Conference Call Number: 1-888-808-6929
Public Participant Code: 915042#

Oregon Health Policy Board
AGENDA
August 7, 2018
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 2:30 p.m.

#	Time	Item	Presenter	Purpose
1	8:30	Welcome, Minutes Approval, Calendar Review	Zeke Smith, Chair	Action
2	8:40	Conflict of Interest Policy	Jeff Scroggin, OHA, Health Policy Analyst	Review
3	8:55	Public Testimony		
4	9:05	OHA Report	Pat Allen, OHA Director	Informational & Discussion
5	9:15	CCO 2.0: Preferred Drug List Analysis	Tim Sweeney, OHA, Health Policy Analyst Trevor Douglas, OHA, Pharmacy Purchasing and Oregon Prescription Drug Program Director Michael Sharp, R.Ph., Pharmacy Consultant, Myers & Stauffer Jennifer Murray, PharmD, Senior Manager, Myers & Stauffer	Discussion
6	10:45	Break		
7	10:55	CCO 2.0: Development Update & Draft Straw Model Development	Jeremy Vandehey OHA, Health Policy & Analytics	Informational
8	11:30	Lunch Break		
9	11:45	CCO 2.0: Draft Straw Model Review	Chris DeMars, OHA Transformation Center Director Leann Johnson, OHA Office of Equity and Inclusion Director Chelsea Guest, OHA Actuarial Unit Manager Jackie Fabrick, OHA Behavioral	Informational & Discussion

			Health Policy	
10	2:30	Adjourn		

Next meeting:
September 11, 2018
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

Everyone is welcome to the Oregon Health Policy Board meetings. For questions about accessibility or to request an accommodation, please call 541-999-6983 or write HealthPolicyBoard.Info@state.or.us. Requests should be made at least 48 hours prior to the event. Documents can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request a document in another format or language please call 541-999-6983 or write to HealthPolicyBoard.Info@state.or.us

Oregon Health Policy Board
DRAFT July 10, 2018
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

Item	
OHPB video and audio recording To view the video, or listen to the audio link, of the OHPB meeting in its entirety click here. Agenda items can be reviewed at time stamp listed in the column below.	
Welcome and Call To Order, Chair Zeke Smith Present: Board members present: Chair Zeke Smith, Vice-Chair Carla McKelvey, Felisa Hagin, David Bangsberg, Oscar Arana, John Santa(phone) The Board voted to approve the June minutes with updated HQMC section added.	
OHA Report: Reorganization, Jeremy Vandehey, OHA Pat provided an organizational update and relayed the Agency is currently seeking applications for Medicaid Director and Behavioral Health Director.	00:27:59
CCO 2.0: CCO 1.0 & Health System Transformation, Jeremy Vandehey, OHA Health Policy & Analytics Director Jeremy provided contextual history regarding Oregon's health reform development. The Board discussed how the process was developed and how it compares to the current process. Jeremy provided an update on procurement design features. He noted the decision to use a Request for Application process and which entities can apply, including current CCOs, plans and providers taking risk in Oregon. CCOs will not be limited to one per area, Dr. McKelvey noted concerns with provider burden from multiple CCOs in a region and Dr. Santa noted concerns with administrative costs when there are multiple CCOs in a region. Zeke asked about assumptions and values tied to the procurement process and how the procurement process is designed to facilitate the reflection of those values.	00:31:21
CCO 2.0: Input Process & Themes, Steph Jarem, OHA, Policy Analyst Steph provided an overview of public meetings and survey results related to CCO 2.0. Jeremy shared major themes captured during the road show including: -Improve BH	01:02:43

Oregon Health Policy Board
DRAFT July 10, 2018
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

-Address social factors that affect health and reduce health disparities -Reduce healthcare costs -Pay for better health -Strengthen transparency and accountability The Board noted other themes and challenges including: focusing on children's needs and early intervention, affordable housing, prescription drug costs, market "critical mass" for value-based payment, administrative costs	
<u>CCO 2.0: Impact Framework, Steph Jarem, OHA, Policy Analyst</u> Steph briefed the impact analysis development process and short-term timeline. Zeke asked for information regarding how committees and partners have helped developed policy options. Felisa asked about how the HEC and early learning were involved in shaping recommendations and the Board considered tweaks like investments in public health in key areas, e.g. school based care.	01:35:25
<u>CCO 2.0: Impact and Analysis, Christ DeMars, OHA Transformation Center Director, Leann Johnson, OHA Office of Equity and Inclusion Director, Chelsea Guest, OHA Actuarial Unit Manager, Mike Morris, OHA Behavioral Health Administrator</u> Statewide priority: Chris DeMars discussed options for SDOH state wide priorities and local control/flexibility. The Board noted that housing is likely a statewide priority but that local areas should have flexibility to address and identify other priorities. CACs: The Board discussed the importance of collecting demographic data. CHAs/CHPs: The Board discussed and supported the concept for shared priorities and strategies to develop CHPs and CHAs VBP: Will be considered another time due to time constraints.	01:58:08

Oregon Health Policy Board
DRAFT July 10, 2018
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

Variable Profit: Chelsea shard information regarding CCO rate setting and medical load builds. The Board discussed Health Related Services as a component of variable profit and efficiency measurement. Zeke articulated support for the policy and asked for more info on Health-Related Services. BH: The Board discussed how regions with multiple CCOs might collaborate on shared outcomes and how a focus on process might be more helpful for the BH delivery system. The Board asked for further clarity on processes needed, outcomes and accountability. Felisa asked what was more helpful to CCOs and the system, process or outcome measures, consider lessons learned about BH outcome incentive metrics. Zeke asked for clear recommendations and information about outcomes and tension points.	
<u>CCO2.0: Final Report Framework & Reflections, Chair Smith</u> Zeke asked for system and OHA capacity to be included in recommendation considerations.	03:12:00
<u>Public Testimony</u> Montana Gay, ORCHW - Effective, sustainable payment model for CHWs - OHA develop a CHW utilization plan for CCOs (increase retention) - Definitions of scope of practice - Clear list of deliverables that demonstrate CHWs being used at top of practice - 5-year trajectory plan for use of CHWs in CCOs - Partner with CBOs Iris, THW supervisor for Cornerstone (THWs in Eugene) - Engage with affordable housing system - Utilize THWs - Sustainable payment mechanisms for THWs Linda, Oregon Latino Health Coalition - Co-chair of SB 558 external workgroup	00:07:33

Oregon Health Policy Board
DRAFT July 10, 2018
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

- Community partnership is vital to success of public policy Jorge Gutierrez, Lower Columbia Hispanic Council (Astoria) - Member of SB 558 - Conducts OHP outreach and enrollment - Members face cultural and linguistic barriers, especially when calling - Phone and mailers come in English despite requests for Spanish Bruce Thomson - HCAO Action - Referenced written public testimony regarding CCO 2.0 policy options	
Adjourn	

Next meeting:
August 7, 2018
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 3:00 p.m.

2018 OHPB CALENDAR

DRAFT

Updated 7/31/18

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items; the Board may take action regarding committee membership and formation as needed)	Action Plan Foundational Strategies	Reports	Legislative Mandates
January 2, 2018	• OHPB Retreat • CCO 2.0 Development & Planning • Action Plan for Health Update	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress	-Oregon Health Insurance Survey Fact Sheets -CCO Metrics Report	Health Care Workforce Assessment due to Leg. Assembly. Behavioral Health Collaborative progress report due to JCW&M
Feb 6, 2018	• 2018 Legislative Briefing	• Improve health equity • Increase access to health care • Enhance care coordination	-Primary Care Spending Report	Legislature in Session
Mar 6, 2018	• Supporting Health System Transformation: The Transformation Center • CCO 2.0 Workstream Review	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items; the Board may take action regarding committee membership and formation as needed)	Action Plan Foundational Strategies	Reports	Legislative Mandates
April 3, 2018	• Workforce Committee Report on Health Care Provider Incentive Program • Action Plan for Health Update (tentative) • Opioid Crisis Discussion • CCO 2.0 Update	• Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		
May 1, 2018 (EXTENDED MEETING: 2 PM)	• PHAB Update & Presentation: baseline accountability metrics • HEC Update • Medicaid Advisory Committee (MAC) SDOH Update • CCO 2.0 Update	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		
June 5, 2018 (EXTENDED MEETING: 2: 30 PM)	• HPQMC Update • CCO 2.0 Update & Draft Model Review	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		
July 10, 2018	• CCO 2.0 Development	• Engage stakeholders and community partners • Pay for outcomes and value • Measure progress	-CCO Metrics Report -Hospital Transformation Performance Program Report	PHAB recommendations to OHPB re: Accountability Metrics. Due date is not in statute.

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items; the Board may take action regarding committee membership and formation as needed)	Action Plan Foundational Strategies	Reports	Legislative Mandates
August 7, 2018 **(EXTENDED MEETING: 2:30 PM)**	• CCO 2.0: High Cost Drugs • CCO 2.0: Development	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress	-Hospital Financial Report	Workforce Financial Incentives Evaluation Report, due to interim health committees of the Leg. Assembly every 2 years, first due Sep. 2018. OHA report to OHPB re: Status of Doulas in Oregon Sep. 2018
September 11, 2018	• CCO 2.0: Finalization	• Engage stakeholders and community partners • Measure progress	-WF composition report	
October 2, 2018 **OUT OF AREA MEETING: LAKE COUNTY (tentative)**	• Workforce Provider Incentive Program Update • Engaging Stakeholders & Partners Discussion • CCO 2.0: Finalization	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress	-Oregon Health Insurance Survey Fact Sheets	
November 6, 2018	• Behavioral Health Collaborative Report • Primary Care Collaborative Update	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		Primary Care Collaborative Report

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items; the Board may take action regarding committee membership and formation as needed)	Action Plan Foundational Strategies	Reports	Legislative Mandates
December 4, 2018	• Health Information Technology Oversight Council (HITOC) Annual Workplan Review	• Increase access to health care • Enhance care coordination • Engage stakeholders and community partners	-Hospital Community Benefit Report	Behavioral Health Collaborative final report due to JCW&M

OHPB Committee Digest

PUBLIC HEALTH ADVISORY BOARD, METRICS & SCORING COMMITTEE, HEALTH PLAN QUALITY METRICS COMMITTEE, HEALTH INFORMATION TECHNOLOGY OVERSIGHT COUNCIL, HEALTHCARE WORKFORCE COMMITTEE, HEALTH EQUITY COMMITTEE, PRIMARY CARE COLLABORATIVE, MEDICAID ADVISORY COMMITTEE, STATEWIDE SUPPORTIVE HOUSING WORKGROUP, MEASURING SUCCESS COMMITTEE

Public Health Advisory Board

During the July meeting, the PHAB heard and discussed examples of how the public health system is modernizing its response to environmental health issues using Cleaner Air Oregon as an example. The PHAB also heard about and discussed progress on progress on the suicide prevention priority of the current State Health Improvement Plan. The PHAB provided informal input to the Public Health Division on criteria to use to establish priorities for the 2020-2024 State Health Improvement Plan, development of which is underway with a steering committee that includes Tribes, and community and organizational stakeholders.

The Public Health Advisory Board (PHAB) discussed policy recommendations to advance population health through CCO 2.0 at their November 2017 and February 2018 meetings, and adopted a set of policy recommendations in February 2018. These were submitted to the Oregon Health Policy Board in March 2018, and presented to the board at their May meeting by Rebecca Tiel, PHAB Chair. PHAB's recommendations highlight areas where health care and public health can partner to achieve maximum impact on health outcomes, and are available on the PHAB website. Recommendations include strengthening opportunities to address local priorities through shared community health assessments and community health improvement plans, and including local public health authorities in value-based payment strategies. The August PHAB meeting is cancelled; the PHAB will reconvene in September 2018.

COMMITTEE WEB SITE: https://www.oregon.gov/oha/ph/About/Pages/ophab.aspx
STAFF POC: Kati Moseley, Katarina.Moseley@dhsoha.state.or.us

Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative convened July 24 to review and provide input on two straw proposals: 1) A primary care payment model developed by the Payment Improvement & Alignment workgroup; and 2) A behavioral health integration payment model developed by the Behavioral Health Integration workgroup. Both payment models were informed in part by CCO 2.0. The workgroups will incorporate input from the Collaborative into the straw proposals over the next three months and will present final drafts of the proposals at the October 23, 2018 meeting. Over the next three months the Metrics & Evaluation workgroup will be reviewing current metrics and making a recommendation on alignment to the Collaborative. This workgroup is also considering evaluation options of the Primary Care Transformation Initiative.

The Collaborative convenes next on July 24, 2018 from 9:00 a.m. – 12:00 p.m.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx.
COMMITTEE POC: Amy Harris, AMY.HARRIS@dhsoha.state.or.us

Healthcare Workforce Committee

The Healthcare Workforce Committee met on July 11.

CCO 2.0
The Committee presented recommendations for additional policy options dealing with the healthcare workforce in May. At the July meeting an update was given on the 2.0 development timeline and advancement of policy options.

Labor Market Information—Trends in Health Care Employment:
The Committee heard from officials with the Employment Department about the latest 10-year trend data, including which professions are considered by employers to be in greater demand over the next decade.

Increasing the Diversity of the Healthcare Workforce:
The Committee has begun to consider promising solutions for increasing the diversity of the healthcare workforce, and has formed a workgroup that includes the involvement of the Health Equity Committee. The working group met prior to the Committee meeting. A report is expected in September.

Behavioral Health Workforce:
Several members of the Committee have formed a working group facilitated by Behavioral Health Policy staff and are advising the Farley Center on the skills and competencies required for the behavioral health workforce of the future. The group met prior to the Committee meeting.

Upcoming Meeting and Work:
The next meeting of the Committee will take place on September 12. At that time there will be continued discussion of strategies to increase the diversity of the healthcare workforce, an update on discussion with health professional licensing boards to improve the accuracy and completeness of provider data, and discussion on the program evaluation and the Needs Assessment required under HB 3261.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/HP-HCW/Pages/index.aspx
COMMITTEE POC: MARC OVERBECK, Marc.Overbeck@dhsoha.state.or.us

Health Plan Quality Metrics Committee

The Health Plan Quality Metrics Committee (HPQMC) published the Final 2019 Aligned Measure Menu on June 1. The list includes 51 health care quality measures within six domains of health care services. The list also includes three on-deck measures that will take effect in 2021 and replace measures currently in the menu. These are measures that are not yet ready to be implemented, but have near-term potential. The complete aligned measure set is available online.

At the June 14th regular meeting, the committee reelected Committee Chair, Kristen Dillon, MD, and Committee Vice-chair, Shaun Parkman, for another one-year term. Also at this meeting, the committee debriefed Year 1 processes and outcomes and began planning for future work to refine the measures menu.

The committee did not meet in July. The next meeting is Thursday August 9, 2018 by webinar only.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/analytics/Pages/Quality-Metrics-Committee.aspx
COMMITTEE POC: Kristin Tehrani, Kristin.Tehrani@dhsoha.state.or.us

Metrics & Scoring Committee

In July the Metrics & Scoring Committee finalized the 2019 CCO incentive measure set. The full measure set can be found here: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOData/2019-Incentive-Measures.pdf. The Committee will choose the challenge pool measures and begin selecting benchmarks at its August meeting.

The Committee has been receiving CCO 2.0 updates for some time. In January 2018 the Committee received a presentation on the CCO 2.0 process. Since that time, the Committee has received standing verbal updates on the CCO 2.0 process. In addition, at its July meeting the Committee had a more substantive update on CCO 2.0, with particular reference to policy options related to the incentive program (the presentation is available on the committee's website.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx
COMMITTEE POC: Sara Kleinschmit, SARA.KLEINSCHMIT@dhsoha.state.or.us

Health Information Technology Oversight Council

HITOC's June meeting featured discussion of CCO 2.0 policy options from the value-based payment and behavioral health workgroups and revisited the HIT policy options being developed for CCO 2.0. HITOC will sponsor a series of public meetings to get input on the HIT policy options beginning on June 27th. HITOC also approved the charter for the network of networks advisory group, which will begin foundational work to support statewide health information exchange, and discussed a proposed federal rule that would change elements of the CMS Meaningful Use Program. HITOC's next meeting is on August 2nd.

HITOC discussed CCO 2.0 in the following meetings: February 1, April 5, June 7, and August 2 (planned). Agendas, minutes, and recordings are available at the HITOC website. The committee provided input on the social determinants of health/equity, behavioral health, and value-based payment policy options. HITOC also reviewed the health IT policy option areas of focus, agreed that they were the right areas of focus, and asked OHA staff to seek further stakeholder input to support development of more specific proposals. OHA hosted two public meetings on the health IT policy option proposals that reached over 100 Oregonians, representing a broad-cross section of stakeholders, and yielded significant public comment. Recordings and materials and comments are available at HITOC'S website.

HITOC's August 2 meeting will include a report back about the public comments on the health IT policy options and an extended public comment period.

HITOC's support for the health IT policy option areas of focus is captured in minutes/recordings of the April 5 meeting and in a letter to OHPB from HITOC

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/OHIT-HITOC/
Committee POC: Francie Nevill, Francie.j.nevill@dhsoha.state.or.us

Medicaid Advisory Committee

The MAC met on July 25, 2018. Key topics and agenda items included:

- An update from OHA's dental and oral health program leaders on various actions and strategies underway;
- Review of the first draft of an upcoming guidance document for CCOs on how they can use Health Related Services to provide housing-related services to OHP members; and
- Listened to a first-hand member story to better understand the experience of OHP members with complex health conditions and needs.

The housing guide for CCOs will be developed in conjunction with OHA, and builds on feedback from the Statewide Supportive Housing Strategy Workgroup, its survey, and follow up interviews with CCOs regarding work in the social determinants of health, and the evidence base around housing and health. The guide is expected to be completed and released to CCOs in the Fall of 2018.

The MAC is currently recruiting new members to replace several members whose terms expire in 2019 and fill existing vacancies. The application deadline for interested individuals is August 15th.

The recruitment announcement can be found here:
https://www.oregon.gov/oha/HPA/HP/Documents/MAC%20Recruitment%20notice__June2018.pdf

The MAC heard CCO 2.0 updates at meetings in April, May, and July and issued a report to the OHA in May titled Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon's CCO Model.

The MAC submitted a second set of recommendations to OHA highlighting how OHA can support and hold CCOs accountable for addressing the social determinants of health, in line with the committee's previous recommendations. These recommendations were included as a specific letter to the agency as part of the CCO 2.0 policy development process and is posted on the OHPB's CCO 2.0 website with recommendations from other outside groups.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/hpa/hp-mac/pages/index.aspx
COMMITTEE POC: Tim Sweeney, Timothy.D.Sweeney@dhsoha.state.or.us

Health Equity Committee

At the May Health Equity Committee members shared that they would like to have more information about the Race, Ethnicity, Language and Disability policy and the implications data has for the work on health equity and the elimination of health disparities. Marjorie McGee, Ph. D and OEI staff leading the development and deployment of the REAL-D policy presented at the July meeting.

HEC Workgroups updates:
The Co-Chairs reported that they met with OEI Director and shared an updated version of the co-chair accountability plan based on the committee's feedback provided at the June meeting.
The Workplan workgroup provided some general updates to the tools presented in the June meeting.
The Recruitment workgroup reported that there was an urgent need for the HEC committee members that have not completed the skills assessment to do so. This is a tool the workgroup will use in the process of replacing members that have left the committee since November 2017.
HEC members are interested in stepping up to lead the policy and TA workgroups. There will be more discussion about this new workgroup at the August meeting

Staff from OHA presented to the Health Equity Committee in the month of April. There were two sets of policy options that were presented to the HEC: Social Determinants of Health and Health Equity and Behavioral Health. In May and June committee members had the opportunity to review the policy options, ask questions and develop a set of recommendations that were approved by the full committee on June 12th, 2018. On June 13th, co-chairs Michael Anderson-Nathe and Carly Hood-Ronick submitted feedback on behalf of the committee to Director Allen and Chair Smith in both areas. Health Equity Committee feedback can be found here: https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx

The August HEC meeting will include an educational component on Legislative process.

COMMITTEE WEBSITE: https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx
COMMITTEE POC: Maria Castro, Maria.Castro@dhsoha.state.or.us

Statewide Supportive Housing Strategy Workgroup

The SSHSW has been meeting since July 2017 to explore what may be needed in both the housing sector and the health care sector to expand permanent supportive housing (PSH) options in Oregon. A critical part of the group's discussion is also what program, funding, policy and other infrastructure is needed to support this work. SSHSW members are external partners from CCOs, Community Mental Health Programs, Hospital Systems, Counties, Housing Authorities, Community Development Organizations, and a variety of community-based housing and behavioral health organizations.

Since March 2018, in relation to health care sector topics that may intersect with CCO 2.0 considerations, the SSHSW has looked at OHA's pending submission of a CMS SUD waiver application (July 2018); the use of health-related services funds on housing supports (May 2018); and Louisiana's PSH bundled Medicaid benefit (March 2018). Louisiana has created a program to train and certify a cadre of PSH provider agencies, who are contracted with every managed care organization in the state to deliver services and connect people to housing through a coordinated system that uses braided funding to leverage multiple sectors. CMS waivers and plan amendments to fund tenancy supports are identified as a key component of successful PSH. Their results have shown a 94% housing retention rate and reductions in emergency department use, hospitalization, and Medicaid costs. Slides, a meeting summary, and brief on Louisiana's model are with the March 2018 meeting materials on the committee website. SSHSW's concluding recommendations for PSH in Oregon are pending and anticipated in November 2018.

COMMITTEE WEBSITE: http://www.oregon.gov/ohcs/Pages/supportive-housing-workgroup.aspx.

COMMITTTEE POC: Heather Gramp, Heather.Gramp@dhsoha.state.or.us

Measuring Success Committee

The Measuring Success Committee of the Early Learning Council did not meet in July, but will resume monthly meetings beginning Wednesday, August 1st. The committee will continue its work on developing an early learning system "dashboard" to track cross-sector efforts to promote readiness for kindergarten and healthy, stable, and attached families. The committee is in the process of identifying a set of both medium-term intermediate outcomes and measures as well as long-term ultimate outcomes and measures. These efforts will continue in parallel to the Council's work on developing an early learning system strategic plan.

COMMITTEE WEBSITE: N/A
COMMITTEE POC: Thomas George, Thomas.George@state.or.us

OREGON HEALTH POLICY BOARD
Conflict of Interest Policy

This Conflict of Interest Policy governs the activities of the Oregon Health Policy Board. Board members are appointed, in part, because of their diverse experiences in their professional and civic lives. The Board further recognizes that persons appointed to this body bring valued histories of service to varied populations in the state or to stakeholder groups. Each Member is reminded that by accepting membership on the Board, they agree to serve the broader goals of establishing health policy for the State of Oregon.

This policy is designed to ensure that voting members of the Oregon Health Policy Board identify situations that present possible conflicts of interest and to describe appropriate procedures if a possible conflict of interest arises. The Board seeks to promote transparency and integrity of its decision-making process, aided by this policy. Questions about this policy should be directed to the Chairperson of the Board or to the Director of the Oregon Health Authority (Director).

1. **What general policies should Board members follow?** Board members should:
    - Put loyalty to the highest ethical standards above loyalty to government, persons, political party, or private enterprise.
    - Not make private promises that are binding upon the duties of a Board member, because a public official has no private word that can be binding on public duty.
    - Expose corruption wherever discovered.
    - Uphold the principles described in this policy statement, and stay conscious to the public's interest.

2. **What is a conflict of interest?** A conflict of interest arises when a Board member has a personal financial interest that conflicts with the interests of the Board.

    An **actual** conflict of interest occurs when the action taken by the Board member ***would*** affect the financial interest of the Board member, the Board member's relative or a business with which the Board member or relative is associated.
    A **potential** conflict of interest exists when the action taken by the Board member ***could*** have a financial impact on that Board member, a relative of the Board member or a business with which the Board member or the relative of the Board member is associated.

    The Board recognizes that the standards that govern its conduct are fully set forth in ORS Chapter 244. It is therefore the policy of this Board that all Board members, upon confirmation of appointment, and periodically thereafter, are made aware of the requirements of this law, or subsequent versions thereof. It is the Board's intent that the statutory requirements set forth in Oregon law are binding authority to which members must adhere, and that this Conflict of Interest Policy, or others adopted in furtherance of its purposes, be viewed and utilized as elaboration and guidance.

3. **How do Board members identify conflict of interest situations?** Board members are encouraged to examine prospective issues at the earliest opportunity for the potential of a conflict of interest and are reminded that compliance with the statutory requirements often require sensitivity to avoiding the appearance of impropriety. Members are to consult with the Chairperson of the Board or the Director for guidance where appropriate.

The following circumstances do not represent a conflict of interest:

- If the conflict arises only from a membership or interest held in a particular business, industry or occupation or other class that was a prerequisite for holding the Board position.
- If the financial impact of the official action would impact the Board member, relative or business of the Board member or relative to the same degree as other members of an identifiable group or class.
- If the conflict of interest arises only from a position or membership in a nonprofit corporation that is tax-exempt under 501(c) of the Internal Revenue Code.

4. **Duty to disclose.** Board members should disclose to the Board Chairperson as soon as the Board member is aware of the actual or potential conflict of interest.

   Board members must publicly announce the nature of the conflict of interest before participating in any official action (discussion or voting) on the issue giving rise to the conflict of interest.

   - Potential conflict of interest: Following the public announcement, the Board member may participate in official action on the issue that gave rise to the conflict of interest.

   - Actual conflict of interest: Following the public announcement, the Board member must refrain from further participation in official action on the issue that gave rise to the conflict of interest.

   - If a Board member has an actual conflict of interest and the Board member's vote is necessary to meet the minimum number of votes required for official action, the Board member may vote. In this situation, the Board member must make the required announcement and refrain from any discussion, but may participate in the vote required for official action by the Board. These circumstances are rare.

5. **Record of proceedings.** The Board shall keep a record of disclosures of conflict of interest and the nature of the conflict in the public record.
6. **Does this policy apply to the Board's Committees?** Committee members should follow this policy when engaged in decision-making with the Committee, conferring as needed with the chairperson of the Committee or the Director of the Oregon Health Authority or his designee. Public employees should follow the conflict of interest policies of their appointing authority.

CCO 2.0 Pharmacy Policy Options & Update

Oregon Health Policy Board
August 2018

Oregon Health Authority

Overview

I. Introductions & Goals for Today's Conversation (5 minutes)
II. Overview of Current Strategies Underway (15 minutes)
  – Oregon Prescription Drug Program
  – HB 4005 Task Force
  – CCO 2.0 & Pharmacy
III. PDL Analysis Presentation from Myers & Stauffer (35 minutes)
IV. Discussion (30 minutes)

Goals For Today's Presentation

- Review the important role of pharmaceuticals with relation to our Triple Aim goals
- Update the Board on several pharmacy policy strategies underway by OHA, including CCO 2.0 policy options
- Understand, review and discuss PDL alignment strategies (informed by Myers & Stauffer analysis)

Key Strategies Underway - OPDP

- NW Prescription Drug Consortium (OPDP & WPDP) expansion
  - Oregon Prescription Drug Program established by the Legislature in 2003
  - Open to state and local government, private sector businesses, labor organizations, and individuals
  - Total NW Consortium participation includes > 1 million lives across two states
- Recent 3rd party market check for NW Consortium, key findings:
  - *Overall Consortium 2017 pricing was deemed "competitive"*
  - *Program performance significantly more favorable than contract pricing guarantees in 2016 & 2017*
  - *Consortium is well positioned in contract negotiations presently underway*

Key Strategies Underway - Medicaid

- Medicaid Program
  - Requirements under the federal Medicaid Drug Rebate Program (MDRP), authorized by section 1927 of the Social Security Act, sets limitations in state's role for managing prescription drug costs
  - Medicaid program still has key role in managing pharmaceutical program and costs for OHP members:
    - Development of prior authorization criteria
    - Prospective and retrospective drug utilization reviews
    - Particular focus on prior authorization criteria for specialty drugs
    - PDL Analysis

Key Strategies Underway – HB 4005 Task Force

- HB 4005 Created the **Task Force on the Fair Pricing of Prescription Drugs**
  - Initial task: develop a strategy to create transparency for drug prices across the entire supply chain of pharmaceutical products, including but not limited to manufacturers, insurers, pharmacy benefit managers, distributors, wholesalers and retail pharmacies.
  - ***Initial report to the Legislature due November 2018 on a "cost-effective and enforceable solution that exposes the cost factors that negatively impact prices paid by Oregonians for pharmaceutical products"***
  - Task force in place through 2020, additional deliverables expected for 2019 & 2020
  - OHPB Rep: Dr. John Santa
  - OHA Rep: Dr. Dana Hargunani (OHA Chief Medical Officer)

CCO 2.0 Pharmacy Proposals

Pharmacy-Specific Items

- Establish new transparency, reporting, and rebate requirements for CCO Pharmacy Benefit Management (PBM) agreements

- Strategic alignment of CCO Preferred Drug Lists with Fee-for-service PDL, based on outside analysis & recommendations

Other Connected Proposals:

- **Establish a statewide reinsurance pool** for CCOs administered by OHA to spread the impact of low frequency, high cost conditions and treatments across entire program Should this be listed a year 2 policy option?

