MEDICAID ADVISORY COMMITTEE
May 25th, 2016
9:30am-12:30pm
Oregon State Library, Room 103
250 Winter St. NE, Salem OR 97301

Webinar registration: https://attendee.gotowebinar.com/register/5672779983090523140
Call– In number: 888.398.2342; code: 3732275

Time	Item	Presenter
9:30	Opening Remarks	Co-Chairs
9:40	2014-2015 Section 1115 Annual Report	Janna Starr, OHA
9:50	Oregon 1115 Waiver Renewal • Waiver renewal update • Housing and health proposal (pgs. 23-32) • Committee Q&A • Letter of Support from MAC	Oliver Droppers and Veronica Guerra, OHA
10:20	Oregon 1115 Waiver Renewal – Public Comment	
10:40	**Break**	
10:50	MAC End of Year Report 2015 and OHA Response	Co-chairs
11:10	Oral Health Access Framework • OHA Oral Health Strategic Planning and Initiatives • The Opportunity: Framework on Oral Health Access in Oregon Health Plan • Oral health access and Oregon's dental care delivery system • Committee Q&A and Discussion	Bruce Austin, Amanda Peden , OHA
11:50	Public Comment	
12:10	Committee Planning Session • Review proposed topical agenda for 2016 • Committee input	Co-chairs
12:20	Closing comments	Co-Chairs

Next Meeting:
Wednesday, June 22nd: 9:00 a.m. – 12:00 p.m.
Oregon State Library bldg. -Room #103
250 Winter St. NE, Salem, OR 97301

APPLICATION FOR AMENDMENT AND RENEWAL

Oregon Health Plan

1115 Demonstration Project

Medicaid and Children's Health Insurance Program

APPLICATION FOR AMENDMENT AND RENEWAL

Oregon Health Plan

1115 Demonstration Project

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Oregon Health Authority

Oregon Health Plan–Project Numbers 11-W-00160/10 & 21-W-00013/10
May 2, 2016 Draft for public comment

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Demonstration Goals

This outlines proposed modifications to Oregon's existing Demonstration under Section 1115(a) of the Social Security Act. Since established in 1994, the Oregon Health Plan Demonstration has provided the state's most vulnerable residents with high-quality, evidence-based health care while containing spending growth, saving the federal and state government more than $29.7 billion over the life of the waiver. Oregon's current demonstration waiver, approved in 2012, has helped transform the delivery system to one of coordinated care, with 16 coordinated care organizations (CCOs) now delivering the vast majority of physical, oral and behavioral health services to Oregon Health Plan (OHP) members. Today, approximately 90% of OHP members are enrolled in a CCO. The combination of the new waiver and Oregon's expansion of Medicaid eligibility under the Affordable Care Act has led to remarkable results:

- Oregon's transformation efforts allowed the state to stand up a new model of care before the Affordable Care Act expansion. Since then, the state has enrolled 430,000 (a 71 percent increase) newly eligible Medicaid enrollees into a new model of care. This model care -- the coordinated care model -- is is more financially sustainable and has already accrued significant savings to the federal government as it pays the greater portion of costs for the expansion
- Oregon's delivery system reform reaches over 1.1 million Oregonians, approximately 25% of Oregon's population;
- With nearly 95% of Oregonians now enrolled in health care coverage, Oregon has one of the lowest uninsured rates in the nation; and
- By 2017, the demonstration will have saved the federal and state government over $1.7 billion. The goal of the demonstration was to provide better care and improve health, while also lowering the rate of growth of per capita cost.

