's webpage.

The Oregon Rural Practice-based Research Network (ORPRN) held interviews with CCOs, clinics and health systems partners to inform technical assistance to CCOs, including work group calls and a peer-learning convening about how CCOs are implementing HRS and what services or initiatives CCOs are funding.

OHA staff reviewed CCOs' 2018 HRS policies and shared opportunities with CCOs to update their policies to align with Oregon administrative rules for 2019. The 2019 CCO HRS policies will be reviewed with an eye toward policy requirement changes due to changes in rule and CCO contract. Staff have also reviewed CCO HRS spending data and will give feedback to each CCO on appropriateness of HRS expenditures, as well as share global themes. Through this process, OHA has learned we need to give more instruction and support for how to submit HRS expenditures.

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

Transformation Center activities

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

Behavioral health integration

The center staffs the Regional Behavioral Health Collaborative (RBHC), which is a partnership with behavioral health leaders and stakeholders in the Portland area to improve behavioral health outcomes through collective action across organizations responsible for behavioral health. The initial focus of the RBHC is peer-delivered services and substance use disorder activities that can make an impact in 12–24 months. Three topic-specific work groups are developing implementation plans and measures of success:

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Oregon Health Authority

Oral health integration

The Transformation Center, working with Health Systems Division, updated the dental coverage awareness toolkit with new translations of key messages for CCOs and DCO partners to use in social media campaigns with members. In addition to English and Spanish, the messages are now available in Russian, Vietnamese, Simplified Chinese, and Traditional Chinese.

The Transformation Center also contracted with a vendor to lead a cross-agency team with oral health and metrics expertise to develop performance indicators of oral health integration for CCOs starting in 2021.

Population health

Community advisory council activities

The Transformation Center continued to host monthly CAC learning collaborative calls on CAC member recruitment and engagement and other topics. The center is planning two CCO 2.0 webinars for December to cover CAC changes taking place through the contract and rule processes.

Community health assessment (CHA) and community health improvement plan (CHP)

OHA reviewed every CCOs second CHP, with CCO feedback planned for November.

The Transformation Center developed guidance for CCOs to reflect changes in requirements for CHAs and CHPs. In 2020, CCOs will be required to have a shared CHA/CHP with local public health authorities, hospitals, other CCOs and tribes that share service areas, as well as two shared health priorities or strategies from the State Health Improvement Plan. Additional TA and guidance will be provided to CCOs in early 2020.

CCO incentive metrics technical assistance

The CCO incentive measure set for 2020 was finalized in July. The Transformation Center is planning needs assessments and technical assistance to support several of the metrics.

Controlling high blood pressure

The Transformation Center closed out the CME-accredited webinar for clinicians on controlling high blood pressure. Seventy-eight people registered and 38 passed the post-test. Eighty-eight percent of evaluation respondents rated it as valuable or very valuable (12% neutral).

Cross-cutting supports

Transformation and Quality Strategy technical assistance

Transformation Center staff shared feedback with each CCO on their 2019 Transformation and Quality Strategy (TQS; submissions now posted on the Transformation Center's webpage) based on OHA subject matter expert reviews. Center staff also worked with component subject matter experts to update all TQS guidance documents for the 2020. Center staff are facilitating a process to design a scoring framework for next year's submissions and are managing the CCO TA development that will run from January through March.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Reports are attached separately as Appendix A – Enrollment Reports. (July-September 2019, as posted for this period, is a preliminary report.)

2. State reported enrollment table

Enrollment	July 2019	August 2019	September 2019
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	948,093	949,156	950,729
Title XXI funded State Plan	90,587	90,385	91,229
Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
<i>Pharmacy Only</i>	N/A	N/A	N/A
<i>Family Planning Only</i>	N/A	N/A	N/A
	N/A	N/A	N/A
Enrollment current as of	July 30, 2019	August 30, 2019	September 30, 2019

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member Months	Percent change from previous quarter	Percent change from same quarter of previous year
Expansion	Title 19	PLM Children FPL > 170%	0	0	0.00%	0.00%
		Pregnant Women FPL > 170%	0	0	0.00%	0.00%
	Title 21	SCHIP FPL > 170%	34,994	94,544	-24.22%	-12.26%
	Title 21	SCHIP FPL < 170%	87,333	235,678	-18.60%	15.24%
Mandatory	Title 19	Other OHP Plus	140,191	406,071	-12.53%	-11.92%
		MAGI Adults/Children	642,167	1,824,364	-15.08%	-13.22%
		MAGI Pregnant Women	9,853	23,372	-17.88%	-24.12%
QUARTER TOTALS			914,538			

Oregon Health Authority
OHP eligible and managed care enrollment

OHP Eligibles*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
July	986,924	892,068	1,101	335	10,370	45,331	1,104
August	988,456	885,484	614	326	10,543	45,887	1,077
September	990,721	877,271	632	310	10,585	45,875	1,058
Quarter average	988,700	884,941	782	324	10,499	45,698	1,080
		89.51%	0.08%	0.03%	1.06%	4.62%	0.11%

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

B. Complaints and grievances

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

C. CCO appeals and hearings

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

D. Neutrality reports

Reports are attached separately as Appendix D – Neutrality Reports.