PDL Analysis

- Myers and Stauffer Staff:
  - Mike Sharp, R.Ph.
  - Jennifer Murray, Pharm. D.
  - Ashley Halterman, CPA

August 7, 2018

OREGON HEALTH AUTHORITY

EVALUATION OF A SINGLE OR ALIGNED PREFERRED DRUG LIST (PDL)

Oregon Health Policy Board Meeting

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

AGENDA

- WELCOME & INTRODUCTIONS
- PROJECT BACKGROUND & SCOPE
- OPTIONS AND KEY CONSIDERATIONS
- STAKEHOLDER CONSIDERATIONS
- DATA ANALYSIS & RESULTS
- KEY RECOMMENDATIONS
- QUESTIONS & CLOSING REMARKS

WELCOME & INTRODUCTIONS

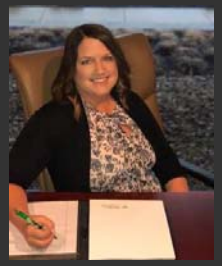
PROJECT TEAM

Allan Hansen
PRINCIPAL

- 23 years experience
- **Practice areas**: Medicaid pharmacy reimbursement & Medicaid program integrity
- Advises state Medicaid agencies and CMS on pharmacy reimbursement issues including dispensing fees and ingredient reimbursement

Michael Sharp, R.Ph.
PHARMACY CONSULTANT

- 25 years experience
- **Practice areas**: Medicaid and commercial pharmacy benefit management, medical policy, procedure coded drugs, pharmacy informatics, pharmaceutical pricing & claims processing
- Consults primarily with CMS Division of Pharmacy, state Medicaid programs & other core practice areas
- Former Indiana Medicaid Pharmacy Director



Jennifer Murray, PharmD
SENIOR MANAGER

- 13 years experience
- **Practice areas**: Pharmaceutical pricing, Medicaid pharmacy benefit management, procedure coded drugs, specialty drugs, pharmacy claims analysis, drug utilization review, cost containment opportunity evaluation, project management
- Project manager and consulting for CMS Division of Pharmacy & other state Medicaid programs

Ashley Halterman, CPA
MANAGER

- 8 years experience
- **Practice areas**: Data informatics, process design & implementation, project management, client relations, quality assurance, & regulatory compliance
- Quality control, project management, and compliance for CMS Division of Pharmacy and multiple state Medicaid programs

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

MYERS AND STAUFFER LC

ABOUT US

We are a public accounting firm with six engagement teams providing diverse services to state and federal agencies managing government-sponsored health care programs.

OUR MISSION

We are dedicated to delivering Medicare and Medicaid expertise with exceptional service.

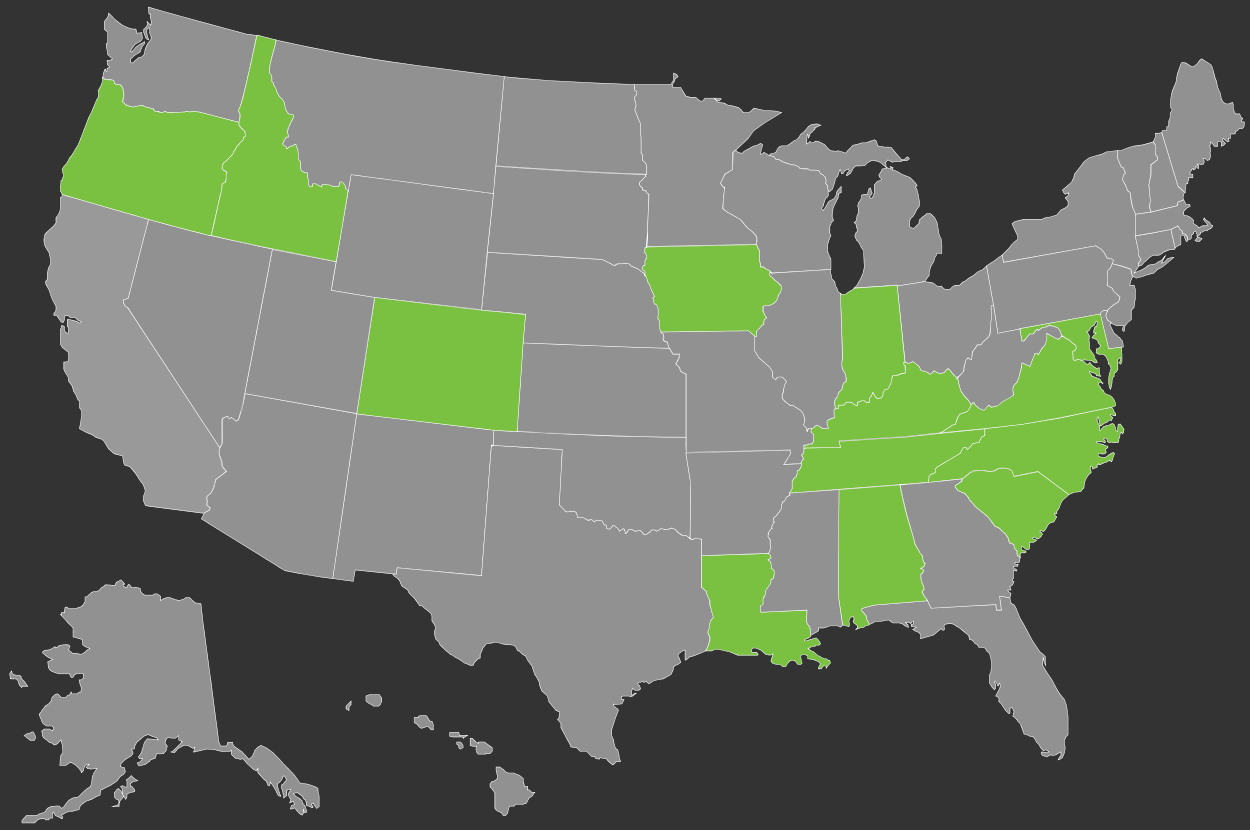
WEBSITE

https://www.mslc.com/

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

CURRENT PHARMACY PROJECTS

- Alabama
- Centers for Medicare and Medicaid Services (CMS)
- Colorado
- Iowa
- Idaho
- Indiana
- Kentucky
- Louisiana
- Maryland
- North Carolina
- Oregon
- South Carolina
- Tennessee
- Virginia



MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

OUR CLIENTS

- State Medicaid Agencies
- Centers for Medicare & Medicaid Services
- U.S. Department of Justice
- Federal Bureau of Investigation
- Other Governmental Agencies & Divisions

PROJECT BACKGROUND & SCOPE

PROJECT BACKGROUND

The Oregon Health Policy Board (OHPB) serves as a policy making and oversight body for the Oregon Health Authority (OHA). They have requested OHA to assess the concept of a state-wide single Medicaid preferred drug list (PDL).

A single PDL would obligate the current coordinated care organizations (CCOs) to adhere to the same PDL as Medicaid fee-for-service (FFS).

CCOs are concerned that a single PDL is not a viable option.

OHA requested a third party vendor analyze Oregon's current position and make analytics-based recommendations around a preferred drug list solution. Myers and Stauffer was selected as the vendor to perform the analysis.

PROJECT SCOPE

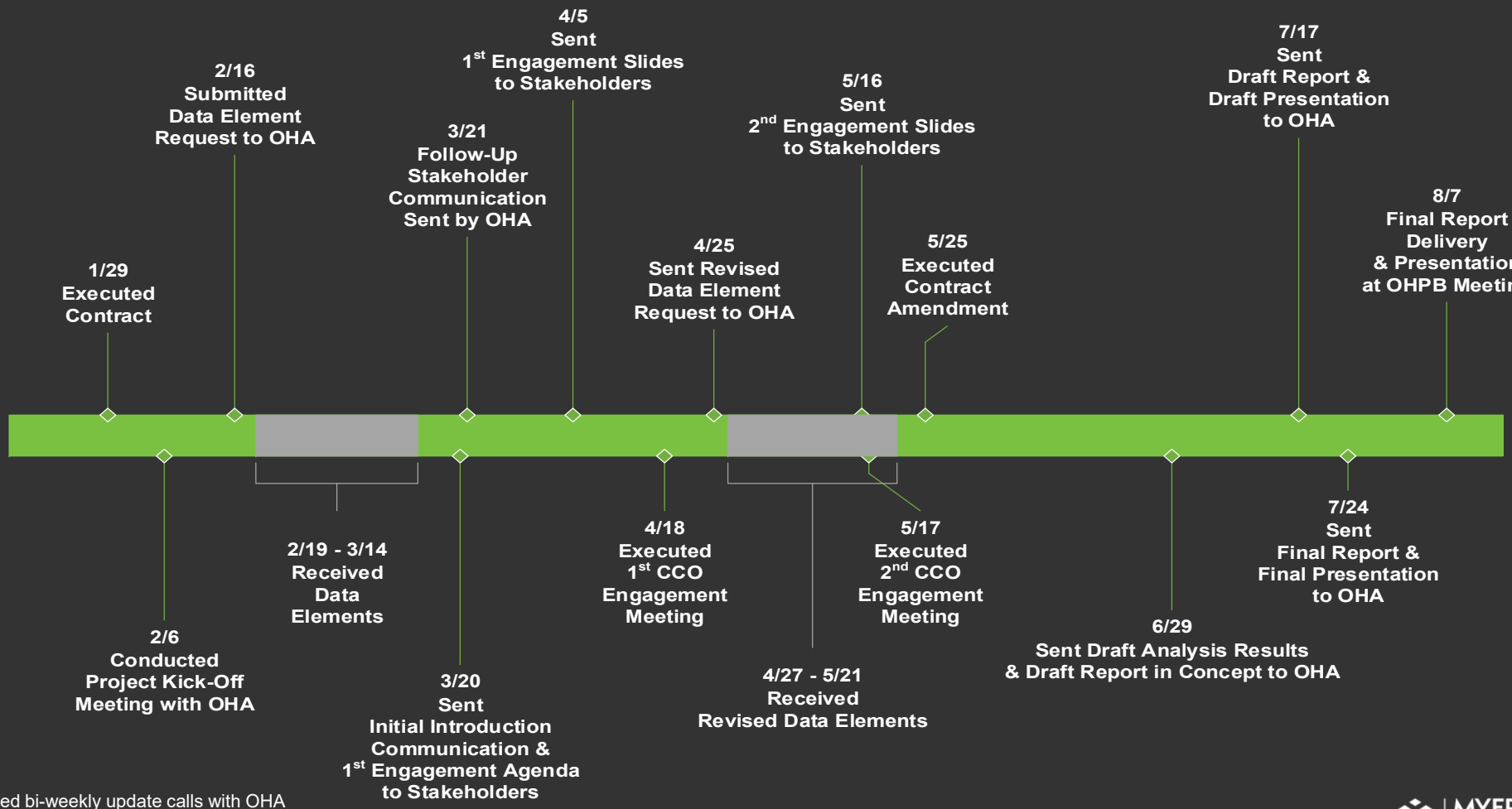
Single PDL
Aligned PDL
Status Quo

CCO Perspectives
Financial Impact
Administrative Efficiency
Consistent Access
Operational Realities

Provide Recommendations
at August OHPB Meeting

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PROJECT TIMELINE



Conducted bi-weekly update calls with OHA

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 23*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

OPTIONS AND KEY CONSIDERATIONS

PDL APPROACHES

- Single PDL Approach
- Aligned PDL Approach
- Status Quo

KEY CONSIDERATIONS

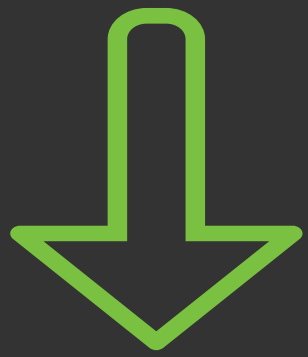
- Operational Realities
- Measurable Program Savings
- Impact Considerations to CCOs, OHA, and the Provider Community

*Note: The implementation of a single or aligned PDL approach would not result in carving out the prescription drug benefit from the CCO capitation payments.

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 24 - 25*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

IMPLEMENTATION AND OPERATIONAL REALITIES OF TRANSITIONING TO A SINGLE OR ALIGNED PDL

DESCRIPTION	SINGLE PDL	ALIGNED PDL
Disruption in Patient Care and Medication Access Issues	**Greater Level of Risk and/or Effort** 	**Lower Level of Risk and/or Effort** 
Pharmacy Provider and Prescriber Impact		
Capitation Rate Impact		
Required System Configuration Changes		
Length of Implementation Period		
Competing Priorities		
Required Resource Bandwidth		
Risk of Negative Financial & Operational Outcomes		

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 24 - 25*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

STAKEHOLDER CONSIDERATIONS

- Established a dedicated email address to allow for continual CCO feedback, questions and interaction throughout the project
- Hosted 2 CCO webinar engagement meetings
- Reviewed CCO single and aligned PDL Whitepapers
- Conducted research and reviewed existing literature and publications regarding implementation of a single or aligned PDL approach

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 25*

PERSPECTIVES & POSITIONS SURROUNDING A SINGLE OR ALIGNED PDL

- IMPROVED PROVIDER EXPERIENCE & ADMINISTRATIVE SIMPLIFICATION
- CONSISTENT ACCESS
- REBATE MAXIMIZATION/LOWER NET COSTS
- PREFERRED MULTIPLE SOURCE BRAND DRUGS OVER GENERICALLY EQUIVALENT DRUGS
- IMPROVED MEMBER EXPERIENCE
- BEST PRACTICE DEVELOPMENT
- BENEFIT ADMINISTRATION TRANSPARENCY
- FEDERAL & SUPPLEMENTAL REBATE TRANSPARENCY

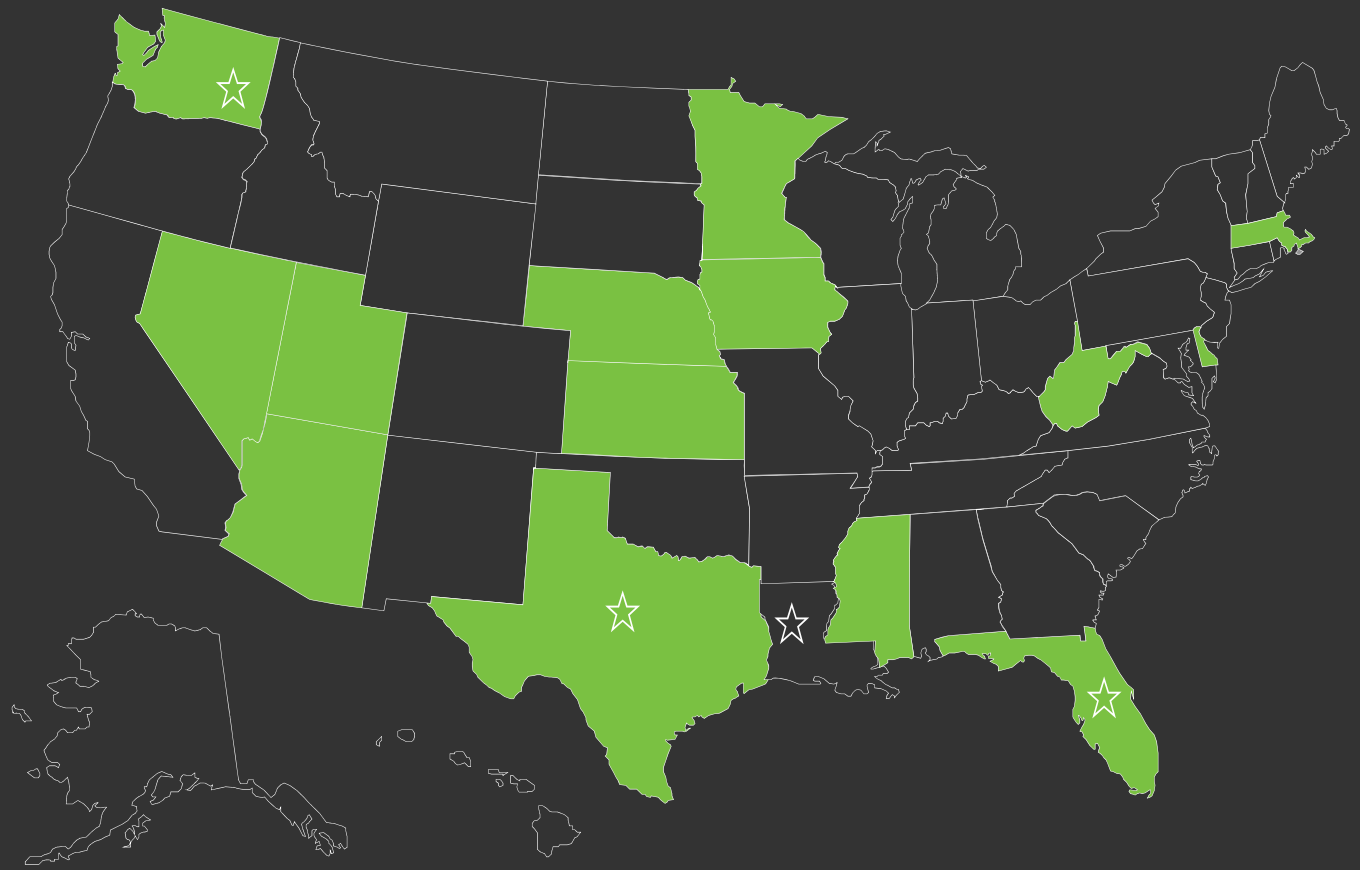
Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 25 - 27*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PDL ENVIRONMENTAL SCAN

Managed Care State Utilizing a Single PDL

☆ State highlighted in *Evaluation of a Single or Aligned Preferred Drug List Report*



Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 27 - 30*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DATA ANALYSIS & RESULTS

- Data Acquisition, Validation & Exclusions
- Analysis Calculation Methodology
- Data Results

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 32 – 37*

DATA ACQUISITION & VALIDATION

Data provided to MSLC by OHA Policy & Analytics and OSU College of Pharmacy Drug Use Research and Management (DURM) Program. Data was obtained from same source used for rebate invoicing and capitation rate calculations.

Data reviewed and validated by OHA Actuarial Services Unit.

MSLC calculated key pharmacy utilization metrics such as generic dispensing rates, average payment rates per claim, drug claim expenditures, claim counts and compared these metrics to OHA published DUR reports for reasonability.

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 32 - 33*

DATA EXCLUSIONS

340B CLAIMS
Not eligible for federal rebates

TITLE XXI CLAIMS
Not eligible for federal rebates

COMPOUND DRUG CLAIMS
Inconsistent claims data, minimal expenditures and limited PDL implications

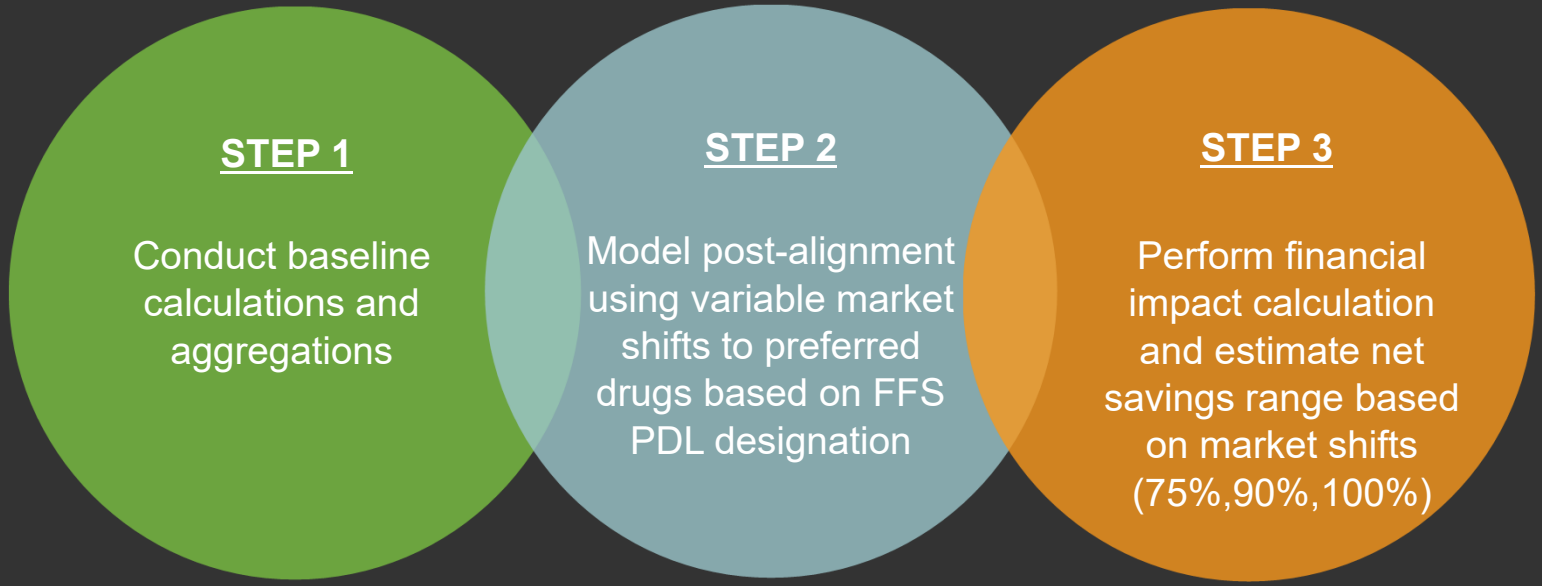
INDIAN HEALTH SERVICES (IHS) CLAIMS
Paid via all-inclusive rate

THIRD PARTY LIABILITY (TPL) CLAIMS
PDL prior authorization claim editing is bypassed and State is not primary payer

MEDICARE PART B CROSSOVER CLAIMS
PDL prior authorization claim editing is bypassed and State is not primary payer

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 32*

ANALYSIS CALCULATION METHODOLOGY

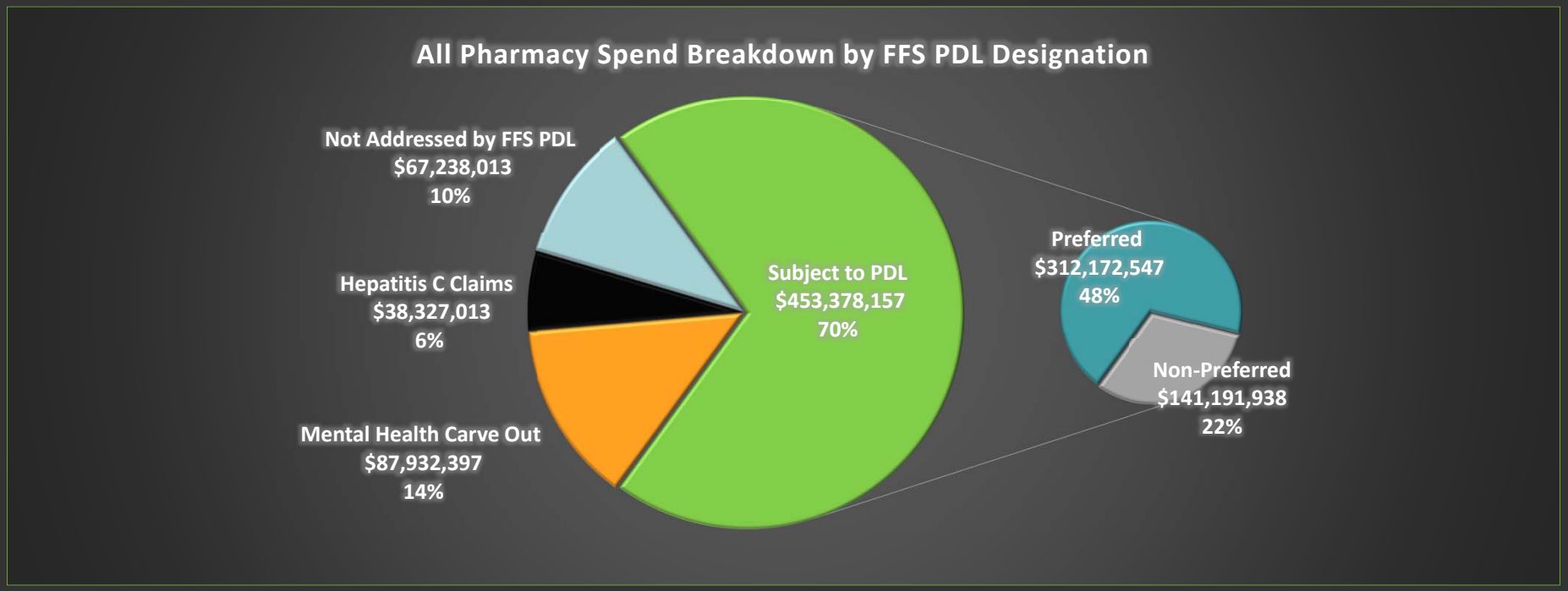


Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 33 - 35*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

CCO and FFS Spend Breakdown by FFS PDL Designation

2017 Service Dates

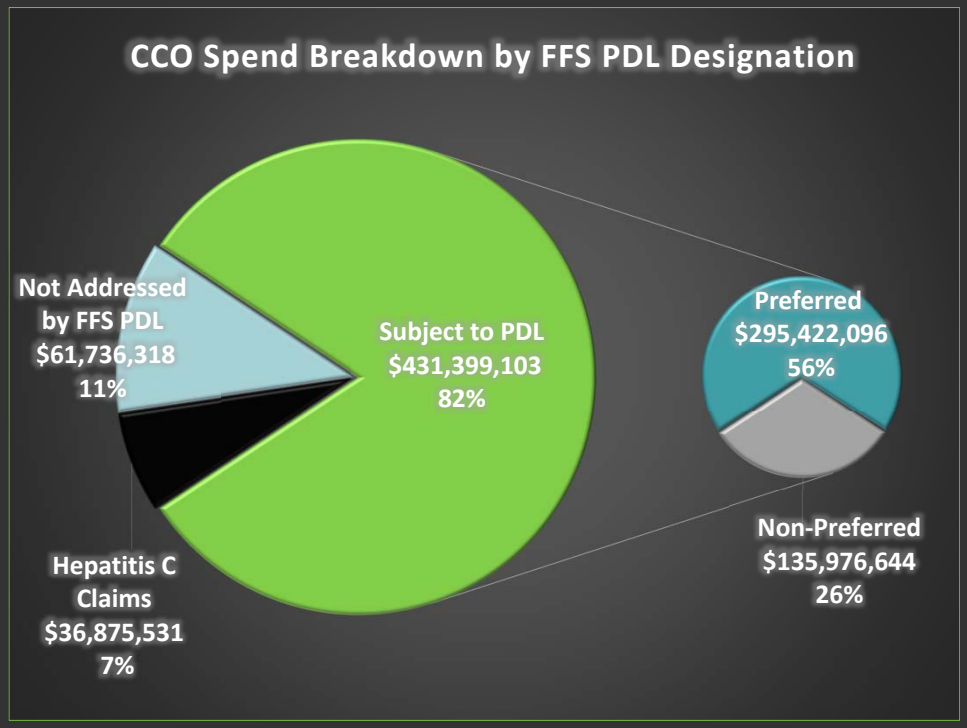


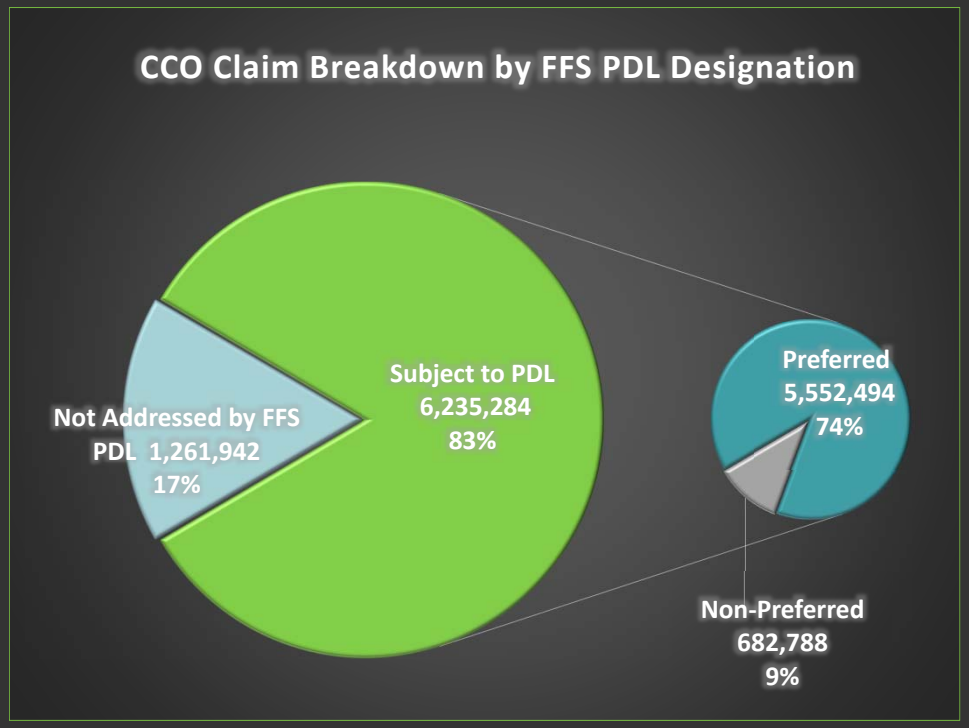
A high degree of alignment between CCO and FFS spend already exists within the current environment. The mental health carve out drugs and the Hepatitis C therapeutic class alignment represent 20% of overall program spend. In addition, 10% of overall spend is not subject to the FFS PDL leaving only 22% of the overall spend for non-preferred drugs based on their FFS PDL designation.

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 22*

CCO SPEND AND CLAIM SUMMARY

2017 Service Dates





Currently, only 26% of the total CCO spend and 9% of the total CCO claims are for non-preferred drugs (based on FFS PDL designation)

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 21*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DATA RESULTS

Therapeutic Classes for Alignment Consideration

Therapeutic Class	Estimated Annual Net Savings Range (S&F)	Estimated Annual Net Savings State Only Dollars**
Insulins*	$17 million - $22 million 74%	$4.75 million - $6.25 million
Multiple Sclerosis Agents		
Biologics for Auto-Immune Conditions		
Pulmonary Anti-Hypertensives	$6 million - $8 million 26%	$1.75 million - $2.25 million
Short-Acting Beta-Agonists Inhalers		
Diabetes, GLP-1 Receptor Agonists		
Inhaled Corticosteroids		
Long-Acting Inhaled Anticholinergics		
Pancreatic Enzymes		
Cystic Fibrosis, Inhaled Aminoglycosides		
Growth Hormones		
Total***	$23 million – $30 million	$6.5 million – $8.5 million

*The estimated fiscal impact for the insulin therapeutic class does not include potential savings related to the interchange of Admelog® and Humalog® because Admelog was not commercially available until 2018. Inclusion of this interchange would increase the estimated savings.

**In order to estimate the financial impact in state only dollars Myers and Stauffer applied a blended FMAP of 72%. The blended FMAP was provided by OHA and is an estimate based upon the enrolled Oregon Medicaid population.

***The vast majority of total net savings was attributable to shifting utilization to FFS preferred products based upon optimal federal rebate return net of CCO spend.