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

The Next Level of Reform

The intense, collaborative effort to reshape the health delivery system in Oregon over the last five years has led to important gains and laid the groundwork for the next level of reform. We have learned a great deal and have a clear view of where we need to concentrate our efforts over the next several years. With this waiver renewal and amendment, Oregon seeks to build on our success with the coordinated care model to meet the following key goals across the next five years:

1. Build on Oregon's Medicaid delivery system transformation with a stronger, expanded focus on integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and continuing to bend the cost curve;
2. Deepen our focus on addressing the social determinants of health and improving health equity across all low-income, vulnerable Oregonians to improve population health outcomes;
3. Commit to ongoing sustainable rate of growth that includes the 2% test, putting the federal investment at risk for not meeting that target and adopting a payment methodology and contracting protocol for CCOs that promotes increased investments on health-related services and advances the use of value-based payments;
4. Expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual -eligible members.

Strategies

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

Build on transformation, including integration

- Expand the behavioral health services integration through partnerships with counties, corrections, and community-based programs.
- Continue to reward CCOs for providing high quality care and access to services through the quality pool, but move to more outcome-based performance metrics.
- Continue investing in the Hospital Transformation Performance Program, which furthers transformation goals, ensures sustainable funding, and aligns care coordination across the delivery system.
- Refine and advance the coordinated care model through a robust measurement program, expanded Patient-Centered Primary Care Home program and an expanded Health Information Technology infrastructure and Transformation Center.

Address social determinants of health and health equity

- Through an enhanced rate setting methodology and new contracting strategies, promote CCO and provider use of health-related services, including flexible services and community benefit initiatives aimed at addressing the social determinants of health.[1]
- In partnership with our local housing agency, increase access to housing and housing supportive services for vulnerable populations.
- Ensure access to health care services and improve health outcomes for American Indians and Alaska Natives.
- Expand the use of traditional health care workers within the delivery system.

Commit to sustainable rate of growth

- In addition to enhancing the CCO rate setting methodology to promote greater use of health-related services and investments in social determinants of health, promote greater adoption of value-based payment arrangements between CCOs and their network providers.

Expand the coordinated care model

- Increase the health care workforce in underserved areas and in behavioral health settings using evidenced-based, best practices for recruiting and retaining workforce.
- Promote better coordination and improve health outcomes for those Medicare and Medicaid dual-eligible members.

Financing Support and Initiatives

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

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

Historical Narrative

Since its initial approval in 1994 under Section 1115 of the Social Security Act, the Oregon Health Plan) Demonstration (Project Numbers: 21-W-00013/10 and 11-W-00160/10) has provided the state's most vulnerable residents with high-quality, evidence-based health care, while advancing an innovative and effective framework to deliver and provide health care coverage, and containing spending growth, saving the federal and state governments approximately $29.7 billion over the life of the waiver. Under the Demonstration, Oregon promotes the objectives of titles XIX and XXI of the Social Security Act.

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

Key Accomplishments of the current demonstration

During the current approval period of July 5, 2012 through June 30, 2017 the Demonstration has been invaluable in helping build a firm foundation of quality and value-based care by transforming Oregon's health care delivery system to one of coordinated care, with 16 coordinated care organizations (CCOs) -- which geographical cover the entire state -- now delivering the vast majority (90%) of physical, oral and behavioral health services to OHP members.

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

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

estimated to save the federal government $6.5 billion over the period from 2012-2022 (excluding high priced prescription drugs). Because of the success of the current demonstration in transforming the health system, Oregon is in a position to take health system transformation to the next level.