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 36*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

KEY RECOMMENDATIONS

KEY RECOMMENDATIONS

1. Consider pursuing an aligned PDL strategy and the application of consistent pharmacy utilization management criteria for the recommended 11 therapeutic classes. The estimated annual fiscal savings associated with these classes range from $23 million to $30 million (state and federal dollars) with an estimated range of state share between $6.5 and $8.5 million annually.
2. Develop a regulatory strategy and work plan for necessary legislative, rule making, procedural or state plan amendment activities related to an aligned PDL.
3. Measure and regularly monitor fiscal performance for current and future selected therapeutic classes chosen for alignment.
4. The Oregon Health Authority (OHA), with input provided by program stakeholders, should be designated as the sole decision maker with regard to current and future therapeutic classes for PDL alignment.
5. The CCOs should collaborate and actively provide collective input in the public P&T meeting process as a means to establish consistent utilization management tools and best practices between the FFS and CCO delivery systems.
6. Examine, and as necessary, adjust CCO capitation rates to reflect additional expenditures resulting from the aligned PDL classes not previously accounted for in the existing capitation rates. Quantify any rebates or other remuneration paid to the CCOs or their contracted PBMs by drug manufacturers for purposes of CCO contracting transparency and capitation rate setting.

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 38 - 39*

KEY RECOMMENDATIONS CONTINUED

7. Consider the use of an Administrative Services Organization model for aligned classes where OHA pays administrative fees to the CCOs for claims processing-related activities and reimburses the CCO directly for aligned therapeutic class pharmacy expenditures.

8. Develop a consolidated PDL format with electronic search capabilities for the benefit of prescribers, pharmacies, program beneficiaries and other interested parties. The resulting PDL format should also include utilization criteria and required prior authorization forms associated with the specific drugs and/or therapeutic classes. Aligned therapeutic classes should be clearly noted.

9. Focus collaborative efforts on implementing aligned utilization management strategies for specialty drugs, including the role and feasibility of value-based purchasing arrangements as a potential strategy to assist in managing specialty pharmaceutical spend.

10. OHA should evaluate the "provider prevails" requirement established under ORS 414.334 to determine the current associated fiscal impact and determine if regulatory action should be pursued to revisit this requirement. OHA should consider optimizing the use of existing utilization management tools, such as step therapy, to maximize the use of preferred drugs providing the most value and ensure medical necessity of non-preferred drugs.

11. Evaluate the drug utilization, expenditures, reimbursement amounts and contractual requirements for 340B drugs dispensed or administered in the CCO delivery systems. Currently, an OHA payment policy does not exist regarding CCO payment for covered outpatient drugs dispensed by 340B covered entities and their contract pharmacies. This can result in excessive payments for 340B drug claims as well as the loss of substantial federal rebate opportunities.

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 38 - 39*

DISCLAIMER

This PDL analysis report and the recommendations contained within are only applicable to the Oregon Medicaid program. Each Medicaid program should carefully evaluate their own program in the context of its specific structure, pharmacy program design, rebate programs and federal matching considerations.

Reference: *Evaluation of a Single or Aligned Preferred Drug List, Page 45*

QUESTIONS & CLOSING REMARKS

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

Discussion

- Reactions to Myers & Stauffer Analysis
- Implementation Considerations for CCO 2.0 Proposals
  - PBM Transparency
  - PDL Alignment
    - P&T Committee changes
    - Prior authorization ramifications
    - Ongoing evaluation re: level of PDL alignment
- Other Issues & Next Steps?

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

OREGON HEALTH AUTHORITY

EVALUATION OF A SINGLE OR ALIGNED PREFERRED DRUG LIST

JULY 31, 2018

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

Table of Contents

Executive Summary

The expenditure growth of prescription drugs has been an ongoing topic of concern for the last several years in all health care delivery systems and at all levels of government. Across all of the major sectors of health care spending, growth is anticipated to be the fastest for prescription drugs, averaging 6.3 percent for 2017 through 2026.[1] According to the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, this growth is due, in part, to increases in drug pricing and utilization trends for costly specialty drugs. Although no consistent definition for specialty drugs exist, specialty drugs are generally those that are high in cost, require special handling, and need more intensive patient education regarding their use. In response to the various national prescription drug pricing concerns, the Trump administration has released "American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs".[2]

The ongoing expenditure growth of Medicaid spending for prescription drugs continues to be an area of great concern for Medicaid executive management, advisory bodies, coordinated care organizations (CCOs), and state legislators. State Medicaid programs continue to be innovative in developing mechanisms to ensure appropriate access to medically necessary pharmaceuticals, while working within budgetary limitations and ongoing enrollment expansion. The State of Oregon Medicaid program's pharmacy costs (net, after rebate) have increased by 9.1 percent from 2015 to 2016.[3] In response to managing this growth, the Oregon Health Policy Board (OHPB) has proposed exploration of a single or more aligned preferred drug list (PDL) approach. The PDL is a listing of drugs that represent a major component of the covered outpatient drugs available to Medicaid members. It was developed to better manage utilization and expenditures, taking into account clinical evidence, along with gross (before rebate) and net (after rebate) cost perspectives. This single or more aligned approach would require all enrolled Medicaid members to utilize all or a portion of the fee-for-service (FFS) PDL regardless of the delivery system they are enrolled in. It is important to note that the implementation of a single or aligned PDL approach would not result in carving out the prescription drug benefit from the CCO capitation payments.

The Oregon Health Authority (OHA) contracted with Myers and Stauffer, an accounting firm that provides consulting services to government programs and health care agencies (further described on page 44), to perform an evaluation of a single or aligned PDL approach. This evaluation involved the review and analysis of FFS and CCO pharmacy claims data, fiscal estimations, PDLs, related initiatives in other state Medicaid programs, stakeholder perspectives, ongoing meetings with OHA pharmacy leadership, operational realities, and other potential areas to explore related to controlling costs in the Oregon Medicaid pharmacy benefit.

---

[1] CMS, Office of the Actuary, *National Health Expenditure Data: Projected*. www.CMS.gov (last updated Feb. 16, 2018, 11:11 a.m.), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.
[2] DEPT OF HEALTH AND HUMAN SVCS., AMERICAN PATIENTS FIRST: THE TRUMP ADMINISTRATION BLUEPRINT TO LOWER DRUG PRICES AND REDUCE OUT-OF-POCKET COSTS (May 2018), https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf.
[3] PRIMARYHEALTH ET AL., HOW A SINGLE STATE-MANDATED PREFERRED DRUG LIST WILL EXACERBATE THE OREGON MEDICAID PHARMACY FUNDING CRISIS (forthcoming) (on file with author).

Based upon the research conducted, Myers and Stauffer recommends OHPB and OHA consider and evaluate the following:

- *1) Consider pursuing an aligned PDL strategy and consistent pharmacy utilization management tools, including prior authorization (PA) criteria for the recommended 11 therapeutic classes or subset listed on page 36. The classes identified will not impact overall generic dispensing rates (GDRs) or negatively impact the relative drug mix. The estimated range of annual fiscal savings associated with these classes is $23 to $30 million state and federal dollars [S&F] with an estimated range of state share of $6.5 to $8.5 million.*
- *2) Develop a regulatory strategy and work plan for necessary legislative, rule making, procedural, or state plan amendment (SPA) activities related to an aligned PDL.*
- *3) Measure and regularly monitor fiscal performance for current and future therapeutic classes chosen for alignment.*
- *4) OHA, with input provided by Oregon State University (OSU) College of Pharmacy Drug Use Research and Management (DURM) Program, the Oregon Pharmacy and Therapeutics Committee (P&T) and the CCOs, should become the sole decision maker with regard to current and future therapeutic classes for PDL alignment. These therapeutic classes and related drugs will provide clear and meaningful net cost advantages for the state and federal taxpayers as the current approach has a certain degree of misaligned/competing financial interests.*
- *5) The CCOs should collaborate and actively provide collective input in the public P&T meeting process as a means to establish consistent utilization management tools and best practices between the FFS and CCO delivery systems.*
- *6) Examine, and as necessary, adjust CCO capitation rates to reflect additional expenditures they may experience due to the change to an aligned PDL. Particular attention should be directed at the transparency of the pharmacy encounter claims submitted by the CCOs, and ensure the understanding of the relationship of the encounter pharmacy payment amounts as related to the amounts actually paid to the pharmacies by their contracted pharmacy benefit managers (PBMs). In addition, any rebates or other remuneration obtained by the CCO or their contracted PBMs from drug manufacturers should be quantified for purposes of CCO contracting transparency and capitation rate setting.*
- *7) Alternatively, consider the use of an Administrative Services Organization model for aligned classes where OHA pays administrative fees to the CCOs for claims processing-related activities and reimburses the CCO directly for aligned therapeutic class pharmacy expenditures.*
- *8) Current mechanisms to review and utilize the various PDL formats are difficult and cumbersome. OHA, DURM, and the CCOs should collectively develop a user friendly consolidated PDL format with electronic search capabilities for the benefit of prescribers, pharmacies, program beneficiaries, and other interested parties. The resulting PDL format should also include utilization criteria and required PA forms associated with the*

specific drugs and/or therapeutic classes. Aligned therapeutic classes should be clearly noted.

- *9) Given the current and predicted expenditure growth of specialty pharmaceuticals, OHA, DURM, and the CCOs should collaboratively focus their collective expertise on implementing aligned utilization management strategies for specialty drugs. These specialty drugs include drugs dispensed by pharmacies and billed through pharmacy claims, as well as those purchased/administered by enrolled providers and billed through medical claims. The respective stakeholders should examine the role and feasibility of value-based purchasing (VBP) arrangements as a potential strategy to assist in managing specialty pharmaceutical spend.*
- *10) OHA should evaluate the "provider prevails" requirement established under ORS 414.334 to determine the current associated fiscal impact and determine if regulatory action should be pursued to revisit this requirement. OHA should consider optimizing the use of existing utilization management tools, such as step therapy, to maximize the use of preferred drugs providing the most value and ensure medical necessity of non-preferred drugs.*
- *11) Given the substantial national growth of 340B contract pharmacies and utilization of 340B drugs in recent years, OHA should carefully examine the drug utilization, expenditures, reimbursement amounts, and contractual requirements for 340B drugs in the CCO delivery systems. Currently, an OHA payment policy does not exist regarding CCO payment for covered outpatient drugs dispensed or administered by 340B covered entities and their contract pharmacies. This allows the CCOs to establish their own reimbursement policies for 340B dispensed drugs which may result in the CCO delivery systems paying at or near normal market reimbursement rates for these deeply discounted 340B drugs. OHA is not permitted to collect federal rebates when a 340B program drug has been dispensed; therefore, OHA may not only be grossly overpaying for these 340B drugs, but also sacrificing their ability to collect substantial federal rebates. This is an area that many states are actively evaluating and addressing through state policies or other regulatory channels. It has also gained attention at the federal level, as well as by the National Association of Medicaid Directors, and reports have been issued by both the Office of Inspector General and Government Accountability Office.*

It is important to note that these recommendations to OHPB and OHA represent the viewpoints of Myers and Stauffer and are specific to the State of Oregon Medicaid program. Many other aspects, such as regulatory changes, SPAs, and capitation rate analyses will require additional evaluation and research based upon the direction that is ultimately chosen.

Introduction, Background, and Purpose

In January 2018, OHPB adopted a charter to create a committee to focus on a variety of issues relating to the high costs of prescription drugs in Oregon. Subsequently, the Oregon Legislature passed, and Governor Brown signed HB 4005, which established a task force to examine prescription drug pricing transparency and related issues. This task force has been assigned to develop recommendations by November 2018 and is scheduled to continue through 2020. Based on the HB 4005 Task Force efforts, OHPB has elected to delay the formation of its own committee to best take advantage of, and not impede, the work of the Task Force.

Despite the OHPB decision to delay the formation of its committee, OHPB has directed OHA to continue analysis of pharmacy-related issues facing the Oregon Health Plan and the State in general. One specific idea OHPB has asked OHA to focus on is the ongoing assessment of a single statewide Medicaid PDL or aligning select therapeutic classes across CCO and FFS PDLs. The Oregon FFS PDL contains drugs prescribed for FFS members that have been identified as the most effective and safe drugs for the majority of patients, based on the information available by Oregon researchers and experts. Of the drugs recommended, only those representing the best value are included.[4]

This single PDL proposal would obligate the existing 15 CCOs to adhere to the same PDL as FFS Medicaid or could entail other efforts to align certain therapeutic classes of the CCOs' individual PDLs. During several dialogue exchanges and through public testimony, it is clear there is substantial concern with implementing changes to the PDL requirements without adequate evaluation of the potential savings, associated costs, and operational realities. A number of Oregon's 15 CCOs have signed a white paper that contends that a single PDL is not a viable option within the context of Oregon's Medicaid model that provides local control to the CCO.[5] The CCOs contend that their ability to manage their own PDLs gives them the flexibility they need to deliver under the coordinated care model. Due to the considerable expenditures associated with the pharmacy benefit and the implications to CCOs, OHA has contracted with Myers and Stauffer to perform an independent analysis that will result in recommendations to OHA for a PDL approach, with consideration of the CCOs and the Oregon Medicaid program as a whole.

Prior to delaying its committee, OHPB had directed OHA to explore the single PDL concept and provide an implementation plan for any recommendation by January 1, 2019. The board has not yet revised this timeline, but may update the committee charter and potential timeline after the completion and review of this report, and once additional feedback is available from stakeholders.

It should be noted that the Myers and Stauffer report and recommendations are an initial step in the overall process of reviewing this potential PDL policy change. Many other factors such as capitation rates, regulatory changes, contractual revisions, and consideration of necessary SPA changes will require additional evaluation and research.

---

[4] Oregon Health Authority, *Oregon Health Plan Preferred Drug List*, OREGON.GOV, https://www.oregon.gov/OHA/HSD/OHP/Pages/PDL.aspx (last visited June 20, 2018).
[5] PRIMARYHEALTH ET AL., *supra* note 3

This report contains an analysis of policy options related to the PDL, including estimated potential savings associated with a select number of therapeutic classes, along with perspectives and positions of a single or aligned PDL approach. In addition, the report includes observations, considerations, and recommendations of a single or aligned PDL and other areas of the prescription drug benefit that should be evaluated. The PDL applies to claims primarily dispensed by pharmacy providers. As such, the data analysis evaluated utilization and expenditures for pharmacy claims only, and did not include claims for drugs purchased and billed by a provider through the medical benefit (physician administered/procedure coded drug claims). Performing an analysis on drugs billed through the medical benefit was not included in the scope of work. Currently, these drug claims are not subject to the PDL. Analysis of these claims would require additional time and effort due to the accuracy of submitted fields such as National Drug Code (NDC) and unit of measure (UOM), as well as the necessary related claim unit conversions. Myers and Stauffer is not an actuarial firm, and the evaluation of capitation rates was not within the scope of this project; therefore, we did not evaluate the potential impact to capitation rates and recommend that this exercise be performed by the State's actuarial services unit.

It is important to note that this PDL analysis report and the recommendations contained within are only applicable to the Oregon Medicaid program. Each Medicaid program should carefully evaluate their own program in the context of its specific structure, pharmacy program design, program goals, rebate programs, and federal matching considerations.

Prescription Drug Coverage and Reimbursement in Medicaid

Medicaid is a joint federal-state program that pays for medical assistance for individuals and families with low incomes and relatively few assets. Although pharmacy coverage is an optional benefit under federal Medicaid law, all states currently provide coverage for outpatient prescription drugs to all categorically eligible individuals and most other enrollees within their state Medicaid programs.[6] Outpatient prescription drugs are typically those obtained only by prescription and dispensed by pharmacies, or drugs that are administered by a physician or other licensed health care professional in an outpatient setting. This does not include covered outpatient drugs provided and billed as part of other services or those provided during an inpatient hospital stay. Medicaid programs may also cover drugs sold without a prescription. These drugs are commonly referred to as over-the-counter (OTC) drugs, when prescribed by a physician or other authorized prescriber.

The amount Medicaid spends for a particular outpatient prescription drug reflects two components—the gross initial cost (made up of payment to a provider for the drug and the applicable dispensing fee) and the net cost of the drug after rebates (federal and/or supplemental) which Medicaid receives from drug manufacturers. States set pharmacy payment policy within federal guidelines and requirements; however, these policies must be approved by CMS through the SPA process. Additionally, a drug manufacturer must enter into a statutorily-defined rebate agreement with the Secretary of the U.S. Department of Health and Human Services (HHS) in order for its products to be considered covered outpatient drugs by Medicaid.

[6] CMS, *Prescription Drugs*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/prescription-drugs/index.html (last visited May 31, 2018).

State Medicaid programs may utilize a single delivery system approach or a combination of delivery systems to provide prescription drug coverage to their enrolled beneficiaries. This may depend on a number of factors including, but not limited to, the population being served and/or characteristics of the geographic regions in the state.

In a FFS arrangement, the state enrolls and pays providers directly. The state typically hires vendors or performs some roles internally for various functions such as enrollment, claims processing, auditing, actuarial services, rate setting, medical policy, drug rebate administration, clinical services, and program consulting.

In a risk-based or capitated arrangement, the state procures managed care organizations (MCOs) or CCOs to contract and pay providers directly. This approach requires a SPA or waiver from CMS for implementation. The state pays these organizations through a calculated capitation rate which is required to be approved by CMS. Some services, such as prescription drugs (even specific subsets of drugs), dental, long-term care (LTC), or specific populations may be carved out of the capitation rate. The term "carved out" applies to services or populations that are not included in the capitation rate calculation and payment to the CCO, but paid for directly by the FFS delivery system.

The Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)[7] provided updated regulations regarding the provision of health care services obtained through MCOs/CCOs. Among many other things, this rule specifies requirements for states and managed care plans that provide covered outpatient drugs under a capitated arrangement. Specifically, the rule addresses covered outpatient drug access in managed care and the application of federal rebates for covered outpatient drugs. Highlights of the rule related to covered outpatient drugs include the following:

- *Prescription drug coverage under MCOs/CCOs should demonstrate coverage consistent with the amount, duration, and scope as described by Medicaid FFS.*
- *MCOs/CCOs cannot have medical necessity criteria for prescription drugs that are more stringent than Medicaid FFS.*
- *MCOs/CCOs must provide coverage of covered outpatient drugs as specified in the contract.*
- *If a MCO/CCO is not contractually obligated to provide coverage of a particular covered outpatient drug, or class of drugs, the state is required to provide the covered outpatient drug through FFS that is consistent with the state plan.*
- *Each state may include covered outpatient drug coverage as part of the capitated contractual services or as a carve-out from the capitation rate calculations.*
- *A MCO/CCO that agrees to provide coverage of a subset of covered outpatient drugs under the contract with the state would need to provide coverage of every covered outpatient drug included in the subset if the manufacturer of those drugs entered into a rebate agreement.*

[7] CENTER FOR MEDICAID AND CHIP SERVICES, MEDICAID AND CHIP MANAGED CARE FINAL RULE (CMS-2390-F): COVERED OUTPATIENT DRUGS, https://www.medicaid.gov/medicaid/managed-care/downloads/mco-cod-presentation.pdf.

- *MCOs/CCOs have the flexibility to maintain their own PDLs or formularies and apply their own utilization management practices.*
- *It is incumbent upon the states and MCOs/CCOs to address formulary/PDL requirements in their contract documents. Each party must clearly understand their responsibilities and requirements when administering the Medicaid covered outpatient drug benefit.*
- *MCOs/CCOs need to ensure all covered outpatient drugs are covered unless the drug is contractually carved out of the pharmacy benefit.*
- *Payment to providers, PA requirements, drug utilization review programs and annual reports, access to pharmacy services, utilization data for rebate invoicing, and 340B claim identification.*

Overview of the Medicaid Drug Rebate Programs

Federal Drug Rebate Program

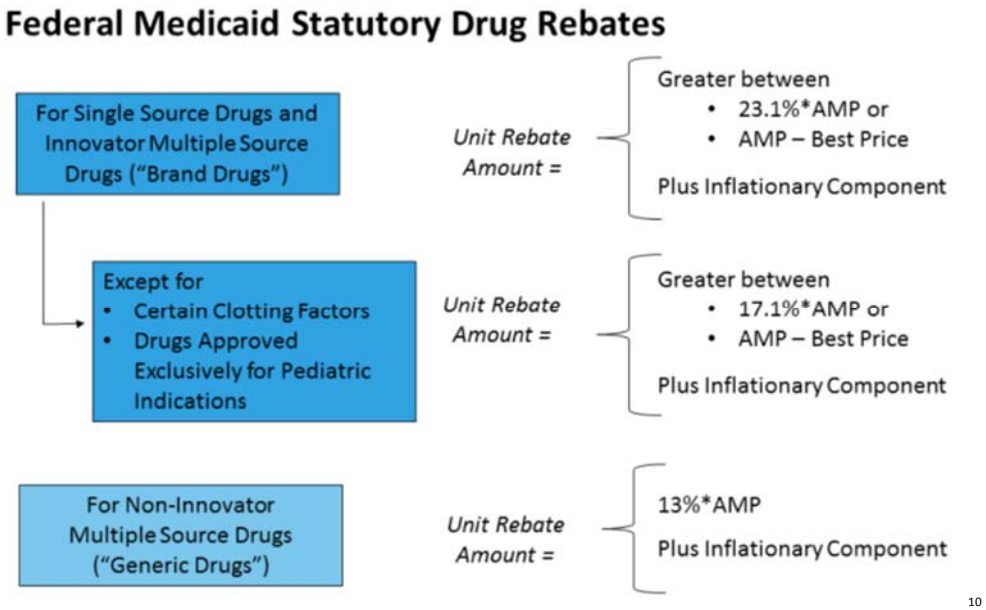
The Medicaid Drug Rebate Program (MDRP) was established by Congress (Title XIX of the Social Security Act) to ensure Medicaid receives a net price that is consistent with the lowest or best price for which manufacturers sell their drugs to other statutorily-defined payers. The state Medicaid agency is responsible for paying claims, submitting invoices to manufacturers, and collecting Medicaid drug rebates for covered outpatient drugs. In exchange for the rebates, state Medicaid programs must generally cover a participating manufacturer's drugs, although, they may limit the use of some drugs through drug utilization management tools such as PDLs, medical necessity reviews, PA programs, or various other claim edits.

The rebates collected through the MDRP are shared between the federal government and states based on the state's current federal medical assistance percentage (FMAP). The FMAP can vary for different populations (i.e., traditional versus expansion) and for certain drugs (i.e., family planning and breast/cervical cancer). CMS calculates a unit rebate amount (URA) for each drug based on a defined formula for that category of drug and provides this URA to each state. The state then utilizes the CMS-supplied URA and the number of drug units that it paid for during the rebate period to calculate the rebate invoice amount. The state then submits a rebate invoice to the manufacturer each quarter. Rebates are invoiced and collected by the state through a process that is separate from their payments to pharmacies and other providers billing for covered outpatient drugs.

There are separate rebate formulas for brand drugs versus generic drugs.[8] The base brand rebate rate is 23.1 percent of the average manufacturer price (AMP) per unit. Rebates for certain clotting factor drugs and drugs approved exclusively for pediatric indications are 17.1 percent of the AMP per unit. The base generic rebate rate is 13 percent of the AMP per unit. The MDRP is intended to guarantee Medicaid the lowest net purchase price. The base rebate formula is supplemented by two additional provisions. The best price component assures that Medicaid pays no more than the lowest price available to any wholesaler, retailer, provider, or paying entity excluding certain government payers. In addition to the base rebate and best price provision, a

[8] CMS, *Medicaid Drug Rebate Program*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html (last visited May 31, 2018).

Consumer Price Index[9] (CPI) penalty is added to the calculation to protect against continual price increases that exceed the CPI for brand and generic drugs. Over recent years, brand name drug price increases have averaged eight to ten percent per year which emphasizes the importance of the CPI penalty. Due to the prescribed methodology used in calculating rebates, a manufacturer can control its rebate liability by virtue of their own pricing policies.



Beginning in 2010, the Affordable Care Act (ACA) extended the federal Medicaid drug rebates to prescriptions paid for by capitated Medicaid programs such as MCOs/CCOs. Previously, the federal rebates were only available for drugs paid for by the state on a FFS basis. In order to capture the rebates, states require MCOs/CCOs to submit their Medicaid drug utilization data to the state. The state then utilizes this information to invoice and collect rebates from the manufacturers. URAs, AMPs, and related calculations are proprietary and confidential.

Federal Offset of Rebates

The ACA increased the minimum rebate percentage for the vast majority of brand drugs from 15.1 percent to 23.1 percent of AMP; increased the rebate percentage for generic and other drugs from 11 percent to 13 percent of AMP; and changed the rebate calculation for line extension drugs. The ACA required states to remit the amounts attributable to these increased rebates to the federal government, and CMS gets both the federal and non-federal share of this rebate increase. In a State Medicaid Director letter, CMS further clarified that the offset would only occur on rebate dollars above that which would have been collected under the old rebate

[9] Bureau of Labor Statistics, *Table 24. Historical Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, all items,* https://www.bls.gov/cpi/tables/supplemental-files/historical-cpi-u-201801.pdf (last visited July 26, 2018)
[10] KATHERINE YOUNG & RACHEL GARFIELD, THE HENRY J. KAISER FAMILY FOUND., SNAPSHOTS OF RECENT STATE INITIATIVES IN MEDICAID PRESCRIPTION DRUG COST CONTROL 2 (2018), https://www.kff.org/medicaid/issue-brief/snapshots-of-recent-state-initiatives-in-medicaid-prescription-drug-cost-control/

formula before implementation of the ACA.[11] In other words, any additional rebate dollars obtained due to the increase in the minimum rebate percentage would be retained by the federal government at 100 percent.

Supplemental Drug Rebate Agreements

Supplemental drug rebates are collected in addition to the statutorily required rebates collected under the MDRP. A total of 47 Medicaid programs participate in supplemental rebate agreements.[12] Some states pursue supplemental rebate agreements on their own (single-state) while others join groups of states (multi-state pools) to increase negotiating power. States negotiate with manufacturers to obtain supplemental rebates within selected therapeutic classes. Manufacturers offer these supplemental rebates through a bidding process as an incentive to be selected for a state's PDL. Preferred drugs on the PDL are often not subject to PA, which results in increased utilization and market share of the preferred drugs over their non-preferred counterparts. It should be noted that a supplemental rebate offer from a manufacturer does not guarantee preferred placement on the PDL. The Oregon Medicaid PDL review process is founded upon evidence based review of safety and efficacy, utilization of experts, and transparency; net cost is a secondary consideration as noted on page 16.

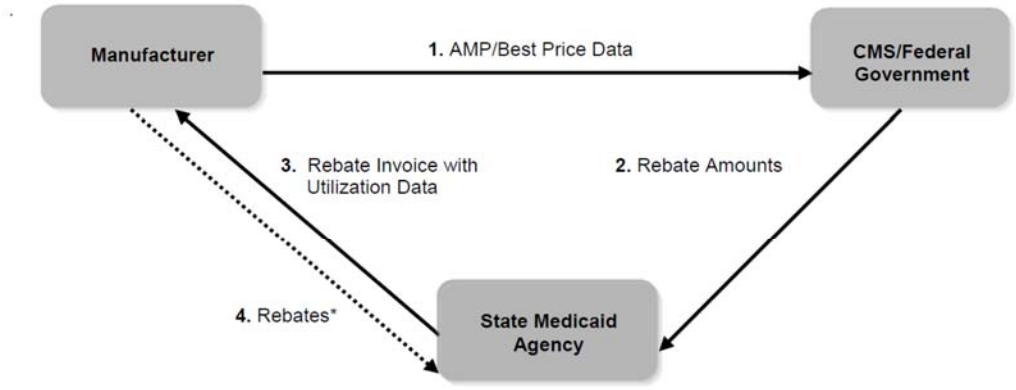
The supplemental rebate agreements between states and manufacturers are typically established through a guaranteed net unit price (GNUP) that the manufacturer will provide to the state. The supplemental rebate is generally calculated by comparing the federal rebate and GNUP to a benchmark price such as wholesale acquisition cost (WAC). GNUP contracts provide protection to state Medicaid programs from manufacturer pricing increases throughout the contract period. It is important to note that the federal rebate is typically responsible for the vast majority of total rebates collected. Often times, the federal rebate satisfies the GNUP contractual requirement by itself.

Per CMS State Release No. 176:

"Given that managed care organizations are often the primary mechanism for health care delivery in Medicaid, we urge that states consider negotiating supplemental rebates with manufacturers for some or all of their Medicaid managed care drug claims. Before negotiating supplemental rebates on managed care drug claims, states should determine the impact of their decision to collect supplemental rebates on their contracts with managed care organizations. States should determine if supplemental rebates in the managed care context will result in better patient outcomes and reduced costs to Medicaid overall. We urge states to work with their supplemental rebate contractors and Medicaid managed care organizations to better understand the impact of this policy. Alternatively, the state may want to align their fee-for-service preferred drug list and the state's Medicaid managed care organizations' formularies only for certain drug classes and collect supplemental rebates on those drugs dispensed to Medicaid managed care enrollees. A state that already has an approved CMS state plan that allows them to collect supplemental rebates on

[11] MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, MEDICAID PAYMENT FOR OUTPATIENT PRESCRIPTION DRUGS 7 (May 2018), https://www.macpac.gov/wp-content/uploads/2015/09/Medicaid-Payment-for-Outpatient-Prescription-Drugs.pdf.
[12] CMS, *Medicaid Pharmacy Supplemental Rebate Agreements (SRA)*, www.medicaid.gov, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/xxxsupplemental-rebates-chart-current-qtr.pdf (last visited June 1, 2018).

Medicaid managed care claims will not need to change their approved state plan to implement such an approach."[13]



Source: CMS, *Medicaid Drug Rebate Data Guide for States*, section 1927(b) of the Act.
* With the exception of offset rebates (which States are prohibited from keeping), CMS and the States share Medicaid rebates on the basis of each State's FMAP.

Overall Rebate Impact

The impact of federal and supplemental rebates in Medicaid is substantial. These rebates guarantee that Medicaid programs obtain the lowest net price of any payer. In 2016, the average federal rebate was 53 percent off of gross pharmacy reimbursement. After inclusion of supplemental rebates, the average total discount ranged from 56 to 59 percent off of gross pharmacy reimbursement.[14] In other words, for every dollar spent in the Medicaid pharmacy program, an estimated 56 to 59 percent of that dollar comes back in the form of a federal and/or supplemental rebate, making Medicaid rebates a critical tool in managing pharmacy expenditures and their overall impact to state and federal Medicaid budgets.