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

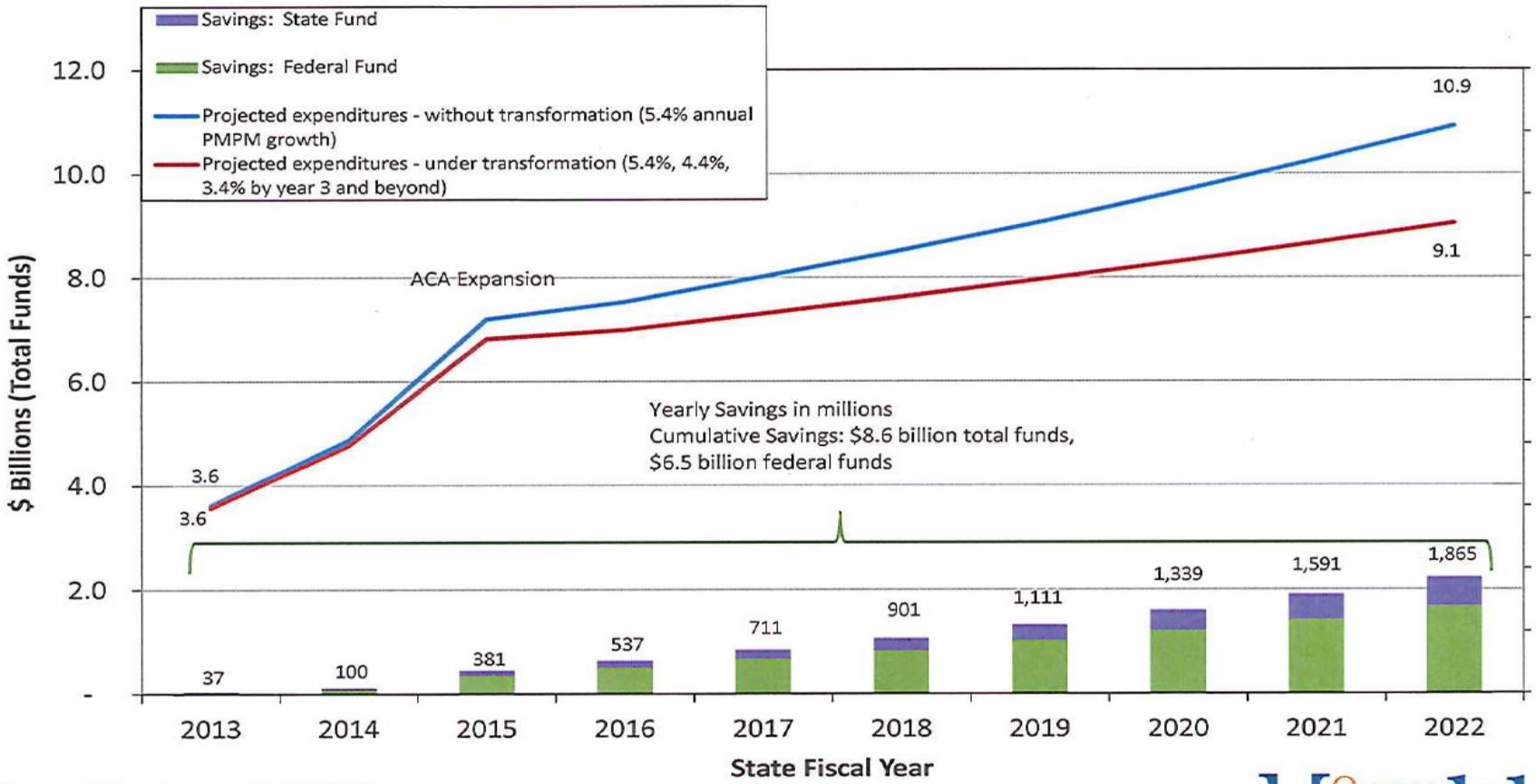
- Oregon passed bipartisan legislation in 2011 and 2012 to establish a new integrated and coordinated approach to deliver Medicaid health care services throughout Oregon.
- Stood up 16 Coordinated Care Organizations (CCOs), covering the entire state geographically.
- Enrolled approximately 90% of all Medicaid enrollees into CCOs and this new model of care, including the vast majority of the nearly 450,000 newly eligible Medicaid enrollees under the Affordable Care Act;
- Integrated new services and budgets into the CCO model, including behavioral health, oral health, non-emergency medical transportation, addiction services, and children's wraparound services. These services were not part of the prior managed care model.
- Bent the cost curve by staying within the 3.4% sustainable rate of growth which is 2% less than the President's 2012 budget projection of 5.4%.
- Developed a successful, robust measurement and public reporting process to align incentive metrics; 5% of CCO budgets are now paid based on meeting incentive targets.
- Established a vigorous evaluation of the demonstration and an ongoing learning environment among CCOs.
- CCOs have developed governance structures that include major components of the health system and community partners. Community partnerships have been integral to addressing health improvement goals in individual communities.