Pharmacy Benefit Utilization Management Tools in Medicaid

Existing Medicaid regulations may limit the flexibility of a state Medicaid program to fully manage prescription drug coverage and spending. As previously stated, drug manufacturers are required to pay rebates to Medicaid; however, in return, the Medicaid program generally cannot exclude coverage of drugs produced by manufacturers enrolled in the MDRP. This includes coverage of new, high-cost drugs when they enter the market.[15] Unlike Medicaid, other payers have flexibility to make decisions regarding drug coverage and can use beneficiary cost sharing as a tool to drive volume to the most cost-effective options. Beneficiary cost sharing in Medicaid has limited impact in drug benefit design due to the nominal co-pay typically allowed under federal regulation

[13] Medicaid Drug Rebate Program Notice Release No. 176, CMS, Value-based Purchase Arrangements and Impact on Medicaid (July 14, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Prescription-Drugs/Downloads/Rx-Releases/State-Releases/state-rel-176.pdf.
[14] MAGELLAN RX MGMT., MEDICAID PHARMACY TREND REPORT 7 (2nd ed. 2017), https://www1.magellanrx.com/media/671872/2017-mrx-medicaid-pharmacy-trend-report.pdf.
[15] Medicaid Drug Rebate Program Notice Release No. 185, CMS, State Medicaid Coverage of Drugs Approved by the FDA under Accelerated Approval Pathway (June 27, 2018), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/rx-releases/state-releases/state-rel-185.pdf

and described in State Medicaid Director Letter #06-015.[16,17] The nominal copay does not effectively incentivize the beneficiary to pursue lower cost alternatives.

While the statutory rebates help offset the expense of covered outpatient drugs, there are many utilization management tools that state Medicaid programs implement to effectively administer the pharmacy benefit. These tools provide a mechanism to control costs and assure appropriate medically necessary use of covered outpatient drugs. Some of the more common tools utilized by both FFS and CCO delivery systems include PDLs, PA programs, step therapy protocols, mandatory generic substitution, prospective and retrospective drug utilization review, and pharmacy claim edits related to quantity, days supply, age, gender, and diagnosis.

Prescription Drug Spending Trends in Medicaid

Medicaid spending on prescription drugs continues to be an important topic among state and federal policymakers. HHS recently published "American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs".[18] Medicaid prescription drug spending increased 24.6 percent in 2014, reaching its highest rate of growth since 1986, and slowed to 13.6 percent in 2015. The faster growth in 2014 was primarily due to increased spending for hepatitis C drugs. A higher amount of rebates helped temper the spending growth in 2015.[19] Slower enrollment growth and a decline in spending for hepatitis C drugs further reduced drug spending growth to 5.5 percent in 2016.[20] Even so, controlling prescription drug spending remains a focus for policymakers because prescription drugs are expected to experience the fastest average annual spending growth among major health care goods and services over the next 10 years.[21]

According to the *Magellan Rx Management Medicaid Pharmacy 2017 Second Edition Trend Report,* traditional (i.e., non-specialty) drug expenditure trend has been relatively flat on a gross cost per claim (-0.3 percent) and a net cost (post rebates) per claim (-5.1 percent). In contrast, the specialty drug expenditure trend experienced double-digit growth for the two-year study period (2015 through 2016) on both a gross cost per claim (22.8 percent) and a net cost per claim (20.5 percent).[22] *Table 1 and Table 2* on the following page illustrates these trends.

[16] State Medicaid Director Letter No. 06-015, Ctr. for Medicaid and State Operations, Ctrs. for Medicare & Medicaid Servs. (June 16, 2006), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD061606.pdf
[17] VERNON K. SMITH ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, MANAGING MEDICAID PHARMACY BENEFITS: CURRENT ISSUES AND OPTIONS (SEPTEMBER 2011) https://www.kff.org/medicaid/report/managing-medicaid-pharmacy-benefits-current-issues-and-options/
[18] DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 2.
[19] Anne B. Martin et al., *National Health Spending: Faster Growth in 2015 As Coverage Expands And Utilization Increases*, 36 HEALTH AFF. 166, 173 (2017), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1330.
[20] Micah Hartman et al., *National Health Care Spending In 2016: Spending And Enrollment Growth Slow After Initial Coverage Expansions*, 37 HEALTH AFF. 150, 156 (2018), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1299.
[21] Gigi A. Cuckler et al., *National Health Expenditure Projections, 2017-26: Despite Uncertainty, Fundamentals Primarily Drive Spending Growth*, 37 HEALTH AFF. 482, 484 (2018), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1655.
[22] MAGELLAN RX MGMT., *supra* note 14, at 4-5.

Table 1: Medicaid FFS Traditional Drug Spend

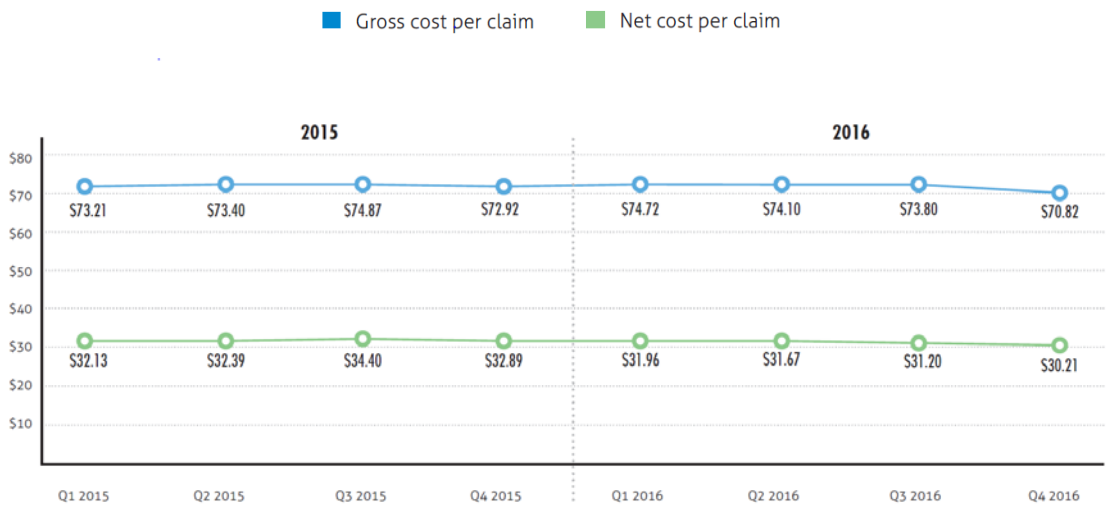
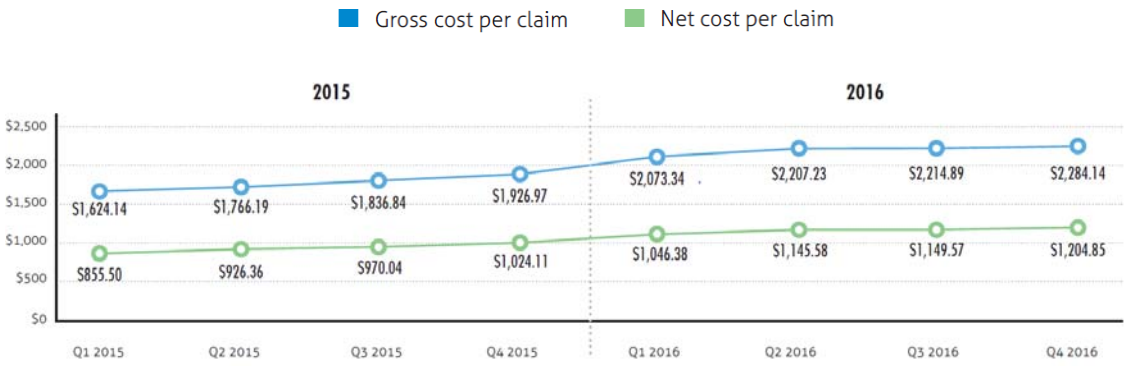


Table 2: Medicaid FFS Specialty Drug Spend



It is important to note that there is no universally accepted definition of specialty drugs. However, in the report, Magellan defines traditional and specialty drugs[23] in the following manner:

Traditional: therapeutic classes that have a lower cost per claim and a traditional route of administration, such as oral (tablets, capsules, liquids) or inhaled drugs.

Specialty: therapeutic classes with either, or any combination of, a higher cost per claim and lower claim volume or a route of administration such as infused or physician injectable drugs.

The CMS Office of the Actuary projects that Medicaid as a whole is expected to average 5.8 percent annual growth, and prescription drug spending will increase an average of 6.3 percent per year from 2017 through 2026, the fastest amongst the major sectors of health care spending.

[23] MAGELLAN RX MGMT., *supra* note 14, at 6.

This is primarily attributed to growth in utilization and pricing trends for high-cost specialty drugs.[24] Although the net drug spend constitutes only six percent of Medicaid total spending, the high cost of specialty drugs continues to be a concern among Medicaid policy directors looking to control future spending.[25] State Medicaid programs continue to face the challenges of providing access to new, high-cost specialty drugs while working within the confines of state budgets. Specialty drug expenditures are expected to reach 45 to 50 percent of total pharmacy spend by 2020. This continual growth will drive states to evaluate program design and how to best allocate available resources in order to provide treatment to beneficiaries that require specialty drugs. Innovative approaches are still developing and it is not clear yet where the balance of best practices will land related to access, quality, and cost. Specialty drug benefit and utilization management represents an opportunity for Oregon to establish innovative best practices and set an example for other state Medicaid programs to follow.

OHA Prescription Drug Benefit Design

OHA provides pharmaceutical benefits to nearly one million beneficiaries through two primary delivery systems. The FFS delivery system is comprised of approximately 150,000 beneficiaries (15 percent), while the CCO delivery system provides services to the remaining beneficiaries.

Currently, there are 15 CCOs providing services to Oregonians throughout various regions of the state who receive health care coverage through Medicaid. Some regions have a single CCO, while others may have multiple CCOs providing services.

Under Oregon Administrative Rule 410-141-0070, CCOs must provide payment for prescription drugs as a covered service with the exception of mental health drugs.[26] OHA pays for covered mental health drugs on a FFS basis and these drugs are not included in the capitation rates. For the purposes of this payment policy, “mental health drugs” are defined as those drugs classified by First Databank, a drug file compendia provider, in the Standard Therapeutic Class equal to Class 07 (ataractics, tranquilizers) and Class 11 (psychostimulants, antidepressants). In addition, lamotrigine and divalproate, although commonly used to treat seizure disorders, are also considered mental health drugs. These mental health drugs are often referred to as the 7-11 Drug Carve-Out List.

The FFS delivery system and each of the 15 CCOs currently establish and maintain their own PDL. Currently, while commonality exists between the various PDLs, the process for establishing and maintaining these PDLs is not consistent. In addition, the pharmacy utilization management tools discussed previously on page 12, including PA criteria, are not uniform or determined through a collaborative process. One notable exception to this statement is related to the hepatitis C class of drugs. This particular class has a uniform PDL and consistent PA criteria across all delivery systems. This uniformity and alignment was achieved in response to access concerns

[24] Press Release, CMS Office of the Actuary releases 2017-2026 Projections of National Health Expenditures (Feb. 14, 2018), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-02-14.html.
[25] YOUNG & GARFIELD, *supra* note 10, at 1.
[26] OR. ADMIN. R. 410-141-0070 (2017).

outlined by CMS in MDRP Release Number 172.[27] For this class of drugs, the FFS and CCO delivery systems working in collaboration with DURM and the P&T Committee developed a uniform and consistent PDL policy. The approach included the implementation of a risk corridor in the CCO contracts.

PDL Development and Maintenance Processes

OHA maintains the FFS PDL and PA criteria in consultation with their P&T Committee with clinical support and evidence-based research provided by DURM. The process is primarily based upon evidence based review of safety and efficacy, utilization of experts, and transparency; net cost is a secondary consideration. The OHA FFS process includes a public meeting forum which provides a level of transparency to the resulting PDL.[28] The National Academy for State Health Policy has recognized the OHA PDL process in an April 2016 publication, noting, "While other states operate similar clinical groups reviewing pharmaceutical and therapeutic products, Oregon's program is distinguished by the involvement of experts in the field of evidence-based policy making, introducing a heighted level of independent scrutiny to the process, and that process is transparent to the public."[29] The FFS program, working in concert with their contracted multi-state pooling program, the Sovereign States Drug Consortium (SSDC), may obtain supplemental rebates from drug manufacturers in addition to the statutorily required federal rebates.

The SSDC is a collaborative group of state Medicaid programs, in which members are collectively focused on providing quality pharmaceutical care while controlling costs. The primary activity of the SSDC is to negotiate rebates that are in addition to those required under the federal MDRP. The SSDC also provides a forum for member states to cooperate in other areas of pharmacy benefit administration and management in Medicaid and other publicly-funded pharmacy benefit programs.

Each CCO in Oregon maintains their own PDL and associated PA criteria by working within their delivery system and their contracted PBM. The CCO PDL process is generally not open to the public and the resulting PDL is not subject to comprehensive review and approval by OHA. The CCOs, through their contracted PBM, may establish rebate agreements with drug manufacturers for preferred status on the CCO PDL. These rebates are paid by the manufacturer to the CCO's PBM, in addition to the federal rebates that are statutorily provided directly to the state.

Outpatient Covered Drug Benefit – Claims and Payment Summary

The PDLs maintained by the FFS and CCO delivery systems are only applicable to a subset of the overall covered drug benefit. Based on data from the DURM Drug Utilization Review (DUR) Report for the first quarter of 2018, the annual total spend for the entire outpatient covered drug benefit is comprised of approximately $863 million S&F. This includes expenditures for pharmacy

[27] Medicaid Drug Rebate Program Notice Release No. 172, Ctrs. for Medicare & Medicaid Servs., Assuring Medicaid Beneficiaries Access to Hepatitis C (HCV) Drugs (Nov. 5, 2015), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/rx-releases/state-releases/state-rel-172.pdf.
[28] *Drug Use Research and Management: Policies and Procedures*, OR. STATE UNIV. COLL. OF PHARMACY, https://pharmacy.oregonstate.edu/drug-policy/oregon-pharmacy-therapeutics-committee/policies-and-procedures (last visited July 17, 2018).
[29] ELLEN SCHNEITER, NAT'L ACAD. FOR STATE HEALTH POLICY, STATES AND PRESCRIPTION DRUGS: AN OVERVIEW OF STATE PROGRAMS TO REIN IN COSTS 5 (2016), https://nashp.org/wp-content/uploads/2016/04/Drug-Brief1.pdf.

claims, as well as physician-administered drugs billed via procedure coded drug medical claims, which are not subject to a PDL. Pharmacy claims comprise approximately 82 percent of overall outpatient drug spend ($706 million S&F). The pharmacy claim population included in this analysis, after data exclusions referenced on page 32, represents approximately 92 percent of the $706 million.

CCOs currently pay for approximately 77 percent of the state's Medicaid outpatient drug claims (by claim count), including both pharmacy claims and physician-administered drugs billed via procedure coded drug medical claims. These claims total approximately $700 million S&F and represent 81 percent of Medicaid outpatient drug expenditures. Pharmacy claims represent 87 percent of all CCO outpatient drug claims, totaling approximately $571 million S&F. The relative percentage of claims and the percentage of spend paid by the CCOs for all outpatient covered drug claims has remained about the same over the past three years based on DURM drug utilization reports. The CCO pharmacy claim population included in this analysis after data exclusions on page 32, represents approximately 93 percent of the $571 million S&F. *Table 3* summarizes the gross spend and claim count by delivery system.

Table 3: Gross Spend and Claim Count by Delivery System[30]

Delivery System	Total Outpatient Drug Spend	Pharmacy Drug Spend	Physician Administered Drug Spend	Average Monthly Claim Count	Average Monthly Pharmacy Claim Count	Average Monthly Physician Administered Drug Claim Count
FFS	$163M (19%)	$135M (83%)	$28M (17%)	233,487 (23%)	214,868 (92%)	18,619 (8%)
CCO	$700M (81%)	$571M (82%)	$129M (18%)	786,085 (77%)	681,305 (87%)	104,780 (13%)
BOTH	$863M (100%)	$706M (82%)	$157M (18%)	1,019,572 (100%)	896,173 (88%)	123,399 (12%)

Myers and Stauffer utilized a data set provided by OHA for the PDL analysis to generate the claims payment and utilization summaries on the following pages for all pharmacy claims. The data included pharmacy claims with a date of service between January 1, 2017 and December 31, 2017.

A significant portion (85 percent) of the total pharmacy drug claims included in the analysis were for generic drugs. While brand drugs only accounted for 15 percent of the claim population, they represented 75 percent of spend. This inverse relationship of claim count versus claim spend occurs across all Medicaid programs. The GDR was calculated by dividing the number of generic drug claims by the total number of drug claims. This was performed utilizing claims for each delivery system and resulted in a GDR of approximately 83 percent, in aggregate, for the CCO delivery systems, and over 90 percent for the FFS delivery system. The higher GDR for FFS is partially due to the high utilization of generic drugs from the 7-11 Drug Carve-Out List. *Chart 1* below illustrates pharmacy spend and claims by brand versus generic designation by delivery system.

[30] OR. STATE UNIV. COLL. OF PHARMACY, PHARMACY UTILIZATION REPORT: OCTOBER 2016—JUNE 2017 (forthcoming) (on file with author).

Chart 1: Brand versus Generic Claims and Spend by Delivery System – 2017 Service Dates

Table 4 below illustrates OHA gross pharmacy claim payment averages and are categorized in various groupings by delivery system.

Table 4: Average Gross Payment per Pharmacy Claim by Delivery System – 2017 Service Dates

	Overall	FFS	CCO
All	$66.62	$52.82	$70.68
Brand	$326.19	$333.18	$325.03
Generic	$19.76	$23.14	$18.68
Specialty	$3,119.39	$2,046.01	$3,295.16
Non-Specialty	$40.99	$42.52	$40.54
Hepatitis C	$21,751.99	$24,601.39	$21,653.28
7-11 Drug Carve-Out	$53.78	$53.75	$145.99*
Non-Carve-Out	$69.22	$50.18	$70.68

**A small number of claims for drugs on the 7-11 Drug Carve-Out List existed in the CCO claims data.*

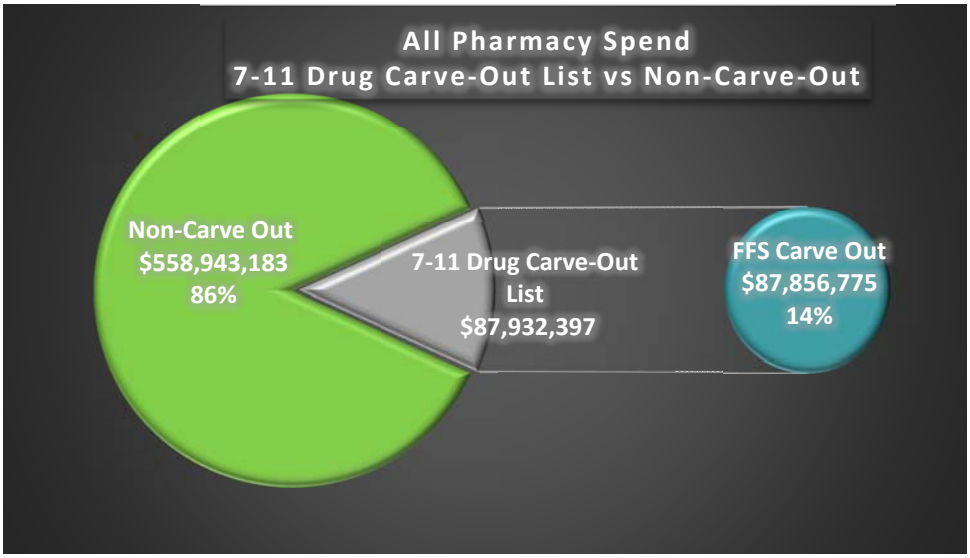
Although specialty drug claims account for less than one percent of all OHA pharmacy claims, total OHA expenditures for specialty drugs represent almost 40 percent of overall pharmacy spend. Currently, CCO specialty spend for non-preferred specialty drugs, based on the FFS PDL designation, is approximately 23 percent. *Chart 2* below illustrates the breakdown.

Chart 2: Specialty Pharmacy Claims and Spend by Delivery System – 2017 Service Dates

Claims were identified as specialty if the NDC existed on the Myers and Stauffer Specialty Drug List. This list is utilized to perform various analyses regarding specialty utilization and spend. The initial list was established by comparing numerous specialty drug lists published by specialty pharmacies and PBMs and was subsequently reviewed by a team of pharmacists. On a weekly basis, compendia drug files are reviewed by a team of pharmacists to identify new drugs that are potential candidates for addition to the list. Several considerations are made to determine if a drug should be added to the specialty list, including but not limited to, cost of therapy, indication, route of administration, drug distribution mechanism, the requirement of special handling, and orphan drug designation.

CCOs are not required to make payment for drugs on the 7-11 Carve-Out Drug List as these are covered through the FFS benefit. The portion of spend for drugs on this list represents 14 percent of the total pharmacy spend. As expected, a review of the claims data indicated that the FFS delivery system paid for 99.9 percent of the 7-11 Carve-Out Drug List spend. *Chart 3* below illustrates the breakdown.

Chart 3: 7-11 Drug Carve-Out List Pharmacy Spend by Delivery System – 2017 Service Dates



Under the current pharmacy benefit design, each CCO establishes and maintains their own PDL; however, a large portion of CCO utilization and spend is already aligned with the FFS PDL. Only nine percent of the CCO claims and 26 percent of the CCO spend were for FFS non-preferred drugs under the FFS PDL. This result is driven by the high utilization of generic drugs in both delivery systems, the existing alignment requirement of the hepatitis C class, the 7-11 Drug Carve-Out List, and a subset of covered outpatient drugs not subject to the FFS PDL. *Chart 4 and Chart 5* on the following page illustrates the breakdown of spend and claims.

Chart 4: CCO Spend Breakdown by FFS PDL Designation – 2017 Service Dates

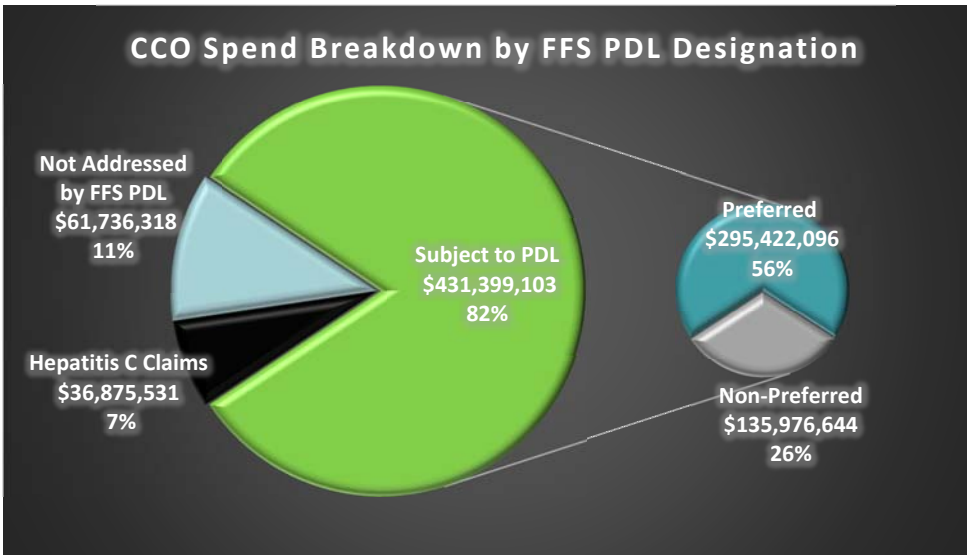
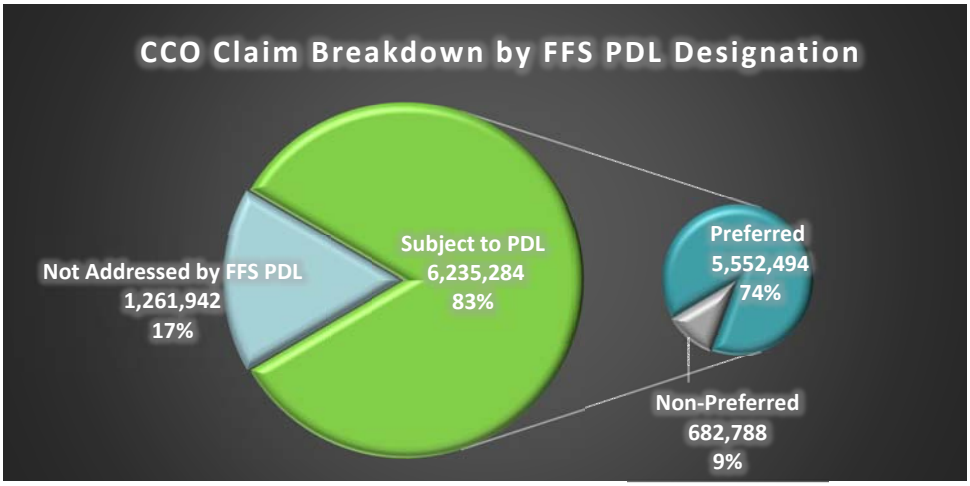
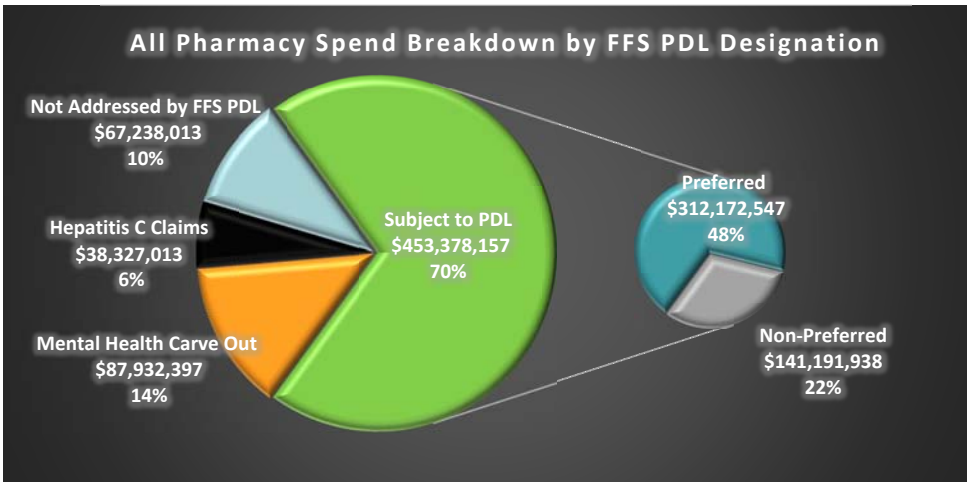


Chart 5: CCO Claim Breakdown by FFS PDL Designation – 2017 Service Dates



*Hepatitis C claims are not included in *Chart 5* as they represent only 0.02% of CCO claims.

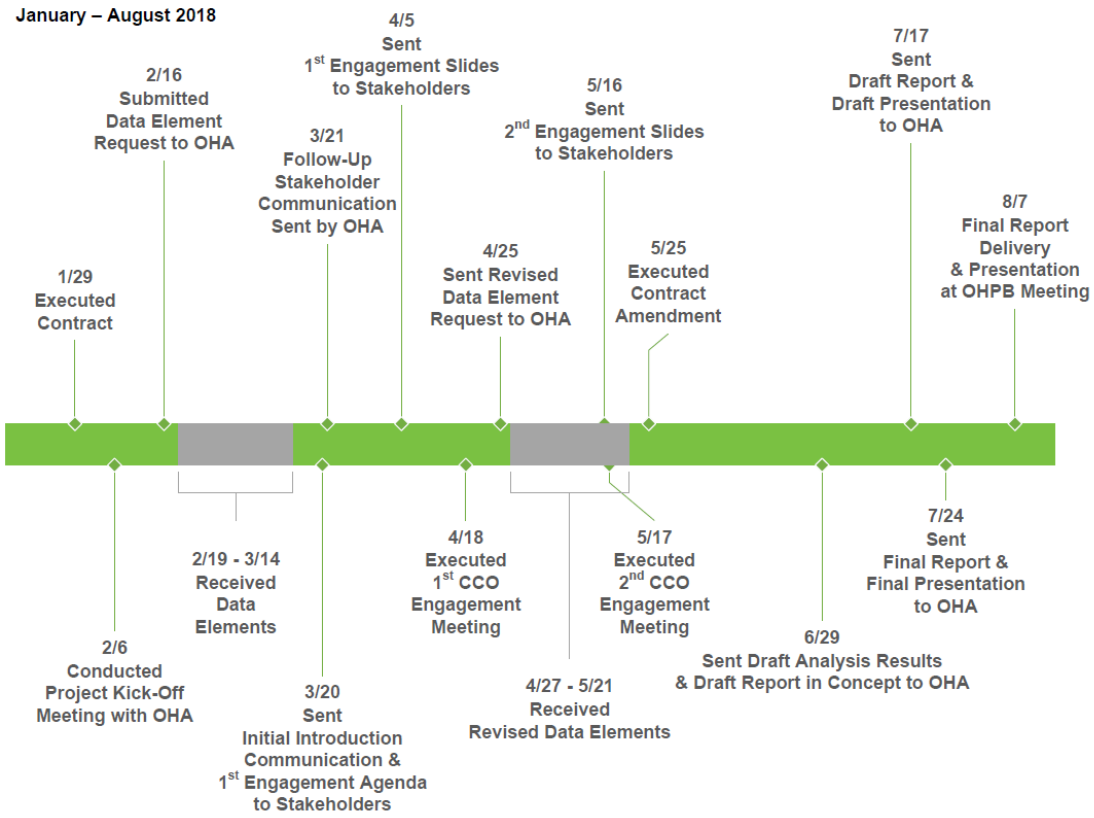
Chart 6: CCO and FFS Spend Breakdown by FFS PDL Designation – 2017 Service Dates



The claims and payment summary charts and tables above illustrate the allocation of total spend and claims by delivery system. In addition, the data demonstrate the high GDR existing in both delivery systems along with the inverse relationship between a high GDR and the amount of spend attributable to generic drug claims. Overall, brand drug spend and the subset of specialty spend (primarily comprised of brand drugs) represent the majority of total drug spend on a program wide basis. These two spend areas represent the greatest areas for savings opportunity when considering a single PDL or an aligned PDL approach. Specialty spending and uniformity of benefit design (including physician administered drugs billed on medical claims) also represent opportunities for program wide collaboration between the FFS delivery system and the CCO delivery systems. Due to the inherent existence of the high generic dispensing rates in both delivery systems it is evident that there is already a high degree of PDL alignment taking place. For the drugs subject to the FFS PDL, 56 percent of the total CCO spend and 74 percent of total CCO claims were for preferred FFS drugs and are essentially already aligned. In addition, the 7-11 Drug Carve-Out List paid for through the FFS delivery system represents 14 percent of total program spend. Lastly, the hepatitis C therapeutic class is already aligned and has consistent prior authorization criteria, representing approximately 6 percent of total program spend. *Chart 6* above illustrates the overall spend, inclusive of both CCO and FFS delivery systems, partitioned by FFS PDL designation.