Significant Progress

Health system transformation has kept costs below the national rate of growth for health care expenditures (see graph below).

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

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



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

Oregon Health Authority

Data as of 10/2015

While doing so, there have been significant improvements in quality, access and health according to data from Oregon's robust quality measurement program (for a full report of health system transformation, see www.oregon.gov/oha/Metrics/Pages/index.aspx). Highlights include:

- Decreased emergency department visits - Emergency department visits by CCO enrollees have decreased 23 percent since 2011.
- Decreased hospital admissions for short-term complications from diabetes **-** The rate of adult patients (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease has dropped by 32 percent since 2011.
- Decreased rate of hospital admissions for chronic obstructive pulmonary disease **-** The rate of adult patients (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma has decreased by 68 percent since 2011.
- Patient-Centered Primary Care Home (PCPCH) enrollment continues to increase **-** CCOs continue to increase the proportion of members enrolled in a patient-centered primary care home. PCPCH enrollment has increased 61 percent since 2012. Additionally, primary care spending continues to increase, which means more health care services are happening within primary care settings rather than other settings, including emergency departments.

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

- One-percentage point below the 5.4 percent (without HST) growth rate for DY 12 (7/1/2013-6/30/2014), and
- Two-percentage points below the 5.4 percent (without HST) growth rate for DY 13, 14 and 15.

Oregon reports quarterly to CMS on its progress in meeting the growth rate reduction requirement, using a growth reduction test template. The Oregon Health Plan quarterly reports demonstrate that the state has and continues to meet the requirement to reduce the per capita growth under the parameters of the test. Oregon projects it will meet the test requirements through the end of the current demonstration period, ending June 30, 2017 (see chart on page 7).

Increasingly, Oregonians – beyond the Oregon Health Plan — are receiving coordinated care because of this transformed system. Currently, about 94 percent of Oregon's primary care providers serve OHP members. When these providers transform their model of care, these changes reach not only OHP members, but also benefit patients across a provider's practice. Along with increased provider and community accountability, payment reform including alternative payment methodologies that promote quality, improvements to the state's health care workforce and the use of flexible services and

Traditional Health Workers (THW), these enhancements translate directly into better health for Medicaid enrollees and savings for the Centers for Medicare and Medicaid Services (CMS).

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

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

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

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

Health System Transformation 2.0

While Oregon has had many successes in transforming the health care system, the work is not done. There have been lessons learned that indicate where the state needs to concentrate its efforts for the next several years. Though there is evidence of improvements in quality and health outcomes, measured improvements in population health, social determinants of health, and health care quality can take several years and require sustained effort. CCOs have started to integrate behavioral, physical and oral health, but it will take additional time, effort, and coordination among various entities (e.g., providers, corrections, counties, other agencies) to fully integrate health services. Addressing social

determinants of health requires the deployment of various strategies, including the use of health-related services, payment enhancements (i.e., enhanced rate setting methodology) and contracting strategies. Oregon will continue to spread its coordinated care model that was developed during the current demonstration period, and will further integration of behavioral health and improve social determinants of health, while continuing to maintain a sustainable rate of growth of health care costs.

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

1. Build on transformation of Oregon's Medicaid delivery system with a stronger, expanded focus on integration of physical, behavioral, and oral health care through a performance driven system with the goal of improving health outcomes and continuing to bend the cost curve;
2. Improve the social determinants of health and health equity across all low-income, vulnerable Oregonians with the goal of improving population health outcomes;
3. Commit to ongoing sustainable rate of growth that includes the 2% test with penalties and an integrated budget that promotes increased spending on health related services and advances the use of value based payments;
4. Establish supportive partnerships with CMS to expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual eligible members.