PDL Evaluation Key Milestones

Throughout the course of the project, Myers and Stauffer conducted bi-weekly update calls with OHA. A dedicated email address was established to allow for continual CCO feedback, questions, and interaction throughout the process. The timeline below highlights key milestones during the course of the project.



Options for Consideration

Myers and Stauffer considered and assessed three approaches related to the administration of the PDLs: 1) a single PDL approach; 2) an aligned PDL approach; and 3) status quo. Key considerations in the evaluation and formulation of recommendations related to these three approaches included operational realities, measurable program savings, and consideration of the impact to the CCOs, OHA, and the provider community. It is important to note that the implementation of a single or aligned PDL approach would not result in carving out the prescription drug benefit from the CCO capitation payments.

Single PDL

A single PDL approach would obligate the CCOs to utilize and adhere to the FFS PDL for all therapeutic classes. This would include consistent application of utilization management tools and PA criteria across all delivery systems.

Implementation and Operational Realities

Implementation of a single PDL approach in an established delivery system environment, such as the current state of the Oregon Medicaid pharmacy benefit, requires careful consideration and attention to many details. Wholesale changes, especially when considering the fact that Oregon has 15 CCOs operating and managing their own PDLs, have a greater potential to result in disruption to patient care and access to medications patients are currently taking. In addition to beneficiary disruption, the program must also consider the impact to prescribers and pharmacies in regard to therapy conversions and PAs. Capitation rate impact must also be considered, especially since the CCOs receive capitation rates with a five-year, 3.4 percent spending growth target for total cost of care. Configuration changes to CCOs' pharmacy claims processing systems and the associated cost must be considered. The breadth and depth of the PDL changes, combined with the extended implementation timeframe needed, will determine the overall impact to all stakeholders, including the bandwidth and feasibility of OHA to implement such a change. In addition, OHA must balance program priorities with the return on investment necessary to support a change of this magnitude in light of other opportunities that could be pursued. While a single PDL could be an ideal approach for a new program or a long-term solution for an existing program, moving directly from the current approach to a single PDL does not allow adequate time for OHA to properly monitor and evaluate the associated operational and financial outcomes.

Aligned PDL

An aligned PDL approach would obligate the CCOs to utilize the FFS PDL for only a select number of therapeutic classes.

Implementation and Operational Realities

Implementation of an aligned PDL has many of the same considerations as mentioned above with the single PDL approach. While the considerations are similar, the overall magnitude of the aligned PDL approach is much smaller than that in the single PDL approach. This approach limits the initial number of therapeutic classes for alignment and prioritizes those classes identified with the greatest program savings for OHA. In addition, this minimizes disruption to all stakeholders,

limits the potential capitation rate impact, and allows time to measure and monitor the impact of the initial recommended therapeutic classes. The aligned PDL approach could be implemented over a shorter duration of time and allow for other OHA priorities such as collaborative efforts related to utilization management of specialty pharmaceuticals.

Status Quo

Continuing with the status quo would allow the CCOs to continue to operate and maintain their PDLs without regard to the FFS PDL. However, the current approach does not take advantage of the administrative and financial opportunities available through a single or aligned PDL.

Stakeholder Considerations

Myers and Stauffer conducted research and reviewed existing literature and publications regarding implementation of a single or aligned PDL approach. Feedback was solicited throughout the project from the 15 CCOs via two webinars and a dedicated email address. The CCOs also provided two whitepapers on the subject of a single or aligned PDL.[31,32] In addition, conversations were held with representatives of other state Medicaid programs that have implemented or are considering implementation of a single or aligned PDL. Based upon these activities, Myers and Stauffer has summarized the relevant common themes, findings, and observations outlined on the following pages.

Perspectives and Positions Surrounding a Single or Aligned PDL

There are several common considerations noted in a number of publications with both supporting and opposing positions regarding PDL approaches. The following table illustrates and describes the common considerations and the varying positions for each.

Table 5: Single or Aligned PDL Considerations

Single or Aligned PDL Considerations	Supporting Position	Opposing Position
Improved Provider Experience and Administrative Simplification	▪ Creates administrative efficiencies and advantages for prescribers and enrolled pharmacies. ▪ Reduces the burden of tracking multiple PDLs which are published in variable formats and locations updated at different frequencies. ▪ Reduces the burden of navigating different PA criteria and utilization management tools. ▪ Provides for more uniformity and simplicity across the 16 unique PDLs. ▪ Reduces Oregon Medicaid provider concerns and complaints related to administrative burden.	▪ Pharmacies and prescribers routinely deal with multiple formularies, PDLs, and varying PA requirements from other payers. ▪ Does not eliminate the use of PA completely. ▪ Other tools exist that can be utilized to ease administrative burden, such as electronic PA and electronic prescribing, combined with real-time pharmacy benefit checking and verification.

[31] PRIMARYHEALTH ET AL., *supra* note 3

[32] PRIMARYHEALTH ET AL., PHARMACY BENEFIT ALIGNMENT: PRINCIPLES/CONCEPTS/OPPORTUNITIES/RISK MITIGATION (forthcoming) (on file with author).

Single or Aligned PDL Considerations	Supporting Position	Opposing Position
	▪ Reduces pharmacy burden of PA volume and inventory management challenges.	
Consistent Access	▪ Offers more consistent access for all Medicaid beneficiaries to the same set of medications regardless of the delivery system being utilized.	▪ Diminishes the ability of CCOs to meet the unique need of the communities they serve.
Rebate Maximization/Lower Net Costs	▪ Will result in shifting utilization to medications with the lowest net unit cost after rebate consideration. ▪ Will result in lower net costs for state and federal taxpayers. ▪ After the review of clinical evidence, federal rebates are often the key determinant of the favorable net cost equation for PDL status.	▪ Financial incentives should be provided to each stakeholder to align to lower net cost medications. ▪ Will, in some cases, result in additional up front expenditures by the CCOs. ▪ May require potential adjustment to capitation rates. ▪ Impacts the drug mix being utilized and negatively impacts the finances of the CCO. ▪ Supplemental rebates should be optimized but should not drive health care strategy/structure.
Preferred Multiple Source Brand Drugs Over Generically Equivalent Drugs	▪ Will result in lower net costs for state and federal taxpayers. ▪ Select opportunities may exist with high savings, but minimal capitation rate/GDR impact.	▪ Will result in lower GDRs. ▪ Will result in higher CCO gross expenditures and capitation rate adjustments. ▪ Requires coordination and timing of PDL changes to appropriately capture savings. ▪ Requires pharmacies to maintain a higher inventory for brand drugs that cost more to purchase than the generic alternative.
Improved Member Experience	▪ Minimizes or eliminates the occurrence of Medicaid beneficiaries switching between delivery systems to pursue access to their drug of choice. ▪ Reduces risk of delays in starting or abandoning medication therapy.[33] ▪ May result in improved adherence to the prescribed regimen resulting in improved health outcomes.[34] ▪ Reduces the need for additional pharmacy visits requiring transportation.	▪ Reduces CCOs flexibility to prioritize "whole person" care coordination within their unique and specific population.
Best Practice Development	▪ Allows for coordination between CCOs and FFS on consistent best	▪ May be difficult to agree on best practices when financial interests are not aligned.

[33] AMERICAN MED. ASS'N, 2017 AMA PRIOR AUTHORIZATION PHYSICIAN SURVEY 1 (2017), https://www.ama-assn.org/sites/default/files/media-browser/public/arc/prior-auth-2017.pdf.
[34] MICHELLE LASTER-BRADLEY ET AL., ACS GOV'T HEALTHCARE SOLS., EVALUATION OF THE INDIANA MEDICAID PREFERRED DRUG LIST (PDL) PROGRAM (2006), http://www.in.gov/legislative/igareports/agencyarchive/reports/FSSA56.pdf.

Single or Aligned PDL Considerations	Supporting Position	Opposing Position
	practice approaches to drug benefit design.	
Benefit Administration Transparency	▪ Allows for ongoing collaborations between CCO and FFS delivery systems. ▪ Aligns FFS and CCO, PDL, and PA criteria review processes, improving visibility and transparency. ▪ P&T Committee meetings open to the public. ▪ Increases participation in P&T committee meetings.	▪ Allows drug manufacturers to participate in P&T committee meetings, which could allow them to influence PDL product placement. This, in turn, could result in the inclusion of higher cost products that do not deliver added clinical value in return for the large cost difference to the CCO.
Federal and Supplemental Rebate Transparency	▪ Improves CCOs' understanding and insight of federal and supplemental rebate impact relative to CCO gross cost versus the state's net cost. ▪ Allows OHA to measure the impact to the CCOs' gross expenditures and predict the need to adjust capitation rates when necessary.	▪ No incentives exist for the CCOs to establish PDLs that result in the lowest net cost to the state after rebates are considered.

PDL Environmental Scan

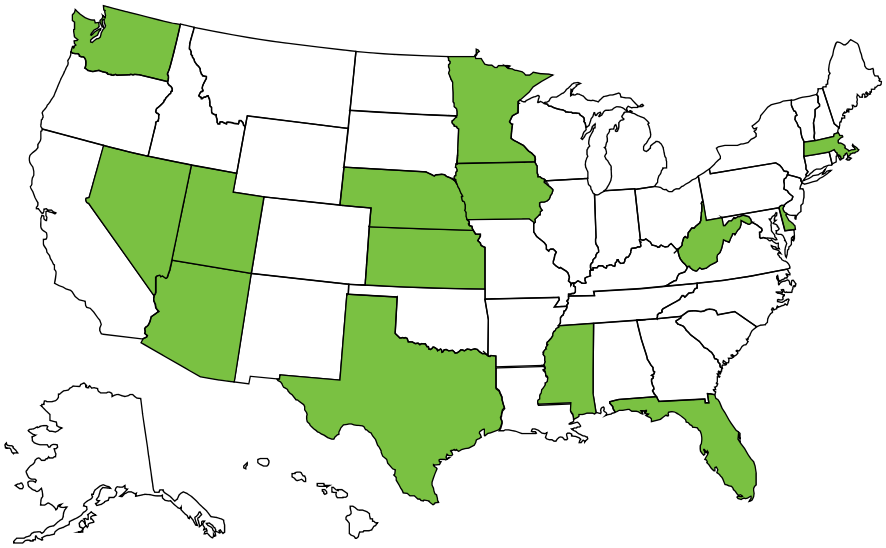
Myers and Stauffer reviewed publicly available information about states that utilize a single or aligned PDL. Based on this review, various approaches were identified across the 51 Medicaid programs with regard to the administrative flexibility of a MCO/CCO to administer and maintain their own PDL. While some states require the MCOs/CCOs to adhere to the FFS PDL, other states do not impose any requirements. A 2014 report by the Menges Group "State Policies Regarding Medicaid MCO Preferred Drug Lists" states "a middle ground policy has been established in several states (e.g., Ohio), where a Medicaid MCO's PDL is required to be largely aligned with the Medicaid fee-for-service PDL." [35]

A number of other states have taken this type of approach, aligning select therapeutic classes as opposed to a single PDL. Some states, such as Alabama and West Virginia, carve out the pharmacy benefit from managed care capitation rates altogether. It is worth noting that an increased number of states are more closely evaluating the change to a single PDL in light of the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) discussed on page 8. In addition, state Medicaid programs are examining other related areas that can impact PDL spending such as drug pricing transparency, 340B drug discount payment policies.[36,37] MCO/CCO PBM

[35] THE MENGES GROUP, STATE POLICIES REGARDING MEDICAID MCO PREFERRED DRUG LISTS 3 (2014), https://www.themengesgroup.com/upload_file/acap_fact_sheet_on_pdls.pdf.
[36] Informational Letter No. 1638-MC, Iowa Dep't of Human Servs. & Iowa Medicaid Enter., Update 340B Drug Pricing Program (Mar. 21, 2016), https://dhs.iowa.gov/sites/default/files/1638-MC_Update-340B_DrugPricing%20Program.pdf
[37] Ariz. Health Care Cost Containment Sys., 340B FQHC Look-Alike Pharmacy Bill and Reimbursement Requirements Frequently Asked Questions, https://www.azahcccs.gov/Shared/Downloads/Reporting/PerformanceMeasures/Pharmacy/Pharmacy_340BFAQsFinal3_12_2012.pdf (last visited July 26, 2018).

contractual agreements regarding spread pricing[38,39] and drug rebates. The map below, from a recent Louisiana Medicaid stakeholder presentation regarding consideration of a single PDL, indicates that 14 states with managed care currently require the use of a single PDL. It should be noted that other states may utilize a single PDL, but do not have managed care programs and other states with managed care align certain PDL classes or carve out certain drugs or classes from managed care capitation rates.

Chart 7: States with Managed Care Utilizing a Single PDL[40]



State-Specific Efforts

Washington

The most recent state to move forward with the implementation of a single PDL is the State of Washington. The Washington State Health Care Authority (HCA) was required to implement a single Medicaid PDL due to a legislative provision. All MCOs must use the FFS PDL and must not negotiate or collect rebates for drugs listed on the PDL regardless of their preferred or non-preferred designation. HCA noted that the priorities of implementing a single Medicaid PDL involved patient care and access to necessary medications, minimizing patient and provider

[38] Catherine Candisky, *DeWine Threatening to Sue Pharmacy Benefit Managers*, AKRON BEACON J./OHIO.COM (July 23, 2018 8:10PM), https://ohio.com/akron/business/dewine-threatening-to-sue-pharmacy-benefit-managers

[39] HEALTHPLAN DATA SOLS., LLC, EXECUTIVE SUMMARY OF REPORT ON MCP PHARMACY BENEFIT MANAGER PERFORMANCE (2018), http://www.healthtransformation.ohio.gov/Portals/0/Press%20Releases/PBM%20HDS%20Final%20Report%20Executive%20Summary.pdf?ver=2018-06-21-114617-170.

[40] JEREMY PALMER & STEVE LILES, MILLIMAN, LOUISIANA MEDICAID SINGLE PREFERRED DRUG LIST 7 (2018), http://ldh.la.gov/assets/docs/BayouHealth/Pharmacy/Louisiana_Single_PDL-Stakeholders_Presentation-20180427.pdf.

disruption, and providing easy access to the right information for patients, prescribers, and pharmacies.[41]

Texas

The Texas Vendor Drug Program, which administers the Medicaid pharmacy benefit, utilizes a single PDL. Based on concerns from the MCOs operating in Texas, the Vendor Drug Program requested that an actuarial consulting firm perform an analysis to evaluate the estimated financial impact of a mandated single PDL versus an approach with no mandate (i.e.,MCO maintains their own PDL). The results of this analysis estimated that despite the additional rebates collected in the mandated single PDL, the no mandate scenario would be 1.8 percent less costly ($40 million in general revenue) over a two-year period.[42] A second report regarding the financial impact of the Texas mandated single PDL, sponsored by the Texas Association of Health Plans, was published by the Menges Group. The Menges report found that "the current uniform PDL policy is costing Texas taxpayers over $1 million for every four days it remains in effect".[43] Unlike the analysis performed by the actuarial firm, the Menges report could not incorporate the impact of detailed federal and supplemental rebate amounts and relied on publically available aggregated data to estimate net cost per prescription in the aggregate. This difference in approach may have contributed to the large financial discrepancy between the two reports.

Florida

The Florida Medicaid program implemented a single PDL in 2014. A study regarding the effect of Florida's implementation of a single PDL was published in February 2018 in the *Journal of Managed Care & Specialty Pharmacy*.[44] The report concluded that the state-mandated PDL resulted in declines in overall and generic drug use and an increase in drug plan costs. However, a major limitation to this study is that it did not take into account federal or supplemental rebates that the state receives from pharmaceutical manufacturers. Due to this significant limitation, the financial results of this study are not reliable from a net cost impact perspective. A recommendation worth noting from the study is that states need to anticipate increased drug costs for health plans and make equitable adjustments to plan capitation rates. Funding for this study was provided by Express Scripts, a PBM, who provides services to MCOs/CCOs in multiple states.

Louisiana

The Louisiana Medicaid program has been evaluating the implementation of a single PDL and recently held a stakeholder engagement meeting in April 2018 highlighting the rationale behind this evaluation. The presentation indicated that the intent was not to reduce the cost of the Louisiana Medicaid pharmacy program, but rather to address the practical challenges of multiple PDLs faced by their Medicaid members and enrolled providers. However, they did note that they

---

[41] DONNA L. SULLIVAN, WASH. STATE HEALTH CARE AUTH., SINGLE MEDICAID PREFERRED DRUG LIST 6 (2017), https://www.dev.hca.wa.gov/assets/program/dur-single-pdl-2017-7-7.pdf.
[42] KHIEM D. NGO, RUDD AND WISDOM, INC., STATE OF TEXAS VENDOR DRUG PROGRAM: FORMULARY CONTROL STATE VS. MCO 1 (2017), https://hhs.texas.gov/sites/default/files/formulary-control-state-vs-mco.pdf.
[43] JOEL MENGES ET AL., THE MENGES GROUP, ASSESSMENT OF MEDICAID MCO PREFERRED DRUG LIST MANAGEMENT IMPACTS 1 (2016), https://www.themengesgroup.com/upload_file/report_on_texas_pdl_february_2016.pdf.
[44] Kiraat D. Munshi et al., *The Effect of Florida Medicaid's State-Mandated Formulary Provision on Prescription Drug Use and Health Plan Costs in a Medicaid Managed Care Plan*, 24 J. OF MANAGED CARE & SPECIALTY PHARMACY 124 (2018), https://www.jmcp.org/doi/pdf/10.18553/jmcp.2018.24.2.124.

were committed to ensuring the change would be budget neutral and any realized savings would be reinvested in the Medicaid pharmacy program.[45]

Preferred Multiple Source Brand Drugs

A consistent concern and operational reality of a single PDL involves the state maintaining preferred status for brand drugs over their available generic equivalents. This occurs when a significant net cost savings is realized by the state because of high federal rebates (and potential supplemental rebates) for brand drugs with recent patent expirations. The primary concern voiced by CCOs is that the generic equivalent is less costly on a gross spend basis, and the CCOs have no financial incentive to maximize rebates collected by the state or lower the net cost (after rebates) to the state.

Selective opportunities for preferring brand drugs over their available generic equivalents do exist and result in lower net cost for state and federal taxpayers.[46] This lower net cost advantage may exist for only a short period of time depending on the level of generic competition or it may go on for an extended period of time in certain situations. For some brand drugs, especially during the six-month exclusivity period following the brand patent expiration, the URAs can result in the net cost for the brand drug to be substantially lower than that of the generic alternative. During the six-month exclusivity period, "the average retail price of the true generic is about 86 percent of the brand drug's retail price without a competing authorized generic, and 82 percent of the brand drug's retail price with a competing authorized generic (FTC 2011). Once the 180-day period expires and other generics enter the market, the generic price drops substantially (Kirchhoff et al. 2018)."[47] In addition, the CPI penalty and best price features of the Medicaid rebate formula may result in substantially lower net costs as opposed to other brand alternatives in the same therapeutic class. While these lower net costs would be realized at the state and federal level, it is important to note that this may result in additional gross expenditures by the CCOs. This has the potential to impact capitation rates and CCO finances, and should be thoroughly evaluated by the State's actuary to understand how the generic drug entry was factored into existing capitation rates.

In order for OHA to capitalize on these opportunities within a more aligned environment, they must have the flexibility to make more efficient and timely changes to the PDL than what currently is in place. This includes identifying when a savings opportunity exists to keep the brand drug as preferred and identifying at what time the savings associated with preferring the brand over the generic is eliminated. It is also important to have sufficient stakeholder coordination and communication in place so enrolled pharmacy providers can properly manage inventory levels and CCOs can configure their claims processing systems. *Chart 8* on the following page illustrates an example of the net savings opportunities that can exist by preferring multiple source brands over their generic equivalent(s) and *Chart 9* provides an illustration of the net cost savings that can exist in a therapeutic class between a multiple-source brand, an equivalent generic, and another brand drug alternative in the same therapeutic class.

[45] PALMER & LILES, *supra* note 40, at 6.
[46] MAGELLAN RX MGMT., *supra* note 14, at 4-5.
[47] MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, REPORT TO CONGRESS ON MEDICAID AND CHIP 8 (June 2018), https://www.macpac.gov/wp-content/uploads/2018/06/June-2018-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

Chart 8: Brand and Generic Equivalent Price Trending Example

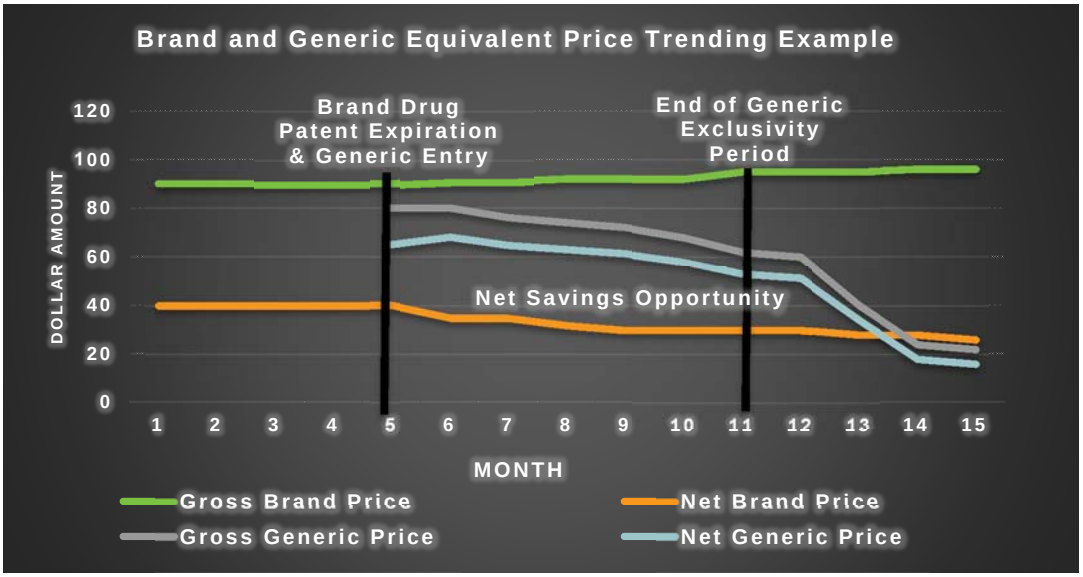
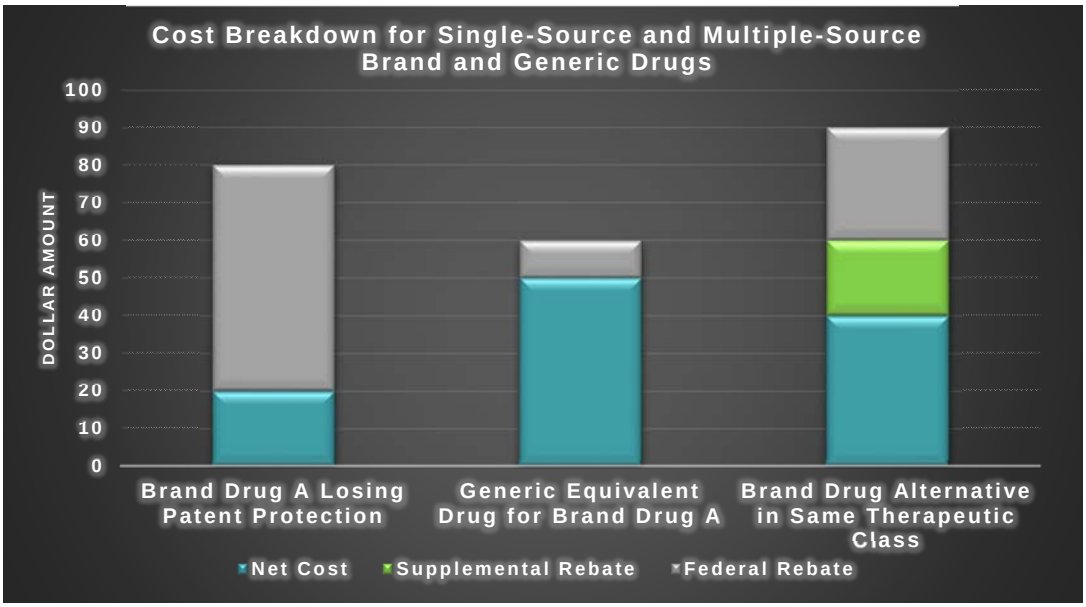


Chart 9: Cost Breakdown for Single-Source and Multiple-Source Brand and Generic Drugs



Data Analysis

Data Acquisition and Validation

For purposes of the PDL analysis, Myers and Stauffer obtained several data sets from OHA and their Medicaid Management Information System (MMIS) vendor. Pharmacy claims and other data elements were requested for dates of service between January 1, 2017 and December 31, 2017. The following data sets were provided:

- *All final paid FFS pharmacy claims grouped by therapeutic class code, NDC, and quarter (OHA).*
- *All final paid CCO pharmacy claims grouped by therapeutic class code, NDC, and quarter (OHA).*
- *All final paid CCO pharmacy claims grouped by therapeutic class code, NDC, CCO Plan ID, and quarter (OHA).*
- *Federal unit rebate quarterly files by NDC (MMIS vendor).*
- *Supplemental rebate quarterly files by NDC (MMIS vendor).*
- *National Council for Prescription Drug Programs (NCPDP) to CMS unit rebate conversion crosswalk by NDC (MMIS vendor).*
- *PDL categorization for FFS by Generic Code Number (GCN) and NDC (MMIS vendor).*
- *Monthly enrollment reports for FFS and each CCO.*

Certain conditions/exclusions were applied to the claims data sets provided by OHA. The following conditions, along with the rationale for their exclusion, are provided below:

- *340B claims: Not eligible for federal rebates.*
- *Title XXI claims: Not eligible for federal rebates under the MDRP.*
- *Compound drug claims: Inconsistent claims data, minimal expenditures, and limited PDL implications.*
- *Indian Health Services (IHS) claims: Paid via all-inclusive rate.*
- *Third-party liability claims: PDL PA claim editing is bypassed and State is not primary payer.*
- *Medicare Part B crossover claims: PDL PA claim editing is bypassed and State is not primary payer.*

To ensure the quality and accuracy of the pharmacy claims data sets, the following validation checks were performed:

- *Data provided by OHA to Myers and Stauffer was obtained from the same source used for rebate invoicing and capitation rate calculations.*
- *Data provided to Myers and Stauffer was reviewed and validated by OHA actuarial staff.*

- *Myers and Stauffer calculated key pharmacy utilization metrics such as GDRs, average payment rates per claim, drug claim expenditures, and claim counts and compared these metrics to OHA published DUR reports for reasonability.*

Analysis Calculation Methodology

The methodology utilized by Myers and Stauffer for purposes of estimating the fiscal impact can be summarized into three steps: 1) baseline calculations and aggregation; 2) post-alignment modeling and calculations; and 3) post-alignment impact calculation. For purposes of illustration, the specific steps and example calculation tables are included below.

Step One: Baseline Calculations and Aggregation.

- *Sum CCO 2017 spend, claims, and units by NDC.*
- *Calculate average CCO spend per claim by NDC (CCO spend ÷ CCO claims).*
- *Calculate rebates (federal and supplemental), applying conversions when applicable, for CCO claims by NDC (CCO units x URA).*
- *Calculate average rebate amount per CCO claim by NDC (rebates ÷ CCO claims).*
- *Calculate average net cost per claim by NDC (average CCO spend per claim - average rebate per claim).*
- *Reprice CCO 2017 claims by NDC and compare to actual CCO spend for reasonability (WAC per unit (effective December 31, 2017) x CCO units).*
- *Compare average CCO units per claim and average CCO days supply per claim across all NDCs within the therapeutic class to ensure consistency and reasonability for claim interchange.*
- *Evaluate drugs within each therapeutic class and evaluate clinical reasonability for claim interchange (i.e., insulin therapeutic class: long-acting, intermediate-acting, short-acting, etc.).*
- *Assign FFS PDL designation to the NDCs of the CCO claims and sum total of CCO claims categorized as non-preferred and preferred.*
- *Calculate existing preferred and non-preferred market share within the therapeutic class.*

Pre-Alignment: CCO Spend and Utilization – 2017 Service Dates

FFS PDL Designation	Drug	NDC	Market Share	Spend	Claims	Units	Average Spend per Claim	Federal Unit Rebate Amount	Supp. Unit Rebate Amount	Rebates	Average Rebate per Claim	Net Spend	Net Spend per Claim
Preferred	Drug A	NDC 1	7%	$350,000	700	21,000	$500	$16.66667	$ -	$350,000	$500	$0	$0
Non-Preferred	Drug B	NDC 2	93%	$3,952,500	9,300	279,000	$425	$3.33333	$ -	$930,000	$100	$3,022,500	$325
Total				**$4,302,500**	**10,000**					**$1,280,000**		**$3,022,500**	

Step Two: Post-Alignment Modeling and Calculations.

- *Calculate the post-alignment CCO claim breakdown by NDC by shifting variable percentages of CCO claims designated non-preferred to preferred drug claims (100 percent, 90 percent, and 75 percent).*
  - *If more than one FFS preferred NDC exists, shift post-alignment claims based on CCO market share breakdown between the preferred NDCs.*
- *Calculate CCO estimated post-alignment spend by NDC (CCO post-alignment claims x pre-alignment average spend per claim).*
- *Calculate the estimated post-alignment rebates by NDC (CCO post-alignment claims x pre-alignment average rebate per claim).*
- *Calculate the estimated post-alignment net spend (CCO post-alignment spend - post-alignment rebates).*

FFS PDL Designation	Drug	NDC	Claims	Average Spend per Claim	Average Rebate per Claim	Spend	Rebates	Net Spend
Post-Alignment: Assumes 100% Conversion of Non-Preferred to Preferred								
Preferred	Drug A	NDC 1	10,000	$500	$500	$5,000,000	$5,000,000	$0
Non-Preferred	Drug B	NDC 2	0	$425	$100	$0	$0	$0
Total			**10,000**			**$5,000,000**	**$5,000,000**	**$0**
Post-Alignment: Assumes 90% Conversion of Non-Preferred to Preferred								
FFS PDL Designation	**Drug**	**NDC**	**Claims**	**Average Spend per Claim**	**Average Rebate per Claim**	**Spend**	**Rebates**	**Net Spend**
Preferred	Drug A	NDC 1	9,070	$500	$500	$4,535,000	$4,535,000	$0
Non-Preferred	Drug B	NDC 2	930	$425	$100	$395,250	$93,000	$302,250
Total			**10,000**			**$4,930,250**	**$4,628,000**	**$302,250**
Post-Alignment: Assumes 75% Conversion of Non-Preferred to Preferred								
FFS PDL Designation	**Drug**	**NDC**	**Claims**	**Average Spend per Claim**	**Average Rebate per Claim**	**Spend**	**Rebates**	**Net Spend**
Preferred	Drug A	NDC 1	7,675	$500	$500	$3,837,500	$3,837,500	$0
Non-Preferred	Drug B	NDC 2	2,325	$425	$100	$988,125	$232,500	$755,625
Total			**10,000**			**$4,825,625**	**$4,070,000**	**$755,625**

Step Three: Post-Alignment Impact Calculation.