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

Expand behavioral health services integration through partnerships

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

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

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

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

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

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

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

The Transformation Center has been a valuable resource to advance behavioral health integration. Targeted technical assistance on behavioral and physical health integration is available to CCOs. Thirty hours of technical assistance are available to each CCO to achieve the integration standards established by the Patient-Centered Primary Care Standards Advisory Committee. The Transformation Center has also supported Oregon's Project ECHO initiative n. Project ECHO is a telementoring program to connect specialty providers with rural and frontier areas that have limited access. The Transformation Center plans to support an organization to establish a statewide Project ECHO infrastructure with initial focus on adult and pediatric psychiatric medication management. In an effort to address payment models that support behavioral and physical health integration, the center recently released a Request for Proposals for carriers to plan and implement value-based payment arrangements that support behavioral and physical health integration.

Expanding access to psychiatric clinicians through telephonic consultation

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

Oregon would like to expand the OPAL-K concept for adults. Oregon would use the existing partnership with OHSU to expand the population focus of the OPAL-K program to include adults. There is also a shortage of psychiatrists treating adults, especially of those with geriatric expertise. Oregon is interested in piloting a psychiatric telephonic consultation line for adults and older adults. Oregon would identify one provider to operate this service. Case consultation/collateral contact would be limited to this identified provider.

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

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

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

Expanding the Patient-Centered Primary Care Home Program

As one of the original seven focus areas for transformation, Oregon's patient-centered primary care home (PCPCH) program is integral to health system transformation. Oregon intends to build on the success of the PCPCH program and continue using the model and its standards to improve primary care for the Oregon Health Plan population Appendix A: Supports for Health System Transformation. More than 600 clinics have been recognized for their commitment to patient-centered care to -date, and more than 80 percent of CCO members are enrolled in a PCPCH. Ongoing evaluations of the PCPCH model indicate it is improving patient access to and experience of care, as well as health outcomes. For reports, visit www.oregon.gov/oha/pcpch/Pages/reports-and-evaluations.aspx.

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

Leveraging health information technology for health system transformation

The Three Goals of Health IT-Optimized Health Care

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

1. Providers have access to meaningful, timely, relevant, and actionable patient information at the point of care including information about the whole person, including information pertaining to relevant physical, behavioral, social and other needs.
2. Systems (health plans, CCOs, health systems, and providers) have the ability to effectively and efficiently use aggregated clinical data for quality improvement, population management and incentivizing value and outcomes. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.

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

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

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

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

- Increased information exchange across providers to support care coordination
- Making new data available to assist providers with identifying patients most in need of support/services and to help providers target their care effectively
- Improved CCO population management and quality improvement activities, through better use of available claims data, while pursuing access to and use of clinical data.

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

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

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

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

Oregon intends to leverage federal Medicaid HIT funding to support Oregon's providers, leveraging new federal funding to support Medicaid behavioral health, long-term care, and other social services providers to connect to HIT/HIE. Recently, CMS has issued guidance about the availability of federal funding at the 90 percent matching rate for state expenditures on activities to promote HIE and encourage the adoption of EHR technology by certain Medicaid providers. Oregon intends to explore using these funds to build HIE infrastructure. To be eligible for onboarding funds, Oregon is considering requiring HIE entities (e.g., regional HIEs) to meet minimum criteria. Criteria could include: participating in provider directory, contribute to clinical quality metrics and/or public health reporting, provide base HIE service (Direct Secure messaging), participating in a trust community that connects statewide, no data blocking, interoperability with disparate systems, and using certified technology/standards-based.

Continuing to spread the coordinated care model through the Transformation Center

Launched in 2013, the Oregon Health Authority Transformation Center serves as the state's hub for innovation, improvement and learning to support the triple aim across Oregon's health system. The Transformation Center helps good ideas travel faster through learning collaboratives, targeted technical

assistance, and other methods for sharing best practices and innovations. The Transformation Center responds to challenges faced by CCOs, PEBB and OEBB as determined by performance metrics and evaluation outcomes, and advances the integration of population and behavioral health within the health system to improve health outcomes.