- *Calculate the estimated post-alignment impact range based on non-preferred claim conversion percentages (100 percent, 90 percent, and 75 percent).*
  - *CCO spend impact = post-alignment spend - pre-alignment spend.*
  - *Rebate collection impact = post-alignment rebate - pre-alignment rebate.*
  - *Net impact (fiscal savings) = rebate collection impact - CCO spend impact OR pre-alignment net spend - post-alignment net spend.*

100% Non-Preferred Conversion	**Spend**	**Rebates**	**Net Spend**
Pre-Alignment	$4,302,500	$1,280,000	$3,022,500
Post-Alignment	$5,000,000	$5,000,000	$0
Net Impact	$697,500	$3,720,000	$3,022,500
90% Non-Preferred Conversion	**Spend**	**Rebates**	**Net Spend**
Pre-Alignment	$4,302,500	$1,280,000	$3,022,500
Post-Alignment	$4,930,250	$4,628,000	$302,250
Net Impact	$627,750	$3,348,000	$2,720,250
75% Non-Preferred Conversion	**Spend**	**Rebates**	**Net Spend**
Pre-Alignment	$4,302,500	$1,280,000	$3,022,500
Post-Alignment	$4,825,625	$4,070,000	$755,625
Net Impact	$523,125	$2,790,000	$2,266,875
Estimated range of additional CCO spend = $523K – $698K Estimated range of additional rebates collected = $2.8M – $3.7M (S&F) Estmated range of potential net savings = $2.3M – $3.0M (S&F)			

Data Results

Based upon the results of the post-alignment calculations, therapeutic classes with the greatest potential for net savings were identified and further evaluated to ensure they were appropriate for alignment recommendation. Due to the proprietary and confidential nature of both federal and supplemental rebates, estimated annual net savings are not quantified by the specific therapeutic class in this public report; however, these specific estimates will be provided to OHA for internal use and verification. *Table 6* below includes those therapeutic classes selected for initial alignment and the estimated range of potential annual net savings.

Table 6: Estimated Range of Annual Net Savings for Selected Therapeutic Classes – Ordered by Savings Opportunity Descending

Therapeutic Class	Estimated Annual Net Savings Range (S&F)	Estimated Annual Net Savings State Only Dollars**
Insulins*	$17 million - $22 million 74%	$4.75 million - $6.25 million
Multiple Sclerosis Agents		
Biologics for Auto-Immune Conditions		
Pulmonary Anti-Hypertensives	$6 million - $8 million 26%	$1.75 million - $2.25 million
Short-Acting Beta-Agonists Inhalers		
Diabetes, GLP-1 Receptor Agonists		
Inhaled Corticosteroids		
Long-Acting Inhaled Anticholinergics		
Pancreatic Enzymes		
Cystic Fibrosis, Inhaled Aminoglycosides		
Growth Hormones		
Total	**$23 million – $30 million 100%**	**$6.5 million – $8.5 million**

***The estimated fiscal impact for the insulin therapeutic class does not include potential savings related to the interchange of Admelog® and Humalog®. Admelog was not commercially available until 2018, therefore was not included in the claims or rebate data analyzed by Myers and Stauffer. Inclusion of this interchange would increase the estimated savings.

****In order to estimate the financial impact in state only dollars Myers and Stauffer applied a blended FMAP of 72%. The blended FMAP was provided by OHA and is an estimate based upon the enrolled Oregon Medicaid population.

Based on the suggested classes for alignment, the State's actuary should perform an analysis to determine the potential impact to the CCO capitation rate calculation and OHA should confirm with more current data that claims utilization mix or other factors that could impact the estimated net savings are comparable to that contained in the data set provided.

Assumptions, Exclusions, and Limitations of Analysis

The following assumptions, exclusions, and limitations of analysis are noted relative to issues encountered or considerations made in compilation of this fiscal analysis.

- *The analysis was based on outpatient pharmacy claims data with dates of service from January 1, 2017 through December 31, 2017. Claims data was obtained from OHA on April 27, 2018 and is based on data at that point in time. Additional paid claims data within these dates of service may alter the results of this analysis.*
- *Myers and Stauffer did not adjust its analysis to remove the impact of any pharmacy initiatives or pharmacy program changes that may have occurred or had an impact during or after the study period reviewed.*
- *For this analysis, Myers and Stauffer relied upon data, as well as other sources of information as described in this report. Myers and Stauffer relied upon this data without independent audit; however, the data was reviewed for reasonableness and consistency.*
- *This review may not identify all data imperfections. We assume the data provided is both accurate and complete based upon the validation performed by OHA. The results of our analysis are dependent upon this assumption.*
- *Due to the dynamic nature of the prescription drug marketplace, it is difficult to predict precise financial impacts; therefore, estimates are presented as a range based upon various levels of market share shifts for the selected therapeutic classes. We assumed that the aggregate utilization of drugs within a therapeutic class will not materially differ when comparing the current approach to an aligned approach.*
- *The estimated ranges were calculated based upon 2017 data and cannot predict or account for subsequent changes to the 16 PDLs, utilization mix, drug pricing, federal and/or supplemental rebate amounts, including offsets, beneficiary enrollment, or regulatory changes that may impact prescription drug payment or Medicaid funding.*
- *Myers and Stauffer did not have visibility or access to manufacturer-provided rebates or other remuneration obtained by CCOs or their contracted PBMs; therefore, these amounts are not accounted for within the analysis. These rebates or other remuneration should be considered by the State's actuarial unit when capitation rates are calculated.*
- *Due to the proprietary and confidential nature of federal and supplemental drug rebates, the estimates were provided in the aggregate to avoid any potential disclosure of this sensitive financial information.*
- *This PDL analysis report, and the recommendations contained within, are only applicable to the Oregon Medicaid program. Each Medicaid program should carefully evaluate their own program in the context of its specific structure, pharmacy program design, rebate programs, and federal matching considerations.*

Single or Aligned PDL Recommendation

Summary Observations, Recommendations, and Best Practices

Based upon the activities conducted, Myers and Stauffer recommends OHPB and OHA consider and evaluate the following:

- *1) Consider pursuing an aligned PDL strategy and consistent pharmacy utilization management tools, including PA criteria for the recommended 11 therapeutic classes or subset listed on page 36. The classes identified will not impact overall GDRs or negatively impact the relative drug mix. The estimated range of annual fiscal savings associated with these classes is $23 to $30 million S&F with an estimated range of state share of $6.5 to $8.5 million.*
- *2) Develop a regulatory strategy and work plan for necessary legislative, rule making, procedural, or SPA activities related to an aligned PDL.*
- *3) Measure and regularly monitor fiscal performance for current and future selected therapeutic classes chosen for alignment.*
- *4) OHA, with input provided by the DURM, the Oregon P&T, and the CCOs, should become the sole decision maker with regard to current and future therapeutic classes for PDL alignment. These therapeutic classes and related drugs will provide clear and meaningful net cost advantages for the state and federal taxpayers as the current approach has a certain degree of misaligned/competing financial interests.*
- *5) The CCOs should collaborate and actively provide collective input in the public P&T meeting process as a means to establish consistent utilization management tools and best practices between the FFS and CCO delivery systems.*
- *6) Examine, and as necessary, adjust CCO capitation rates to reflect additional expenditures they may experience due to the change to an aligned PDL. Particular attention should be directed at the transparency of the pharmacy encounter claims submitted by the CCOs, and ensure the understanding of the relationship of the encounter pharmacy payment amounts as related to the amounts actually paid to the pharmacies by their contracted PBMs. In addition, any rebates or other remuneration obtained by the CCO or their contracted PBMs from drug manufacturers should be quantified for purposes of CCO contracting transparency and capitation rate setting.*
- *7) Alternatively, consider the use of an Administrative Services Organization model for aligned classes where OHA pays administrative fees to the CCOs for claims processing-related activities and reimburses the CCO directly for aligned therapeutic class pharmacy expenditures.*
- *8) Current mechanisms to review and utilize the various PDL formats are difficult and cumbersome. OHA, DURM, and the CCOs should collectively develop a user friendly consolidated PDL format with electronic search capabilities for the benefit of prescribers, pharmacies, program beneficiaries, and other interested parties. The resulting PDL format should also include utilization criteria and required PA forms associated with the*

specific drugs and/or therapeutic classes. Aligned therapeutic classes should be clearly noted.

- *9) Given the current and predicted expenditure growth of specialty pharmaceuticals, OHA, DURM, and the CCOs should collaboratively focus their collective expertise on implementing aligned utilization management strategies for specialty drugs. These specialty drugs include drugs dispensed by pharmacies and billed through pharmacy claims, as well as those purchased/administered by enrolled providers and billed through medical claims. The respective stakeholders should examine the role and feasibility of VBP arrangements as a potential strategy to manage specialty pharmaceutical spend.*
- *10) OHA should evaluate the "provider prevails" requirement established under ORS 414.334 to determine the current associated fiscal impact and determine if regulatory action should be pursued to revisit this requirement. OHA should consider optimizing the use of existing utilization management tools, such as step therapy, to maximize the use of preferred drugs providing the most value and ensure medical necessity of non-preferred drugs.*
- *11) Given the substantial national growth of 340B contract pharmacies and utilization of 340B drugs in recent years, OHA should carefully examine the drug utilization, expenditures, reimbursement amounts, and contractual requirements for 340B drugs in the CCO delivery systems. Currently, an OHA payment policy does not exist regarding CCO payment for covered outpatient drugs dispensed or administered by 340B covered entities and their contract pharmacies. This allows the CCOs to establish their own reimbursement policies for 340B dispensed drugs which may result in the CCO delivery systems paying at or near normal market reimbursement rates for these deeply discounted 340B drugs. OHA is not permitted to collect federal rebates when a 340B program drug has been dispensed; therefore, OHA may not only be grossly overpaying for these 340B drugs, but also sacrificing their ability to collect substantial federal rebates. This is an area that many states are actively evaluating and addressing through state policies or other regulatory channels. It has also gained attention at the federal level, as well as by the National Association of Medicaid Directors, and reports have been issued by both the Office of Inspector General and Government Accountability Office.*

It is important to note that these recommendations to OHPB and OHA represent the viewpoints of Myers and Stauffer and are specific to the State of Oregon Medicaid program. Many other aspects, such as regulatory changes, SPAs, and capitation rate analyses will require additional evaluation and research based upon the direction that is ultimately chosen.

Glossary of Key Terms

340B Drug Discount Program: Section 340B of the Public Health Service Act (created under Section 602 of the Veterans Health Care Act of 1992) requires pharmaceutical manufacturers participating in the Medicaid program to enter into a second agreement with the Secretary under which the manufacturer agrees to provide deep discounts on covered outpatient drugs based directly upon the Medicaid rebate formula. These 340B drugs are purchased by specified government-supported facilities called covered entities. 340B entities include disproportionate share hospitals, as well as specified grantees of the Public Health Service, including certain federally qualified health centers (FQHCs), state-operated AIDS drug assistance programs, the Ryan White CARE Act Title I, Title II, and Title III programs, tuberculosis, black lung, family planning and sexually transmitted disease clinics, hemophilia treatment centers, public housing primary care clinics, homeless clinics, urban Indian clinics, and Native Hawaiian health centers.

Authorized Generic Drug: An authorized generic drug is most commonly used to describe a drug that is approved under a new drug application (NDA) that is marketed without the brand name on its label. It is the exact same drug product as the branded product. An authorized generic may be marketed by the brand name drug company, or another company with the brand company's permission. Typically, the manufacturer sells the authorized generic at a lower cost than the original brand name drug.

Average Manufacturer Price (AMP): The average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to retail community pharmacies and retail community pharmacies that purchase drugs directly from the manufacturer. The calculation of AMP excludes the prices paid by certain payers (e.g., Department of Veterans' Affairs, Department of Defense, or Federal Supply Schedule) and non-retail community pharmacy providers (e.g., hospitals, LTC facilities, mail order pharmacies, or MCOs) and certain discounts to wholesalers (e.g., prompt pay or bona fide service fees). The calculation of AMP does not include drug rebates.

Best Price: The lowest price available to any wholesaler, retailer, provider, or paying entity excluding certain governmental payers such as the IHS, Department of Veterans' Affairs, Department of Defense, Public Health Service (including 340B), Federal Supply Schedule, and Medicare Part D plans. Medicaid supplemental rebates are also excluded from the best price calculation.

Brand Drug: A drug that is produced or distributed under an original NDA or biologic licensing application (BLA) approved by the Food and Drug Administration (FDA), covered by a patent, and marketed and sold under a proprietary, trademark-protected name. A brand drug may be a single source drug or an innovator multiple source drug. In addition, some drugs approved under an abbreviated new drug application (ANDA) may be considered a brand name drug by payers based upon price and/or their proprietary name.

Compound Drug Claim: A prescription drug claim involving two or more ingredients that are separately billed within the same claim.

Covered Outpatient Drug: An FDA-approved prescription drug, an OTC drug that is written on a prescription, a biological product that can be dispensed only by a prescription (other than a vaccine), or FDA-approved insulin which has a manufacturer or labeler who has a Medicaid drug rebate agreement in place with the Secretary of Health and Human Services.

Dispensing Fee: A professional dispensing fee is defined in federal regulations (42 CFR 447.502) as the professional fee that pays for pharmacy costs in excess of the ingredient cost of an outpatient prescription drug each time a drug is dispensed. The dispensing fee covers the pharmacy's costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid beneficiary.

Drug Mix: An evaluation of the type of drugs prescribed by a licensed health care professional or utilized by a defined population of beneficiaries.

Federal Matching Assistance Percentage: The Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures, called the Federal Matching Assistance Percentage (FMAP). States must ensure they can fund their share of Medicaid expenditures for the care and services available under their state plan. The FMAP may vary between various program types and specific services provided.

Federal Medicaid Rebates: Federal rebates are based on a statutory formula and are only available to state Medicaid agencies. In general, federal rebates are much higher for brand than generic drugs. Federal rebates account for well over 90 percent of the total rebates collected by state Medicaid agencies. Federal rebates differ in both concept and magnitude from prescription drug rebates in the commercial sector which are more similar to supplemental rebates. Federal rebates are not available under the Title XXI CHIP program.

Generic Dispensing Rate: A standard pharmacy benefit management metric which measures the number of generic claims divided by the total number of drug claims. The generic dispensing rate (GDR) is expressed as a percentage. Higher GDRs are considered important because, for the vast majority of drugs, their usage results in lower overall prescription drug costs.

Generic Drug: A drug that is produced or distributed under an ANDA approved by the FDA. Generic drugs are typically distributed by multiple manufacturers and are rated therapeutically equivalent to a brand drug by the FDA. Drug products evaluated as therapeutically equivalent can be expected to have equal effect and no clinical difference when substituted for the brand product.

Gross Pharmacy Cost: Gross pharmacy cost is equal to the total amount paid to the pharmacy by the PBM. It includes ingredient cost and dispensing fee minus any applicable copay or co-insurance.

Innovator Multiple Source Drug: A multiple source drug that was originally marketed under an original NDA approved by the FDA as a brand drug. A brand drug (i.e., single source drug)

becomes an innovator multiple source drug as it loses its patent protection and generic equivalents become available.

Line Extension Drug: A single source or innovator multiple source drug that is an oral solid dosage form that has been approved by the FDA as a modification to the initial listed drug. The modification represents a new version of the previously approved listed drug, such as a new ester, a new salt or other non-covalent derivative; a new formulation of a previously approved drug; a new combination of two or more drugs; or a new indication for an already marketed drug.

Multiple Source Drug: A drug that is distributed by multiple manufacturers who provide therapeutically equivalent products having the same active ingredient, strength, dosage form and route of administration. For purposes of the MDRP, a multiple source drug means, with respect to a rebate period, a covered outpatient drug for which there is at least one other drug product that is rated therapeutically equivalent and may include the innovator multiple source drug.

National Drug Code (NDC): An 11-digit code used as a universal product identifier for uniquely identifying and billing prescription drugs.

Net Pharmacy Cost: Net pharmacy cost is equal to gross pharmacy cost paid less federal and supplemental rebates collected by the state Medicaid program.

Non-innovator Multiple Source Drug: A multiple source drug that is not originally marketed under an original NDA. Non-innovator multiple source drugs are commonly referred to as generic drugs and are typically approved under an ANDA.

Non-preferred Drug: Drugs that are not preferred drugs within each therapeutically equivalent or therapeutically similar class of drugs utilizing a PDL. Non-preferred drugs typically require PA or the use of a preferred drug prior to their use.

Over-the-counter (OTC) Drug: A drug that may be obtained without a prescription. In most cases, Medicaid programs still require that a prescription be written for the drug to be reimbursed by Medicaid. In general, most Medicaid programs cover a limited number of OTC drugs.

Pharmacy Benefit Manager (PBM): An organization that manages pharmaceutical benefits for MCOs, CCOs, employers, and other health plans. PBM functions typically include plan benefit design, maintenance of retail, mail and specialty networks, claims processing, help desk administration, PA, utilization management, drug utilization review, rebate negotiation, and formulary/PDL management.

Preferred Drug List (PDL): A listing of commonly utilized preferred and non-preferred drugs. In general, preferred drugs are selected after a clinical and economic review and do not require PA. Non-preferred drugs typically require PA. Typically combined with a supplemental rebate program.

Prior Authorization (PA): PA is required for non-preferred drugs and drugs subject to clinical PA edits. The goal of PA programs is to ensure the client receives pharmaceutical treatment that is both medically appropriate and cost-effective. If a beneficiary presents the pharmacy with a

prescription for a non-preferred drug, the claim will require additional information in order for the claim to be paid and dispensed. There are various levels of PA requirements or other utilization edits depending on the drug.

Rebate: A monetary amount that is returned to a payer or PBM from a drug manufacturer based upon utilization of a drug by a covered beneficiary.

Single Source Drug: A drug that is produced or distributed under an original NDA or BLA approved by the FDA, including a drug product marketed by any cross-licensed labelers or distributors operating under the NDA. Single source drugs are brand drugs that are still under patent and are available only from the manufacturer(s) listed on the application.

Step Therapy: The required use of one or more drugs prior to being able to utilize another drug. Also referred to as step edits. Can be systematically or manually administered through PA.

Supplemental Rebates: Supplemental rebates are obtained by state Medicaid programs through direct contracts with drug manufacturers and are in addition to federal rebates. Supplemental rebates are tied to contracts with the drug manufacturers based upon bidding for market share placement as preferred drugs on the PDL.

Unit Rebate Amount (URA): The rebate amount calculated by CMS that a drug manufacturer must pay under the MDRP. The rebate amount is calculated on a per unit basis for each drug at the NDC level. The specific methodology used is determined by statute and depends on the drug's classification as a single source, innovator multiple source, non-innovator multiple source, a clotting factor drug, or an exclusively pediatric drug. CMS provides the URA to the state on a quarterly basis to assist the state in invoicing the manufacturer. The manufacturer remains liable for the correct calculation of the rebate amount.

Utilization Management Tools: Pharmacy benefit management tools, such as step therapy and PA, which are utilized to ensure prescribed drugs are economical, effective, clinically appropriate, and medically necessary for program beneficiaries.

Wholesale Acquisition Cost (WAC): A list price created by the manufacturer of the drug which is published in drug file compendia. The price paid by a wholesaler (or direct purchaser) in the United States for drugs purchased from the drug's manufacturer or supplier. WAC prices do not represent actual transaction prices and do not include prompt pay or other discounts, rebates, or reductions in price.

About Myers and Stauffer

Myers and Stauffer is a public accounting firm with six engagement teams providing diverse services to state and federal agencies managing government-sponsored health care programs. Specializing in accounting, consulting, program integrity, and operational support services, we currently have active health care-related engagements with Medicaid agencies in 48 states, and with CMS on projects involving both the Medicaid and Medicare programs. For more than 40 years, we have assisted state Medicaid programs with complex compliance and reimbursement issues for pharmacies, hospitals, LTC facilities, home health agencies, FQHCs, rural health clinics, physicians, and other practitioners. At the federal level, Myers and Stauffer provides extensive audit and consulting services to CMS, the U.S. Department of Justice and state Medicaid Fraud Control Units.

Myers and Stauffer administers the Survey of Retail Prices related to the development and maintenance of the National Average Drug Acquisition Cost on behalf of CMS, and provides consultation on value-based purchasing and drug pricing reform. Additional pharmacy experience includes consulting and providing services and financial analysis related to pharmacy pricing and reimbursement, pharmacy cost of dispensing, pharmacy benefit management, PDL analysis, procedure coded/physician administered drug reimbursement, 340B drug program audits, pharmacy claims analysis, and regulation/policy review.

Other health care experience includes, but is not limited to, providing audit and desk review services; assisting in the development of state reimbursement systems; defending reimbursement rates and audit findings from health care providers' administrative and judicial challenges; performing recovery audit contractor services; monitoring MCOs; delivery system payment reform initiatives; and performing data management and analysis services to assist our clients better manage their health care programs. We have earned a reputation for being creative and innovative in assisting our clients to adapt to an ever-changing health care delivery system.

Disclaimer

This PDL analysis report, and the recommendations contained within, are only applicable to the Oregon Medicaid program. Each Medicaid program should carefully evaluate their own program in the context of its specific structure, pharmacy program design, rebate programs, and federal matching considerations.

Oregon Health Policy Board

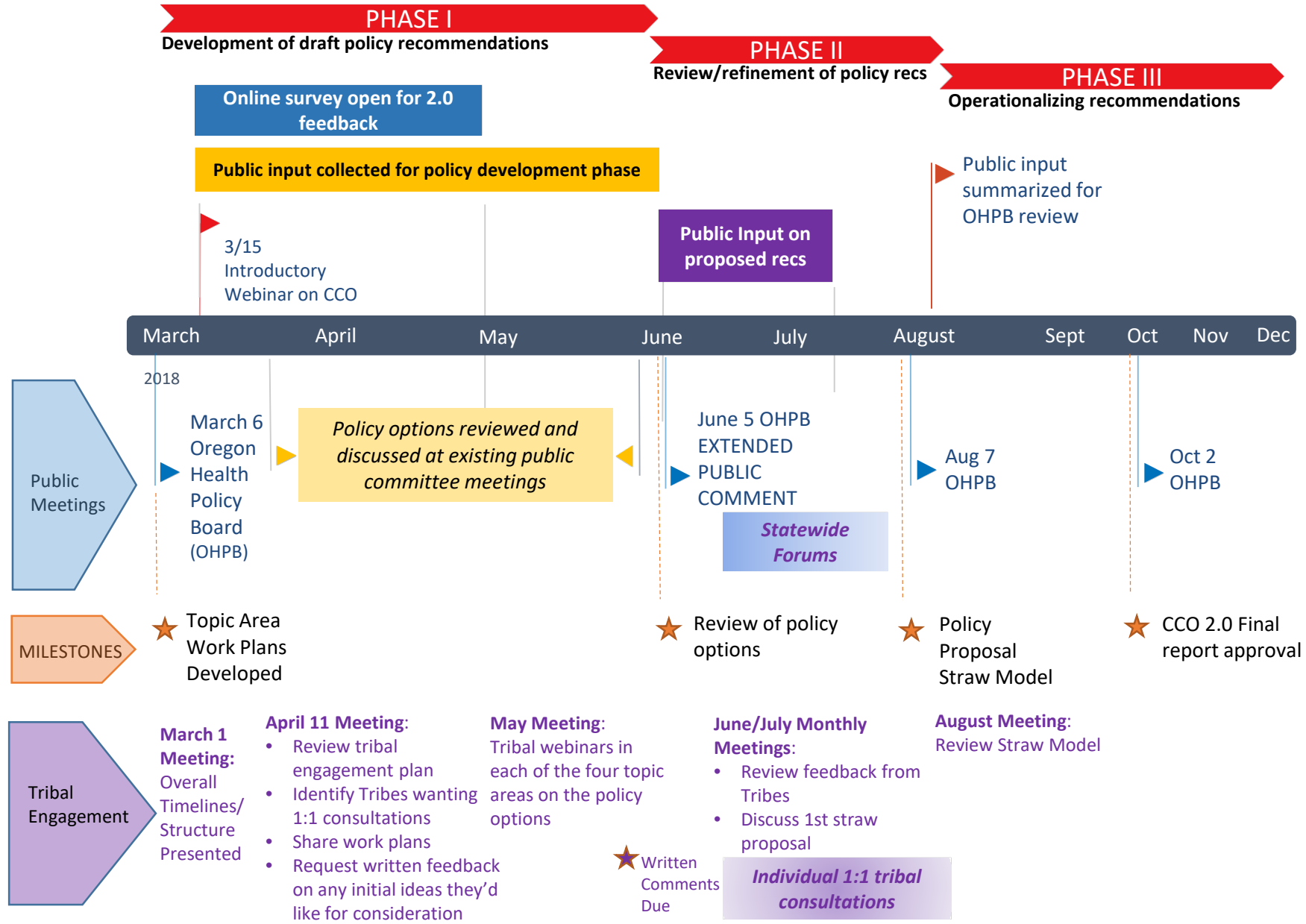
August 7, 2018

Agenda

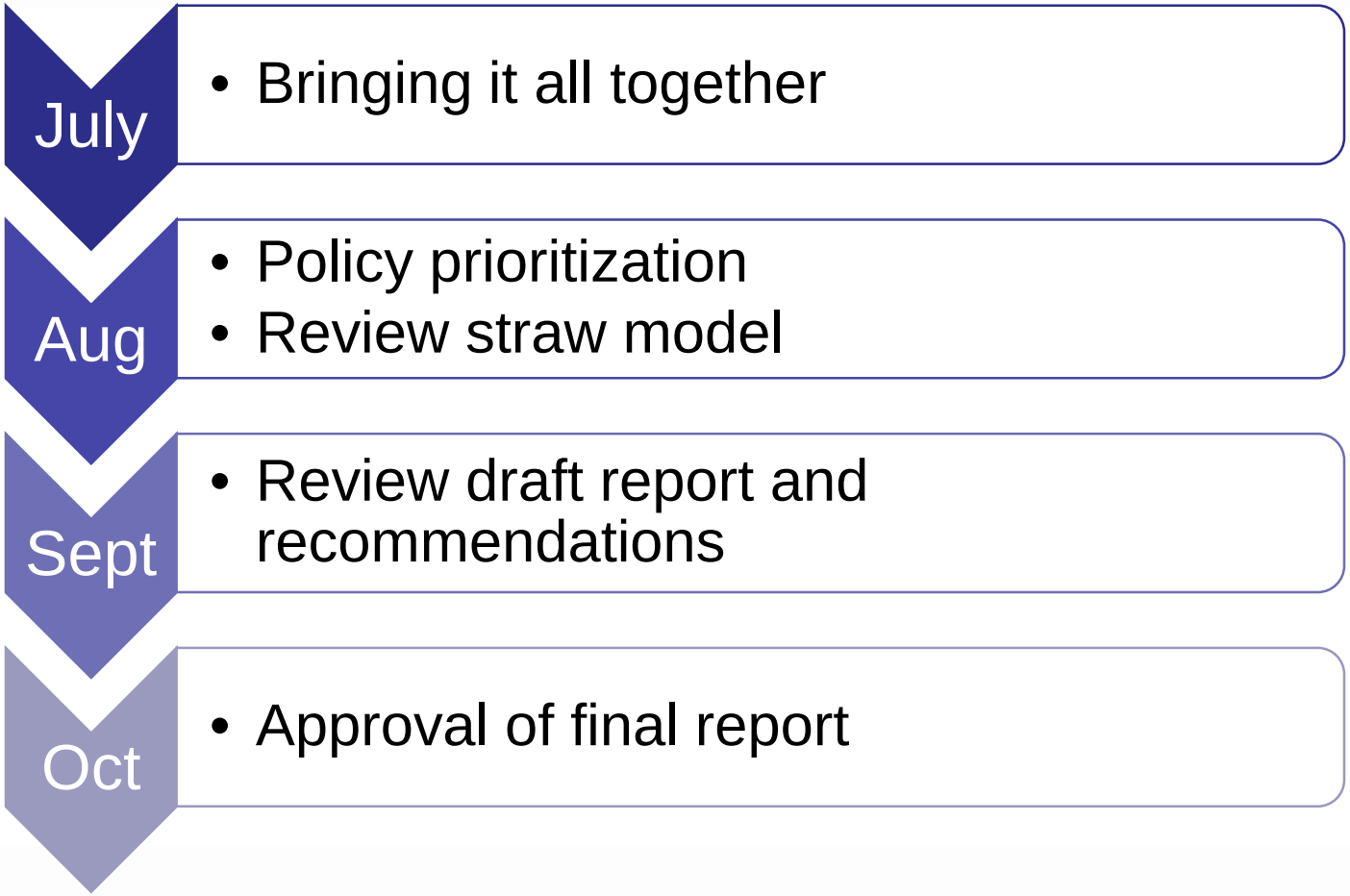
- Timeline review
- CCO 2.0 Straw Model
- CCO 2.0 Final Report Framework & Reflections

CCO 2.0 Timeline

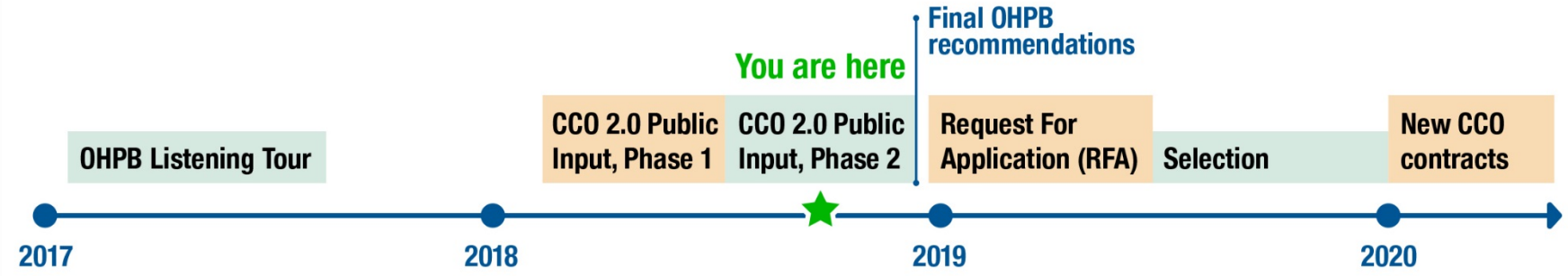
CCO 2.0 Policy Development Timeline



CCO 2.0 and OHPB: The big picture



CCO 2.0 timeline



CCOs will be selected through a Request for Application (RFA) process

- Only current CCOs and companies with an existing Oregon “footprint” can apply
- Considering asking applicants to apply for regions with an option for current CCOs to apply for their current service area

Oregon Health Authority

CCO 2.0
“straw model”

CCO 2.0 Straw Model

Organization of the straw model:

1. New policy ideas
   - Year 1
   - Year 2
2. Policies that currently exist in contract; needs strengthening or improved monitoring
3. Recommendations to/for OHA
4. Policies not recommended at this time

Reminder: Feasibility and Impact Analysis

- **Feasibility – In general, how heavy is the "lift" for this this policy across the system?**

● ○ ○	Generally easy/straightforward to implement, little to no additional work or resources required; is already part of the plan/expectation
● ● ○	Requires moderate increase in staff time, resources, development, or funding; could face some challenges
● ● ●	Will be a challenge to implement and will require new resources (e.g., funding, staff time, significant development, workgroups, etc.)

- **Impact – In general, how much does this policy move the needle in achieving the goals of the model?**

● ○ ○	Plays a supporting role, offers some clarity or direction; will have a small impact on business practices
● ● ○	Medium impact; policy will strengthen Oregon's direction and we'll see some type of effect across the state
● ● ●	Fundamental to moving the needle in this area of the CCM, significant impact or transformational

How to read the straw model

- **Policy description**: What is the policy?
- **Intended Impact:** What are the outcomes or expected results of the policy?
- **Implementation:** How would this policy be put in place? Who is responsible?
- **Considerations:** [varies]
  - Timeline, support/opposition, evidence, best practices, current implementation, etc.

DASHBOARD EXAMPLE:

★	Fulfills state or federal mandate

Priority area:	**BH**

How heavy is lift?	● ● ●
How large is impact?	● ● ●
Equity	TBD – OEI/HEC

	2019 POP planned
	Requires legislation
✓	**Potential to impact children**
	May require OHA TA support
	Could have flexible timeline
	Increases transparency

Note: Impact on equity is currently being identified by the Office of Equity and Inclusion (OEI) in consultation with the Health Equity Committee (HEC) and other community partners. It will be incorporated in August 2018.

Oregon Health Authority

Governor Brown's Vision

The Governor has asked the Oregon Health Policy Board to provide recommendations in four areas for improving CCOs in the future:

- Maintain sustainable cost growth
- Increase value-based payments and pay for performance
- Focus on social determinants of health and equity
- Improve the behavioral health system

CCO 2.0 Final Report Framework & Reflections

CCO 2.0 Final Report Framework

Final report draft outline:

- Vision of CCO 2.0
- Goals of the coordinated care model
- Prioritized policy recommendations, including:
  - Any sequencing needed
  - Contract changes needed in year 1
  - Legislation or support needed from Legislature and Governor
  - Operational changes for OHA
- Appendices:
  - Additional goals and opportunities that have surfaced through this process (not necessarily CCO 2.0)
  - Promising policies that need additional development work
  - Housekeeping changes to contracts

For more information on CCO 2.0 visit:
www.health.oregon.gov

Questions, comments, or recommendations?
Email CCO2.0@state.or.us

Thank you!

Oregon Health Authority

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations

1	**Implement HB 4018: Require CCOs to spend portion of savings on SDOH, population health policy and systems change, and health equity/health disparities, consistent with the CCO community health improvement plan (CHP)**
	a) Require CCOs to hold contracts with and direct portion of required SDOH&HE spending to SDOH partners through transparent process
	b) Require CCOs to designate role for CAC in directing and tracking/reviewing spending.
	
	Years 1 and 2 infrastructure grants: State provide two years of "seed money" to help CCOs meet spending requirement on SDOH&HE in partnership with community SDOH and CHP providers
	
	Require one statewide priority – housing-related supports and services – in addition to community priority(ies)
		★ Fulfills state or federal mandate
		
		Priority area: **SDOH / Health Equity**
		
		How heavy is lift? ●●○
		How large is impact? ●●●
		Equity: TBD – OEI/HEC
		
		✓ **2019 POP planned (see note)**
		Requires legislation
		✓ **Potential to impact children**
		✓ **May require OHA TA support**
		Could have flexible timeline
		✓ **Increases transparency**
			Increased strategic spending by CCOs on social determinants of health and health equity/disparities. Decision-making is inclusive and consumer-informed.	• Mandated by HB 4018; seed money is not required but strongly recommended by OHA staff.
				• HPA and actuarial staff to develop investing guidelines and reporting and monitoring strategy
				• Compliance needed
				
				NOTE: POP is for a SDOH Transformation Analyst that would support a variety of SDOH work; could be applied to this policy option.
					• Seed money proposed to be 0.5-1% of total global budget (prioritize seed money along with quality pool funds; amounts dependent on 2020 budget and operating under 3.4% growth cap)
					• Spending must align with CCO CHP priorities, TQS, waiver
					• Pros: May encourage spending on health related services as key mechanism to track investments in SDOH; May encourage additional spending on SDOH within the global budget
					• Cons: Could reduce funds flowing to clinical providers
					• Feedback:
					  o OHPB 7/10/18: Support for statewide priority of housing-related supports and services
					  o CCO 2.0 Survey and MAC survey ranked housing as a top priority for SDOH work
					• Agency partnerships: OHA is partnering with Oregon Housing and Community Services to expand supportive housing in the state, and there are particular opportunities to leverage this partnership to increase housing infrastructure in communities while expanding the housing-related services and supports that CCOs provide to complement this infrastructure.

2	**Increase strategic spending by CCOs on health-related services by:** a) Encouraging HRS community benefit initiatives to align with community priorities, such as those from the Community Health Assessment and Community Health Improvement Plans; and b) Requiring CCOs' HRS policies to include a role for the CAC in making decisions about how community benefit HRS investments are made.	Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC 2019 POP planned Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	SDOH spending is aligned in communities and across various SDOH spending strategies. Community resources are used more efficiently. Decision-making is inclusive and consumer-informed.	• No contract changes ("encourage") • Contract language change • OHA to develop guidance, FAQs to ensure clarity on HRS requirements	• Pros: Leverages existing work and other SDOH spending requirements • Cons: Competing priorities for investment

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
3	**Encourage CCOs to share financial resources with non-clinical and public health providers** for their contributions to incentive measures, through clarifying the intent that CCOs offer aligned incentives to both clinical AND non-clinical providers with quality pool measure areas **Encourage adoption of SDOH, health equity, and population health incentive measures** to the Health Plan Quality Metrics Committee and Metrics & Scoring Committee for inclusion in the CCO quality pool	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	Community partners are engaged and receive financial resources for their contributions to achieving incentive measures. *Metrics:* CCO quality pool dollars are used to incentivize improvements in SDoH and health equity.	**Policy could go into effect in Year 1 or Year 2 of CCO contract. Year 1 could be used for planning.** Additional OHA resources needed: Staff FTE needed to assess current practices, develop tools and resources for CCO, non-clinical and public health providers to quantify contributions to achieving incentive metrics, and provide technical assistance. • Staff FTE for planning, tool development and ongoing technical assistance are needed in HPA and PHD; monitoring/compliance also needed. *Metrics:* This can be implemented in Year 1 with no additional resources.	• Recommended by the Public Health Advisory Board (PHAB) • Support provided at road show forums. • Pros: o Sets expectation that CCOs assess contributions of non-clinical and public health providers to achieving incentive measures, in addition to clinical providers, and pay for these contributions accordingly. o Maintains local flexibility for CCOs to work with specific providers in their communities that meaningfully contribute to meeting incentive measures. o May allow for better standardization for how non-clinical and public health providers are included in quality pool payment structures. • Cons: As written, this policy option "encourages" rather than "requires", which may lead to inconsistent approaches. However, there are concerns about requiring quality pool payments to a single provider type, which may have unintended consequences and set a precedent for similar requirements from other provider groups. Also, OHA staff believe there may be federal waiver or rule concerns related to requiring incentive payments to specific providers. • *Metrics*: Current statute doesn't allow OHA to require that either HPQMC or M&S take up specific measures or categories of measures. However, both committees are committed to this work.
4	**Strengthen community advisory council (CAC)/CCO partnerships and ensure meaningful engagement of diverse consumers** through the following: a) Require CCOs to align CAC member composition with demographics of Medicaid members in their communities, report to OHA, and explain barriers to and efforts to increase alignment; b) Require CCOs to report CAC member representation alignment with CHP priorities (e.g. public health, housing, education, etc.) and percentage of CAC comprised of OHP consumers; and	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ✓ **Requires legislation** ✓ **Potential to impact children** ✓ **May require OHA TA support**	CCOs have a representative CAC. This builds trust and relationship with members. Systems are designed with the member in mind.	Strongly recommended for Year 1, pending legislation. • OEI/TC further develop standards w/HEC's guidance • HSD work needed to ensure better demographic data of CCO enrollment • TC capacity for TA and receiving and reviewing reports • Complexity of figuring out standards for representation and supporting CCOs/CACs to meet standards • Need to define OHP consumer	• Pros: Supports better representation and meaningful engagement of consumers; Reporting requirements can be added to the TQS; Potential benefit to recruitment/retention (Elevate CAC due to role on board – part C) • Cons: Potential recruitment and retention challenges (including possible resistance to CAC members reporting on their own demographic information to their CAC/CCO); Enrollment data issues/complexity (can use demographic data from American Community Survey or other sources as needed); Possible concern with information privacy and how much of that info is shared with the federal gov't • Requiring alignment with communities came about from interest in supporting more diversity and better representation, but this specific policy option as worded did not come directly from CACs.

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
	c) Require CCOs have two CAC representatives, at least one being an OHP consumer, on CCO board.	✓ **Could have flexible timeline** ✓ **Increases transparency**			• Part C - Requiring CCOs to have more than one CAC representative on the board was included after interviews with key informants
5	**Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities** by implementing the following: a) Require CCOs to adopt a Health Equity plan, including culturally and linguistically responsive practice, to institutionalize organizational commitment to health equity, b) Require a single point of accountability with budgetary decision-making authority and health equity expertise, and c) Require an organization-wide cultural responsiveness and implicit bias fundamentals training plan and timeline for implementation.	Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●○○ How large is impact? ●●○ Equity: TBD – OEI/HEC 2019 POP planned Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Standarization of health equity infrastructure in CCOs. Equitable expertise and infrastructure to facilitate adoption of measures to reduce health disparities	• Work led by OEI, and the Health Equity Committee will provide a framework for the health equity plan. OHA to staff/lead a work group that will develop health equity plan guidelines for CCOs. • OEI to develop training fundamentals plan guidance document. • Compliance needed.	• The lack of detailed tracking mechanisms and data related to health equity contributes to the challenge of understanding how CCOs have impacted these areas over the last five years. The infrastructure proposed will facilitate standarization and will ease the provision of TA by OHA. • Some CCOs have developed a strong organizational infrastructure for health equity, others have not; this represents an inequity. • The development of CCO internal infrastructure and investment to coordinate and support CCO equity is neccesary to ensure a) CCOs around the state are moving in the same direction; b) OHA and OHPB have a conduit to connect with CCOs on health equity activities, build learning collaboratives, and provide guidance and technical assistance; c) Health Equity infrastructure will facilitate the deployment of health equity metrics once they are developed. • Health equity infrastructure refers to culturally and linguistically responsive models, policies and practice including and not limited to language access, workforce diversity, ADA compliance and accessibility, ACA 1557 compliance, training and development, implementation of the CLAS Standards, non-discrimination etc.
6	Implement recommendations of the THW Commission: a) Require CCOs to create a plan for integration and utilization of THWs. b) Require CCOs to integrate best practices for THW services in consultation with THW commission c) Require CCOs to designate a CCO liaison as a central contact for THWs d) Identify and include THW affiliated with organizations listed under ORS 414.629 (Note that d. is also included under Policy Option 8 for CHAs/CHPs) e) Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for traditional health workers (THW) services.	★ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●● Equity: TBD – OEI/HEC 2019 POP planned Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Increases THW workforce by setting up a livable and equitable payment system; Increases access to peventive, high-quality care beyond clinical setting and improves outcomes Increases access to culturally and linguistically diverse providers	Implementation of a), b) and c) will start in Year 1 of the contract. Implementation of d) will coincide with CHA & CHP timeline. (see Policy 8) CCOs will work with THW Commission, OEI and HSD to: • Designate CCO liaison • Develop integration/ utilization plan with metrics to track integration milestones w/score for progress • Determine centralized/ standard reimbursement rates for reimbursement utilizing the Payment Models Grid created by the THW	• **Recommendation of the THW Commission:** Builds upon THW services requirements already in contract. o Strong support came from health systems , health insurance carriers such as Providence, Care Oregon, Kaiser, OPCA and other CBOs, FQHCs o Need to dedicate necessary resources to ensure policies are adequately and appropriately staffed, monitored, and enforced. o The integration and utilization plan **fulfills the mandates** established by the following legislation: HB 3650 (2011), HB 3311 (2011), SB 1580 (2012), HB 3407 (2013)) & HB 2304 (2017). o Literature shows improved health outcome for consumers, which, in return, saves money for OHA through Medicaid programs. Positive return on investment with increased number and utilization of THWs • Payment Model Grid contains a variety of pathways for THW payment Including APM, bundling, value-based payment, and per-member-per-month payment for THW services, Fee for Service, Grants/Contracts,

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
			beyond clinical setting.	Commision Payment Model Committee	Pathways, Medicaid administrative, targeted case and direct employement.
7	Require CCOs share with OHA (to be shared publicly) a **clear organizational structure that shows how the Community Advisory Council connects to the CCO board**	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●○○ How large is impact? ●○○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ☐ May require OHA TA support ✓ **Could have flexible timeline** ✓ **Increases transparency**	Transparency on fulfillment of statutory requirement	TC staff: Monitoring in TQS	Reporting can be added to the Transformation and Quality Strategy (TQS)
8	Require CCOs to partner with local public health authorities, non-profit hospitals, and any CCO that shares a portion of its service area to **develop shared CHAs and shared CHP priorities and strategies.** a) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need. Ensure CCOs **include organizations that address the social determinants of health and health equity in the development of the CHA/CHP,** including THWs affiliated with organizations listed under ORS 414.629.	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	Improved population health outcomes through CHA and CHP collaboration and investment. CHAs and CHPs that reflect the needs and priorities of the entire community. Reduced burden for community members due to streamlined community assessment and planning processes.	• Contract changes and rules changes needed. • Needs to be in contract for year one; work would phase in. CCOs would be required to meet these policy requirements with new CHAs and CHPs developed during the 2020-25 contract period (i.e. next CHA/CHP cycle). • OHA could convene a workgroup in Year 1 of the contract to develop recommendations for addressing barriers to shared CHAs and shared CHP priorities and strategies. This would build upon the work of the 2014 OHA CHA/CHP alignment work group.	• **Shared CHAs and shared CHP priorities and strategies:** Recommended by the Public Health Advisory Board. Supported by OHPB at June meeting. Supported during road show forums. o Likely to reduce burden on community members who are asked to participate in multiple health assessments. Will reflect the needs of entire community, beyond Medicaid. Challenges with shared CHP development can be addressed through implementation and contractual requirements. • **SHIP priority alignment:** Recommended by OHA staff. Support voiced by OHPB at 7/10 meeting. o High level of alignment currently between CHPs and 2015-19 SHIP. All CCOs could meet requirement with 2015-19 SHIP priorites (new SHIP for 2020-24). Ohio and New York have implemented similar requirements. May result in statewide gains on health conditions. • **Including orgs that address SDoH and health equity:** Recommended by the Traditional Health Worker Commission (see policy option 2-2d) o Will ensure the voice of consumers experiencing health disparities into the community health assessment and planning process. May create a small limitation on local flexibility by prescribing the organizations to be involved.

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
				• Staff FTE for TA would sit in HPA and PHD. • Staff FTE for monitoring and compliance in HSD.	
9	**Require CCOs to submit their community health assessment (CHA) to OHA**	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ☐ May require OHA TA support ✓ **Could have flexible timeline** ✓ **Increases transparency**	Transparency and support of community partner efforts.	• Should be included in contract from Year 1. Would go into effect at first CHA cycle in 2020-2025 contract period. • Monitoring is very straightforward (existing Transformation Center capacity)	• Origin of recommendation: OHA Transformation Center • Pros: Promotes transparency and can allow for improved technical assistance to CCOs • Cons: Would add a deliverable to CCO contract, but by rule CHAs are already required so it should be very easy for a CCO to submit their documentation to OHA
10	**Require CCO-specific VBP targets in support of achieving a statewide VBP goal**	★ **Fulfills state or federal mandate** Priority area: **VBP** How heavy is lift? ●●● How large is impact? ●●● Equity: TBD – OEI/HEC ✓ **2019 POP planned** ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Could have flexible timeline ☐ Increases transparency	Each CCO will be responsible for meeting annual VBP growth target calculated with their own baseline VBP data. This will ensure that all CCOs increase their use of VBPs. **Waiver requirement**	NOTE: All CCOs will need to demonstrate a minimum of 20% VBP in primary care in RFA. • Year 1 (2020): Each CCO will be expected to achieve a 1-year VBP growth target tied to the statewide VBP goal and the CCO's baseline data for category 2C ("performance-based incentive payments") and category 3B ("shared risk") as reported in their RFA response. • At end of the 1-year period, OHA will assess CCOs' progress toward meeting growth targets and establish CCO-specific	• Statewide goal of CCO VBPs to providers; aligned with the 1115 waiver requirement. • Preliminary data collection of CCO VBP data indicates approximately 50% of CCOs' payments to providers were at least in category 2C/pay-for-performance (which is similar to the CCO incentive metric program). • Statewide goal: sufficiently high to serve as a statewide goal, but not so high that it would be unachievable. • CCOs' progress will apply to 70% statewide VBP goal progress. • CCOs already at high VBP % can advance in model sophistication or care delivery focus areas (e.g., increase their % in 3B/shared risk, or adopt a VBP to focus on behavioral health integration). • Potentially, develop CCO VBP collaborative to align efforts and share tools to lead this work in their communities. The CCO VBP collaborative could evlove into a multi-payer collaboative in later years.

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
				growth targets for years two–five. • Statewide VBP goal of 70% of the weighted average of all CCOs' payments to all providers will be achieved by the end of the CCO 2.0 period.	
11	**VBP data reporting:** • Report VBP data via All Payer All Claims (APAC) database • Supplemental VBP data and /or interviews • Require complete encounter data with contract amounts and additional detail for VBP arrangements	★ **Fulfills state or federal mandate** Priority area: **VBP** How heavy is lift? ●●● How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ Could have flexible timeline ✓ **Increases transparency**	CCOs reporting to APAC will allow for comparing CCO VBP progress over time, across CCOs and across the health system. Collecting supplemental data and/or interviews will provide important info not captured in APAC, such as how CCOs address racial/ethnic health disparities, what informed the development of their models, longer term VBP goals, etc.	NOTE: CCOs are required to report to APAC beginning in 2019 (and have been notified). Modification of APAC Appendix G will occur in 2019 and APAC Appendix G VBP reporting will begin in 2020.	• **1115 waiver requires reporting of CCO VBP data**. • VBP data is not adequately captured in existing CCO reporting. • APAC already collects non-claims payments from commercial carriers. Modifying APAC to better align with VBP efforts and having CCOs report to APAC will allow for comparing VBP progress across the health system, including CCOs.
12	**Require CCOs to develop Patient-centered Primary Care Home VBPs** (i.e., payments based on PCPCH tier level)	☐ Fulfills state or federal mandate Priority area: **VBP** How heavy is lift? ●●● How large is impact? ●●●	Provides financial support for PCPCHs to implement and sustain a robust PCPCH model of care.	Would require CCOs to pay PCPCHs a PMPM payment by PCPCH tier level, beginning year 1.	• Requires the use of a VBP to invest in a PCPCHs, which a 2016 evaluation showed have achieved better health outcomes and cost savings • Allows for advancement and sustainability of the PCPCH model • Aligned with CPC+ payment methodology, a national CMS, multi-payer primary care payment reform program

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
		Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	Supports staff and activities not reimbursed through FFS.		
13	Evaluate CCO performance with tools to **evaluate CCO efficiency**, **effective use of health-related services (HRS), and the relative clinical value of services** delivered through the CCO. **Use evaluation to set a performance-based profit at individual CCO level.**	★ **Fulfills state or federal mandate** Priority area: **COST** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ✓ **2019 POP planned** ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Could have flexible timeline ✓ **Increases transparency**	Improved delivery of benefits to CCO members including more efficient use of medical services, increased delivery of high-value services and increased use of HRS that improves member health	• Evaluation methodology implemented in 2020 (year 1) but 2021 likely first year CCO profits will be individually determined based on performance evaluation • Methodology to establish performance-based profit needs to be finalized, and could benefit from cross-agency workgroup. Methodology will consider efficiency, effective HRS investment, and clinical value of services delivered. • Methodology development needed in multiple phase and additional OHA staff likely needed	**Policy is required as part of our current 1115 waiver** • CCO-specific profit margins required by 2017 waiver renewal • Waiver language specifically calls out goal of variable profit to motivate effective HRS use by CCOs, but additional evaluation tools likely needed • Methodology to inform CCO-specific profit levels will be closely watched by stakeholders • Evaluation and analysis may require additional staff beyond current capacity (similar structure to HPA metrics team) • OHA could strategically choose to include this program in legislation for the upcoming session • Can be seen as more rigorous & formalized process to evaluate and achieve efficiency in managed care • Could result in base data exclusions of inefficiencies NOTE: Policy option now incorporates policy option to provide rewards for care with higher clinical value in rate-setting process.

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
14	**Incorporate measures of quality & value in any OHA-directed payments to providers** (e.g. hospital payments) and **align measures** with CCO metrics Example: qualified directed payments made directly to hospitals are based in part on quality and value	★ **Fulfills state or federal mandate** Priority area: **COST** How heavy is lift? ●○○ How large is impact? ●●○ Equity: TBD – OEI/HEC 2019 POP planned Requires legislation Potential to impact children ✓ **May require OHA TA support** Could have flexible timeline ✓ **Increases transparency**	Providers are rewarded for improving value and quiality of care, and metrics for CCOs and other providers are aligned and coordinated to achieve maximum impact	• Implementation goal in 2020 • Additional policy development needed to establish the quality & value metrics to be used and their impact on specific payment streams • Alignment across CCOs and hospital quality metrics is key to CCO 2.0 • Implementation of quality / value metrics should build on HTPP experience • Requires policy development coordination between HPA, Finance, and HSD	• **Designed to meet CMS requirements** related to pass-through funds that require OHA to move to a Qualified Directed Payment (QDP) process that includes quality/value • Policy involves hospital provider tax funds which adds to complexity & visibility • OHA could strategically choose to include this program in legislation for the upcoming session, or as part of the budge process • Connects and builds on other policy options to expand CCO use of VBPs
15	**Adjust the operation of the CCO Quality Pool** to allow consideration of expenditures in CCO rate development to: • Align incentives for CCOs, providers, and communities to achieve quality metrics **Create consistent reporting of all CCO expenses** related to medical costs, incentive arrangements, and other payments regardless of funding source (quality pool or global budget)	Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC 2019 POP planned Requires legislation Potential to impact children ✓ **May require OHA TA support** Could have flexible timeline ✓ **Increases transparency**	CCOs invest their quality pool earnings in a timely manner on the providers and partners who help achieve targeted metrics, and focus additional efforts on achieving targets to ensure maximim quality pool earnings	• 2020 capitation rates would reflect the quality pool as being funded by a withhold of capitation payments instead of as a bonus • Adjusting the operation to a withhold allows OHA the flexiblity to increase the percentage of revenue tied to quality and value • Requires policy development coordination between HPA, Finance, and HSD	• Some CCOs have expressed concern that their failure to achieve quality pool earnings in one year effectively limits their rates for the following year – additional methodology development should seek to alleviate concerns • Moving quality pool inside rates allows for creation of bonus funding methodology for social determinants of health funding • Creates consistent reporting of all CCO expenses related to medical costs, incentive arrangements and other payments regardless of funding source (global budget or quality pool)

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
16	**Establish a statewide reinsurance pool** for CCOs administered by OHA to spread the impact of low frequency, high cost conditions and treatments across entire program	☐ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●●● How large is impact? ●●● Equity: TBD – OEI/HEC ✓ **2019 POP planned** ✓ **Requires legislation** ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	OHA has the flexibility and tools necessary to better manage patients with high-cost conditions, which will better enable OHA and CCOs to control program-wide costs associated with these patients	**Staff recommends establishing this reinsurance pool for CCO 2.0; subject to a detailed financial viability analysis** as part of the procurement rate process for 2020 and Legislative Budget process • Initial study needed to assess financial viability & costs associated with a state-backed reinsurance pool that would feed into the legislation • Additional policy development ongoing related to potential need for legislation (currently viewed as a need) and the type of federal sign-off needed • **Timeframe for implementation is year 2+.** Implementation could be phased in and program modified over several years based on experience if year 1 is not feasible.	**Initial phase of implementation would be OHA responsibility.** • Legislation likely needed to fully launch program • Helps fulfil goals of keeping OHP clients in CCOs and not open card • Short term benefits include spreading risk across CCOs and mitigating CCO risk associated with low-frequency, high-cost patients • Long term benefits could include reduced costs from using program-wide purchasing power and could build on efforts to better align PDLs • Connects to rate setting – potential budget risks in short term, ability to remove catestrophic claims from rate-setting reduces rate volatility, especially for small CCOs • DCBS received 1332 waiver to establish a reinsurance program for private carriers could be a resource

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
17	**Address increasing pharmacy costs** and the impact of high-cost and new medications by: increasing transparency of CCOs and their Pharmacy Benefit Managers and increasing alignment of FFS and CCO PDLs (based on recommendations from outside analysis and additional OHA/OHPB guidance)	☐ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Increased transparency of pharmacy costs and spending and increased alignment of PDLs provides new tools to OHA and CCOs to reduce pharmacy costs and ensure consistent access to pharmacy services for members across CCOs	• Transparency provisions could be implemented as broad requirements for how CCOs structure their PBM agreements, could be included in initial RFA and in CCO contracts • Recommendation is to take an incremental approach to strategically and partially align PDLs (ie, starting with slected drugs / classes and building on experience over time) • More specific aspects of the policy options will be informed by third-party analysis currently underway as well as additional policy development	• Varied opinion within CCO community on value/impact of proposed PDL policy • PDL recommendation is informed by outside analysis being presented to OHPB in August 2018 • Ongoing pharmacy policy recommendations may be informed by task force created by HB 4005 (in 2018 session) • Implementing a flexible reinsurance program in CCO 2.0 may help support this policy
18	**Enhance current financial reporting and solvency evaluation tools** by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk Based Capital (RBS) tool to evaluate carrier solvency	☐ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●●● How large is impact? ●●○ Equity: TBD – OEI/HEC ✓ **2019 POP planned** ✓ **Requires legislation** ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Increase solvency protection and reduce risks to the state associated with a CCO insolvency event	• Use NAIC financial reporting templates and modify insurance regulations to fit unique CCO program including supplemental CCO-specific schedules; • Use RBC tool in evaluation of CCO solvency and consider increases to CCO reserves over the five year contract • Work with DCBS to build in a financial oversight framework that leverages the insurance code • Reporting framework requirements would be implemented in year 1, but Phased-in compliance with potentially higher reserve thresholds could be considered	• Phase-in implementation is prefered since NAIC requires new standards that will require CCOs to adjust financial reporting. • RBC thresholds need to be set for Medicaid if this tool is used to assess financial risk and reserves levels. • NAIC reports cover a two-year period and requires a five-year historical data period – OHA will need to decide the reporting timing for both the RFA and for the five-year contract based on this guidance. • OHA will need to become a NAIC member. • Potential impact to OHA and DCBS oversight capacity helps increase the “lift” score. • Approach is consistent with larger trends in Medicaid managed care including a patient and contractor makeup that more closely resembles the commercial insurance world. • Alternative is to enhance current exhibit L reporting tools.

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
19	**Create a statewide reserve pool** in addition to CCO-specific reserve requirements in the event of an insolvency (if move to NAIC or other changes increase required reserves from CCOs)	☐ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●●● How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ✓ **Requires legislation** ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	Adequate financial resources are available to ensure potential CCO insolvency would not harm patient access to health care services or provider reimbursement for services delivered	• Option is connected to proposed move to NAIC reporting standards • Option is a potential funding source for increased reserve requirements • Additional policy development needed from finance and HPA	• Policy option connected to potential for NAIC/RBS requirements to increase required reserves for CCOs o Social funding of reserves could mitigate CCO costs related to increased reserve requirements in CCO 2.0 • Potential sharing of the reserves pool with the reinsurance program • Policy option requires CCO input and to-date OHA has received minimal input on this option • Pros: Provides resource to fund greater reserves for CCOs • Cons: Requires funding. Some risks in using state funds for reserves tied to private CCOs
20	**Require CCOs be fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity.** This includes ensuring an adequate provider network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities.	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ✓ **2019 POP planned** ✓ **Requires legislation** ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Could have flexible timeline ✓ **Increases transparency**	CCOs fully accountable for members' BH care. Increase access to BH services, decreased wait times, allow members provider choice, improve behavioral health outcomes for all Oregonians	• OHA will need to develop monitoring and compliance protocol for CCOs • Monitoring and compliance should be in HSD	• Integration of the behavioral health benefit should promote delivery of the behavioral health benefit. This means that the CCO is responsible for ensuring there is an adequate provider network, that members have access to behavioral health care, and that the CCO is responsible for outcomes. • Pros: Clear owner of the behavioral health benefit for OHA and member • Cons: Current CCOs may not have the expertise or infrastructure • This policy was developed from feedback regarding what is not currently working. Many stakeholders have called for the elimination of carve-outs; however, that may have unintended consequences. • Oregon Academy of Family Physicians states that carve outs "if allowed to exist at all in the future - should not be allowed for primary care behavioral health services;" NAMI, Children's Health Alliance and the Oregon Center for Children and Youth with Special Health Needs support elimination of carve-outs.

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
21	**Identify metrics to track milestones of behavioral health (BH) and oral health (OH) integration** with physical health care by completing an active review of each CCOs plan to integrate services that incorporates a score for progress • OHA to refine definitions of BH and OH integration and add to the CCO contract • Increase technical assistance resources for CCOs to assist them in integrating care and meeting metrics	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●○○ How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Could have flexible timeline ✓ **Increases transparency**	Increase integration, increase access, increase provider network, decrease wait time	• Transformation Center (TC) has contracted with a consultant to identify the metrics and a review proposal • HSD and HPA will collaborate: HPA will monitor and pull data; the review will sit in HSD for compliance; TC will provide TA	• Behavioral health has not consistently been integrated by the CCOs. This will be a lever to ensure CCOs integrate services, for OHA to measure progress and to target technical assistance. • Children's Health Alliance supports and recommends that measurement recognizes appropriate measures for pediatric population; Oregon Medical Association supports quality incentive metrics for integration; Trillium supports.
22	Identify, promote and expand programs that integrate primary care in behavioral health settings (**Behavioral Health Homes)**	★ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●● Equity: TBD – OEI/HEC ✓ **2019 POP planned** ✓ **Requires legislation** ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Could have flexible timeline ☐ Increases transparency	Improve health outcomes; increase access to BH and PH	• Standards and ORS were completed under SB 832 • Would require hiring 3 FTE • Work would be within PCPCH program in HPA	• **SB 832 created the BHH**, but there was no funding to implement • This would enable OHA to identify, promote and expand programs that integrate primary care in behavioral health settings. This will improve whole health outcomes for individuals • AOCMHP supports

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
23	Require **CCOs report on capacity and diversity of the medical, behavioral and oral health workforce** within their geographical area and provider network. CCOs must monitor their provider network to ensure parity with their membership.	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Increase workforce to ensure network adequacy; increase access and outcomes for Oregonians	• HPA to develop report • HPA and HSD to monitor compliance	• This was first suggested in the HCWF by the Medical Director of a CCO while the committee was looking at challenges of collecting data on workforce capacity • This policy can contribute to the development of a shared accountability model for the adequacy of the health care workforce in the state between the CCOs and OHA (and potentially others) • Best practices in this area can be reviewed to help with developing the forms and review process
24	Require CCOs **utilize best practices to outreach to culturally specific populations**, including development of a diverse behavioral and oral health workforce who can provide culturally and linguistically appropriate care (including utilization of THWs)	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●● How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Improve health outcomes for culturally specific populations	• Guidelines and best practices being developed by OEI • Technical assistance recommended for implementation	• Guidelines and best practices need to be developed by OHA (OEI and BH) • Will require ongoing monitoring and TA

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
25	**Prioritize access** to Social-Emotional developmental services, health services, Early Intervention and targeted supportive services, and Behavioral health/mental health treatment **for children ages birth through five years**.	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	Improve health outcomes for children	• CCOs to require and implement social-emotional screening for all children birth through five years in PCP setting • CCO's would pay for Mental Health Consultation in early learning settings for their network of providers	• Fulfills a mandate: early learning hubs. Connects with recommendations of Governor's Children's Cabinet. • Two or more ACEs is associated with poor kindergarten and behavioral outcomes • Intervening early prevents poor long-term outcomes and reduces costs • Currently social-emotional screening is needed to identify children with problems interfering with kindergarten readiness and issues related to early behavioral health intervention needs
26	Implement risk-sharing with the Oregon State Hospital (Behavioral Health Collaborative recommendation)	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●● How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Could have flexible timeline ✓ **Increases transparency**	As CCOs assume risk we anticipate increase in community care and decrease in hospitilizations	• OHA has convened a risk sharing work group of external stakeholders to develop this BHC recommendation • Work will ultimately sit in HSD	• Behavioral Health Collaborative recommendation • This will advance the Oregon Performance Plan by facilitating community placement for individuals transitioning from Oregon State Hospital • May pose challenges in Multnomah County for hospitals regarding utilization review • CCO and CMHP support; AOCMHP supports; Care Oregon supports

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
27	Shift financial role for statewide HIT public/private partnership from OHA to CCOs to cover their fair share	☐ Fulfills state or federal mandate Priority area: **HIT** How heavy is lift? ●○○ How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ☐ May require OHA TA support ☐ Could have flexible timeline ☐ Increases transparency	CCOs are directly connected to cross-stakeholder efforts (such as EDIE and PDMP Integration) to prioritize and improve HIT statewide	Timing – this would be an attestation in the RFA and contractual obligation starting with 2020 contracts. The only change needed is for CCOs to take over paying the HIT Commons dues that OHA is currently paying on their behalf. A dues schedule has already been established, current CCOs have signed MOUs to participate that includes transparency about taking on dues in 2020, and CCOs are participating in HIT Commons efforts and have 3 seats on the HIT Commons Governance Board. OHIT manages this work.	• Pro: HIT Commons continues to support CCO and Medicaid objectives and is informed about the needs of Oregonians across the state. Ensuring CCO participation will demonstrate value to other stakeholders and help ensure the HIT Commons maintains sufficient participation for effective governance of statewide HIT initiatives. • Con: Some CCOs may prefer to focus on local HIT initiatives in the future. • Consideration: 2018 dues range from $1,300 for the smallest CCO to $70,100 for the largest. Dues are paid using FMAP-eligible funds. • Feedback: Stakeholders have had little feedback other than requesting information about the dues – this has been non-controversial.
28	Standardize CCO coverage for telehealth services: CCOs must cover telehealth services offered by contracted providers if those same services are covered when delivered in-person, regardless of a patient's geographic setting (rural, urban). Coverage would include asynchronous communications if there is limited ability to use videoconferencing. This proposal does not address the availability of telehealth services (i.e., does not require CCOs to add new providers to ensure telehealth is broadly available), but focuses on coverage.	☐ Fulfills state or federal mandate Priority area: **BH/HIT** How heavy is lift? ●○○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	Reduced barriers to telehealth services, better access to specialty and behavioral health care in frontier/rural areas, and reduced health disparities based on geographic location	• The rule allowing for coverage for telemedicine services by CCOs is already in place and would just need to be updated. HSD would lead this, OHIT could play a consultative role. • Timing – this would be a contractual obligation starting with 2020 contracts, could decide to phase in (e.g., expectations that CCOs have coverage in their networks no later than end of year 1).	• Pros: Better access to care, reduced barriers for telehealth options, more consistency across CCOs • Cons: Some providers and patients lack the systems to engage in telemedicine consults through video. Some remote areas of Oregon lack high-speed broadband capabilities that would enable telehealth. • Feedback: Multiple stakeholders expressed support for telehealth. Some input that the policy should be flexible to allow exceptions for services not clinically indicated for telehealth, and that quality of telehealth services should be monitored. Telehealth services are frequently needed when there are transportation barriers, or other SDOH related issues (e.g. poverty) creating a hardship for members to access services in person. BH services are especially suited for telehealth approach and used in Oregon in some rural areas. Concerns about patients needing a private setting when engaging with telehealth.

New Policy Ideas: Year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
29	CCOs, with the support of OHA, to **require providers to implement trauma-informed care practices**	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	Improve health outcomes for all Oregonians	• Create OHA-wide trauma-informed approach policy • Internal OHA work group to direct trauma-informed approach within OHA to better support CCOs/providers • Work to sit in HSD and HPA	• HCR 33 • Pros: Oregon is a national leader in trauma awareness and trauma-informed approach • Trauma Informed Oregon in full support of this policy • Legislation may be needed • Many CCOs are already implementing • Requires planful, thoughtful, coordinated response
30	**CCOs identify plans for the development of the medical, behavioral and oral health workforce** including their efforts to: • Develop the health care workforce pipeline in their area; • Develop and support a diverse workforce who can provide culturally and linguistically appropriate care, with attention to marginalized populations • Ensure current workforce completes a cultural competency training in accordance with HB 2611 • Participate in and facilitate the current and future training for the health professional workforce in their area • Support health professionals following their initial training; and • Encourage local talent to return to their home areas to practice	★ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Increase workforce to ensure network adequacy; increase access and outcomes for Oregonians	• Health Care Workforce Committee will continue to contribute to the development of these efforts • HPA and HSD to monitor compliance	• HCWF, HEC and THW support; recommendation directly offered by HCWF; Dr. McKelvey contributed to the list to include in the plan. • Some CCOs have this in place now but not reviewed/supported by OHA; for others, asking for this will help them better think through questions of access. • Federally, HRSA requires states to maintain updated provider data. • HB 3261 requires a biennial needs assessment. • Need to consider whether “area” is only a CCO’s provider network or a geographic area served in part by the CCO.

New Policy Ideas: Years 2+

#	Policy	Dashboard	Intended impact	Implementation	Considerations
31	**Shift mental health residential benefit to CCOs**	★ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●● How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Improve health care for adults with SPMI	• Supporting efforts (need for a workgroup, additional development, standing up of new reports, etc.) • Rate standardization is in process. Review of rates must be completed in one year and must precede transition of the benefit. • HSD resources (PM and analysts)	**Required in 1115 waiver** • Needs significant development • Kids residential and SUD have already transitioned to CCOs. MH res was scheduled in 2014 and a work group planned for transition, but was postponed due to complexity and CCO and provider concerns. • CareOregon supports
32	By year 2, **CCOs required to implement three VBPs focused on key care delivery focus areas** listed below. CCOs should select key care delivery areas that are most critical for their members in their service delivery areas. Required key care delivery focus areas are: 1) Behavioral health 2) Oral health 3) Hospitals 4) Children's health care 5) Maternity care	☐ Fulfills state or federal mandate Priority area: **VBP** How heavy is lift? ●●● How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	Uses VBP as a lever to advance OHA key care delivery goals	• CCOs will be required to add a key care delivery focus area each year so that they gain experience in each by the end of the 5-year contract. • OHA should encourage coordination and alignment by CCOs of VBP models in areas of overlapping CCO service areas.	• Flexibility of VBP models, design and size (i.e., no spend or population size requirement). • VBP models may combine care delivery focus areas. • Information gleaned may lead to more robust VBP requirements in one/more focus areas in future. • In the spirit of the global budget, not prescriptive in terms of dollars or % of members, but CCOs gain experience in key areas. 1) CCO 2.0 priority area; VBP can promote integration 2) Foundational to CCO model; VBP can promote integration 3) High-cost area could be addressed by VBP; minimal CCO VBP experience 4) Governor's priority; widespread public support 5) Governor's priority; major area of spending

Existing in contract; needs strengthening or improved monitoring

#	Policy	Dashboard	Intended impact	Implementation	Considerations
33	Continue CCO role in using HIT for patient engagement and link to health equity	☐ Fulfills state or federal mandate Priority area: **SDOH/Health Equity** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	Patients better understand their health issues and treatment plans. Health disparities are addressed through targeted HIT-based programs that take into consideration member demographics, language, accessibility, and literacy.	• Timing – this would adjust current CCO contract requirements to align with the health equity plan process. • Accountability mechanism will relate to the health equity plan. This has been a component of the TQS in the past. • OHA TA could be useful. • OEI would lead and OHIT would play a consulting role, and would seek to support CCO efforts around HIT for patient engagement where possible.	• Pro: Better patient engagement and health outcomes • Con: Some providers lack the systems to engage with their patients electronically. Some systems may lack the ability to support needed language and accessibility modifications. • Feedback: Need support and guidance from OHA to help CCOs understand and leverage efforts in place (e.g., PCPCH requires patient portals), not sure how to incentivize members to use HIT. Some patients have multiple patient portals – which can be onerous and confusing. Patient control of their own health information is important – including the ability to correct information.
34	**Increase CCO accountability to sustainable growth target by adding accountability and enforcement provisions to CCO contracts** Connect contractual requirements to ongoing evaluation of Oregon's sustainable spending target based on national trends and emerging data to inform more aggressive targets in future while providing CCOs with additional financial incentives to achieve spending targets in the form of shared savings arrangements	☐ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●○○ How large is impact? ●○○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ✓ **May require OHA TA support** ☐ Could have flexible timeline ✓ **Increases transparency**	CCOs are held accountable for achieving spending growth targets and targets reflect aggressive path to ensure costs grow at a sustainable rate	• Include a contract requirement with enforcement options requiring CCOs to achieve current and future sustainable rate of growth targets • RFA language will clarify spending targets set by waiver and legislature are a CCO deliverable • OHA process developed to evaluate current spending targets and inform spending target(s) in future waiver renewals	• OHA has achieved program-wide spending targets in the first five years • Connects OHA's waiver commitment to CCO contracts • OHA may choose to allow CCOs to meet the target over a rolling period (i.e., 3 years, etc.) • Shared savings arrangement provides clarity to CCOs that program-wide savings will be reinvested into program o Similar to initial funding build-up of quality pool

Existing in contract; needs strengthening or improved monitoring

#	Policy	Dashboard	Intended impact	Implementation	Considerations
35	**Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy** (AZ Model) with financial implications	★ Fulfills federal regulatory req. Priority area: **COST** How heavy is lift? ●○○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Encounter data accurately reflects health care services provided to OHP enrollees	• Implementation planned for 2020 contracts utilizing new resources added to the Program Integrity Provider Audit Unit from 17-19 POP • Five of seven auditors funded in POP have already been added	• Intended to fulfil CMS requirements to ensure that encounter data is "complete and accurate" and to ensure it reflects services provided to patients • Capacity being added to provider audit unit related to prior POP • Alternative ways to meet federal requirements necessary without this option
36	**Require CCOs to ensure a care coordinator is identified for individuals with severe and persistent mental illness (SPMI) and for children with serious emotional disturbances (SED),** and incorporate the following: • Develop standards for care coordination • Enforce contract requirement for care coordination for all children in Child Welfare, state custody and other prioritized populations (I/DD) • Establish outcome measure tool for care coordination	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Could have flexible timeline ☐ Increases transparency	Increase access to behavioral health services, allow members provider choice. Improve health outcomes. Ensure care coordination is efficient and impactful for the highest risk members.	• OHA to develop standards and outcomes measure. • Work would live within HSD. HPA Analytics would be involved for outcome measure.	• Feedback we received indicated there are multiple care coordinators assigned and that there needs to be coordination or role clarification. • Oregon Center for Children and Youth with Special Health Needs supports with a call out for those transitioning from pediatric to adult systems; Trillium supports with call out for families; Children's Health Alliance and Oregon Center for Children and Youth with Special Health Needs supports developing standards; Children's Health Alliance supports for care coordination for child welfare and other prioritized populations.

Existing in contract; needs strengthening or improved monitoring

#	Policy	Dashboard	Intended impact	Implementation	Considerations
37	**Develop mechanism to assess adequate capacity of services across the continuum of care.** Ensure members have access to services across the continuum of care.	★ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●● How large is impact? ●●● Equity: TBD – OEI/HEC 2019 POP planned Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** Could have flexible timeline ✓ **Increases transparency**	Provide a full continuum of behavioral health, medical and oral health services throughout the state. Ensure members have access to a provider network. Will improve health outcomes.	• Need to develop or adopt mechanism. OHA to define continuum of care and network adequacy. • Would sit in HSD.	• This is in current contract but has not been enforced. • Likely our understanding of "adequate capacity" will expand and evolve from what it was understood to be in CCO 1.0. Fulfills a federal requirement to identify mental health shortages. • Further development needed, especially around compliance.
38	**System of Care to be fully implemented for the children's system**	Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC 2019 POP planned Requires legislation ✓ **Potential to impact children** May require OHA TA support Could have flexible timeline Increases transparency	Improve health outcomes for children through a system of care	• Hold CCOs accountable to full implementation of existing model to ensure cross system collaboration. • Statewide Systems of Care (SOC) Steering Committee empowerment: State agencies (OYA/OHA/DHS/ODE) to fund the State System of Care steering committee with existing general fund from each child serving state agency for multi-agency needs and development of shared services and supports. • Clarify with CCOs and communities the advisory council roles and responsibilities as they relate to the broader System of Care governance structure.	• The already-existing System of Care (SOC) governance infrastructure was launched in 2014 and continues to mature and develop. OHA contractually requires CCOs to have local SOC structures in place and these have been developed and maintained with consultation from PSU System of Care Institute. The institute is funded jointly, through an interagency agreement between DHS – Child Welfare, OHA and PSU. • Pros: SOC is already established, needs fine tuning for some CCOs/areas. • Cons: Difficulty getting system partners to the table, lack of blended funding hampers efforts. • Much national research exists documenting cost savings. • HB2144 Youth Wraparound Initiative names system partners. • This will reflect values and principles to the local governance structure.

Existing in contract; needs strengthening or improved monitoring

#	Policy	Dashboard	Intended impact	Implementation	Considerations
39	Require **Wraparound is available to all children and young adults who meet criteria**	★ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ☐ **May require OHA TA support** ☐ Could have flexible timeline ☐ Increases transparency	Improve health outcomes for children	• Require CCOs to meet national average for fidelity implementation per WFI-EZ scores (fidelity tool/consumer survey) • Enforcement of existing contractual expectations will be critical to success • Work would sit in HSD	• This was in the CCO contract but not enforced. Enforcement will be critical to success. • Pros: Wraparound is documented to improve outcomes for children and families; long-term cost savings, and improvement in health outcomes for families. • HB2144
40	**MOU between CMHP and CCOs enforced and honored**	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●○○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ☐ **May require OHA TA support** ☐ Could have flexible timeline ✓ **Increases transparency**	Improved health outcomes and increased access to services through coordination of safety net services and CCO Medicaid services	Enforcement would sit in HSD	• The CCOs have the MOUs but not all have been fully implemented • Would result in coordination of safety net services in each region • Supported by AOCMHP

Existing in contract; needs strengthening or improved monitoring

#	Policy	Dashboard	Intended impact	Implementation	Considerations
41	**Require CCOs support EHR adoption across behavioral, oral and physical health contracted providers**	☐ Fulfills state or federal mandate Priority area: **BH/HIT** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Behavioral and oral health providers adopt and use EHRs more effectively and at higher rates, allowing them to better participate in care coordination, contribute clinical data for population health efforts, and engage in value-based payment arrangements.	• Timing – This would be a contractual obligation starting with 2020 contracts, that adjusts current CCO contracts to specify BH, oral and physical providers. • We would expect CCOs to evaluate current EHR adoption rates and opportunities, set targets and report on progress – phased over 5 years. • OHA TA could be useful. • Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO needs for data on EHR adoption where possible.	• Consideration: CCOs' primary care providers successfully increased EHR adoption, with federal incentive payments. This policy option would build on that success. This will be most helpful if BH EHR Incentives (POP requested) are available as well. • Pro: Encouraging and supporting the adoption of EHRs capable of information exchange and connecting to health information exchange tools and services would support increased care coordination and improve patient care. • Con: Providers may lack resources to invest in EHRs or lack staff capacity to implement workflow changes needed for effective use of EHRs. • Feedback: CCOs may face significant challenges to this if resources/incentives are not available.
42	**Require CCOs ensure behavioral, oral and physical health contracted providers have access to health information exchange technology** that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications	☐ Fulfills state or federal mandate Priority area: **BH/HIT** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	Behavioral, oral and physical health providers have the information needed to deliver better care, patients get the right care at the right time, and costly hospital use is reduced Increasing the adoption of HIE among priority providers in support of priority populations will support care coordination and improve patient care, particularly around integration/coordination across physical, behavioral, and oral health care.	• Timing – This would be a contractual obligation starting with 2020 contracts, that adjusts current CCO contracts to specify BH, oral and physical providers. • We would expect CCOs to evaluate current HIE use and opportunities, set targets and report on progress – phased over 5 years. • OHA TA could be useful. OHA is currently supporting TA for hospital event notifications related to the CCO Disparity metric. • Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO efforts around HIE where possible.	• Consideration: OHA currently financially supports PreManage directly for CCOs on a voluntary basis (all CCOs are now using PreManage either directly or through regional HIE), and nearly all CCOs are paying to extend PreManage to their key clinics, including BH, oral, physical. When PreManage subscription ends through the state for CCOs (end of 2019), CCOs have the option to continue with the PreManage tool at their own cost. • OHA is launching the HIE Onboarding program that will support initial costs to connect key clinics (including BH, oral, physical) to approved HIEs (only one is approved at this time). • Pro: Reduction in ED utilization. Increased health outcomes for members with complex care needs and mental illness. Increased care coordination between CCO and contracted clinics • Con: Providers may lack resources to participate in HIE or lack staff capacity to implement workflow changes needed • Feedback: Interest in sharing costs or leveraging OHA financial support to help CCOs in this area, OHA can support education/TA for HIE and for SUD info sharing policies, concerns about this requirement going beyond adoption of PreManage and requiring CCOs to support multiple HIE platforms, which would have less utility for providers.

Existing in contract; needs strengthening or improved monitoring

#	Policy	Dashboard	Intended impact	Implementation	Considerations
					• Consideration of all partners that need to be in HIE including families, caregivers, SDOH entities, jails, etc.
43	**Require CCOs to demonstrate necessary information technology (IT) infrastructure for VBP reporting,** including to risk stratify populations and manage population health efforts, manage VBP arrangements with contracted providers, and manage VBP data. This would include a demonstration that the CCO can work with electronic clinical quality measure data.	☐ Fulfills state or federal mandate Priority area: **VBP/HIT** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ✓ **Increases transparency**	CCOs are better able to achieve population health outcomes at lower costs. Providers engaging in VBP contracts have the information and support needed from the CCO to manage financial risk and improve care.	• CCOs would be encouraged to take advantage of collaborative efforts related to data aggregation, eCQMs, and other VBP data needs. In their RFA response, CCOs would show they meet an initial minimum and explain how, during the first year of the contract, they will ensure they have sufficient HIT capabilities for VBP and population health management. • Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO efforts around HIT where possible. • OHA should consider TA/ support for CCOs in this area – possibly through Transformation Center/TA Bank and/or OHIT.	• Pro: Without data and HIT systems, CCOs cannot deliver on VBP. If we expect CCOs to become more sophisticated around VBP in 2.0, they must have the skills and systems to do so. Ability to use clinical data/metrics is critical to moving toward triple aim. • Con: CCOs face challenges in getting and using clinical data – may need HIE strategy to help with this. Some providers may lack the capability to use CCO data effectively. Possible proliferation of systems across CCOs and payers. • Feedback: Multiple stakeholders expressed support for this – very important for moving into the future. This will be a heavy lift for some of our current CCOs, including obtaining clinical data. Some CCOs will likely need TA and support.

Recommendations to/for OHA

#	Policy	Dashboard	Intended impact	Implementation	Considerations
44	Establish a more robust team in OHA responsible for monitoring, compliance and enforcement of CCO contracts, building on existing resources.	☐ Fulfills state or federal mandate Priority area: **ALL** How heavy is lift? ●●● How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	Streamline and enhance OHA's capacity for contract management and compliance Increase understanding of CCO effectiveness and provide improved support to CCOs over contract issues	TBD – would require assessment of current resources and possible reallocation of existing capacity and/or new capacity.	• In addition to monitoring, tracking, and ensuring compliance with CCO 2.0 policies, this team would be tasked with oversight of policy options 34–45 above, which have already existed in contract but have not been achieved as intended. • Enhancing compliance around CCO contracts is a natural next step from CCO 1.0 – during the first contract, CCOs were building new businesses and the priority was around ensuring the model was successful. CCO 2.0 provides an opportunity to increase accountability around actual contractual obligations
45	**Support providers in utilizing ACEs score, and/or trauma screening tools** to develop individual service and support plans. Additional tools used shall be outcome based and reflective of best/emerging practices.	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ☐ May require OHA TA support ✓ **Could have flexible timeline** ☐ Increases transparency	Creation of a trauma-informed health care system	Formation of OHA-wide work group to advise on trauma-informed approaches and tools; separate linked work group to examine best/emerging practices	• HCR 33 from 2018 session • Trauma Informed Oregon supports use of trauma-informed approach across OHA and by CCOs • Legislation needed: Other states are passing this type of legislation (to address trauma-informed services) • Trauma-informed approaches must be a foundation on which other services are conducted • Recommendation in the OHA-DHS Continuum of Care proposal that state agencies pursue trauma-informed approaches

Recommendations to/for OHA

#	Policy	Dashboard	Intended impact	Implementation	Considerations
46	Identify and address billing system and policy barriers that prevent behavioral health providers from billing from a physical health setting	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●○○ How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ☐ May require OHA TA support ☐ Could have flexible timeline ☐ Increases transparency	Increase integration, increase access, expand provider network	• Will require HSD Medicaid staff to complete this work. The position is currently vacant. • Work to be completed in HSD.	• Work groups have submitted recommendations to OHA. • This will allow providers to bill from integrated settings. • Will increase access and expand the provider network.
47	Develop payment methodologies to reimburse for warm handoffs, impromptu consultations and integrated care management services	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●○○ How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ☐ May require OHA TA support ✓ **Could have flexible timeline** ☐ Increases transparency	Increase integration, access and provider choice by eliminating billing barriers	• Work groups have submitted recommendations, which will be operationalized by HSD. • Work to be completed in HSD with technical assistance through the Transformation Center.	• Will take HSD Medicaid staff to complete. The position is currently vacant. • Payment methodologies will allow for provision on full continuum of behavioral health services. • Oregon Academy of Family Physicians supports all BH in integrated PC be reimbursed; Children's Health Alliance supports BH to be billable in PC for all services provided and should be seamless to provider and patient; Oregon Medical Association supports reimbursement rates to support integration.

Recommendations to/for OHA

#	Policy	Dashboard	Intended impact	Implementation	Considerations
48	Examine equality in behavioral health and physical health reimbursement	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●○○ How large is impact? ●●● Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ☐ May require OHA TA support ✓ **Could have flexible timeline** ☐ Increases transparency	Increase integration by equalizing the reimbursement gap between BH and PH	• Requires additional development – what exactly would CCOs be required to do as part of this examination. • Work would sit in HSD Medicaid.	• Position that would complete this work in HSD is vacant. • Oregon Academy of Family Physicians supports all BH in integrated PC be reimbursed; Children's Health Alliance supports BH to be billable in PC for all services provided and should be seamless to provider and patient; Oregon Medical Association supports reimbursement rates to support integration.
49	Develop an incentive program to support behavioral health providers' investments in electronic health records and other, related HIT. (Feasibility depends on 2019 legislative session)	☐ Fulfills state or federal mandate Priority area: **HIT** How heavy is lift? ●○○ or ●●● How large is impact? ●●● Equity: TBD – OEI/HEC ✓ **2019 POP planned** ☐ Requires legislation ☐ Potential to impact children ☐ May require OHA TA support ☐ Could have flexible timeline ✓ **Increases transparency**	If OHA is able to implement an incentive program, the result would be BH providers have better EHRs allowing them to better participate in care coordination, contribute clinical data for population health efforts, and engage in value-based payment arrangements. CCO participation in prioritizing BH providers for these incentives helps ensure the funding is targeted well and achieves the desired impact for our Medicaid population.	• Timing: Following 2019 legislative session – if OHA is successful in getting POP/funding approved. • Likely process would include leveraging CCO input through an existing work group (CCO HIT Advisory Group – [HITAG]) on development and oversight of the incentive program, as well as a CCO engagement process to identify high priority BH providers. Ideally we would make incentives available in early-mid 2020. • OHIT would staff this program and the CCO HITAG/CCO engagement.	• Pro: BH Providers are incentivized to improve their HIT to support integration and care coordination. CCO involvement is needed to ensure OHA understands local community needs when making decisions about priority providers; incentive dollars make a bigger impact.Con: Providers may lack staff capacity to implement workflow changes needed for effective use of EHRs. Technical assistance may be needed and support from CCOs or OHA to be effective. • Feedback: Strong support among BH providers for incentive program, which would help close the "digital divide" that behavioral health providers face. These providers have been largely left out of federally funded programs that support EHR adoption and use.

Not recommended at this time

#	Policy	Dashboard	Intended impact	Implementation	Considerations
50	Expand/revise existing risk corridor programs **This option is not being recommended as a result of recommendation to examine in greater detail the idea of establishing a program-wide reinsurance program**	☐ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ● ● ○ How large is impact? ● ○ ○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☐ Potential to impact children ☐ May require OHA TA support ✓ **Could have flexible timeline** ☐ Increases transparency	Additional use of risk corridors not a formal component of recommendations	No new proposals for risk corridors	Risk corridors remain a tool at OHA's discretion in the next 5-year contract period.
51	Incentivize health care services with highest clinical value by rewarding their use in rate setting **This option has been incorporated as aspect of variable profit implementation strategy**	☐ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ● ● ○ How large is impact? ● ● ○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Could have flexible timeline ☐ Increases transparency	CCOs focus additional energy on moving providers to deliver health care services with higher clinical value and reduce provision of low-value care	• Phased-in approach preferred • Formal work group (possibly a HERC subcommittee?) needed to evaluate services for placement on a high or low-value list. • Clinical-value could be used as part of methodology informing CCO-specific variable profit levels	• Policy option can be viewed as a next step for Oregon's prioritized list to further shift the system to providing evidence based, high-value services to patients (Benefits 2.0). • Phasing in the development of a high and low value list could ease concerns from CCOs about pushing too hard too fast. • OHA could strategically choose to include this program in legislation for the upcoming session.
52	Development of a Train the Trainer investment in BH models of care	☐ Fulfills state or federal mandate	Increase in BH providers trained in evidence-based	• Formation of a Statewide Train the Trainer Model and/or Training Initiative (less	Would require funding and position authority. May be considered for a future POP.

Not recommended at this time

#	Policy	Dashboard	Intended impact	Implementation	Considerations
		Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Could have flexible timeline** ☐ Increases transparency	practices; improved outcomes	expensive) for 5–10 evidence-based practices (that address two generation clinical models) for the Oregon Mental Health Community targeting clinical needs throughout the state. • OHA to provide initial financial and "lift" investment (1-2 FTE, Transformation Center?) to coordinate and roll out trainings for providers.	