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

Learning Collaboratives

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

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

Clinical Innovation Fellows

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

Convening Stakeholders

The Transformation Center has convened multiple statewide events, including Coordinated Care Model Summits, Community Advisory Council Summits, Complex Care Collaborative meetings, an Innovation

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

Technical Assistance

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

The Transformation Center also works closely with OHA's Innovator agents to ensure that learning and improvement strategies are identified and implemented in a collaborative and effective manner for the CCOs and communities. Innovator agents are assigned to each CCO to serve as a single, constant point of contact with OHA and help champion and share innovative ideas in support of transformation. Innovator agents are critical in linking the needs of OHA, the community, and the CCO and work closely with the community and the CCO to understand the health needs of the region and the strengths and deficiencies of the CCO's health resources. The innovator agents will work closely with the CCOs and their individual communities to enhance CCO accountability for achieving the triple aim.

Innovator agents will continue to:

- Serve as a single point of contact between the CCOs and OHA, providing an effective and immediate line of communication and allowing streamlined reporting, reducing the duplication of requests and information.
- Inform OHA of opportunities and obstacles related to systems and process improvements.
- Assist the CCO in managing and using information to accelerate innovation, quality and health system improvement.

- Work with CCOs and their Community Advisory Councils (CAC) to gauge the impact of health systems transformation on community health needs, and actively participate in the implementation of the CACs.
- Assist CCOs in developing and disseminating strategies to accelerate movement toward the triple aim and the adoption of innovations in care.
- Build and participate in statewide learning collaboratives and community collaborations between CCOs, community stakeholders, the Transformation Center and other OHA divisions, and other state agencies.
- Address social determinants of health and health disparities through partnerships with CCOs, community stakeholders, the Transformation Center and other OHA divisions.
- Gather and disseminate coordinated care model innovations locally, regionally, and nationally.

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

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

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

OHA will continue measuring quality of care and access to care for individuals enrolled in coordinated care organizations (~90 percent of the Oregon Health Plan population), and for the population as a whole. Oregon will maintain a modified quality and access test to ensure that Oregon Health Plan members are not being harmed as a result of Oregon's health system transformation and continued bending of the cost curve. To date, even with the increase in Medicaid members under the Affordable Care Act expansion, CCOs have demonstrated improvements in quality and access measures. Updated parameters for the quality and access test are detailed in Appendix C: Measurement Strategy.

OHA will continue utilizing multiple measure sets for monitoring and accountability across domains of interest, which will likely also include an increased emphasis on measures of health outcomes,

population health, and social determinants of health. Due to a growing interest in improving measurement for both dual eligibles and early childhood, measures will be selected for adults and children. The measurement strategy will evolve to further advance priorities such as behavioral health and oral health integration, CCO collaboration, and coordination with other systems such as early learning hubs and hospitals, health equity, and specific populations of interest, such as members with severe and persistent mental illness. Future measure sets are also expected to reflect increased state and national focus on measure alignment across programs and payers. Measure sets, potential measures, and plans for public reporting are detailed in Appendix C: Measurement Strategy.

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

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

The Oregon Health Authority intends to expand its quality strategy to continue to ensure that Oregon's Medicaid managed care system meets all federal requirements – ensuring members' voices are represented in quality processes and evaluations; additional support and coaching for CCOs developing their individual quality programs for assessment, improvement, monitoring, and evaluation to safeguard members' rights, access, and quality; and enhancing quality assurance monitoring through contracts, external quality review activities, and trainings. The quality strategy will incorporate critical activities for health system transformation to move from innovation to application.

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

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

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

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

To date, the HTPP has led to increased engagement by hospitals and hospital systems in health system transformation. While there have been some growing pains in the initial years of the program as measures were defined and new data systems and workflows were established, hospitals are investing resources and working to make improvements. Preliminary data from the program's second year indicate hospitals are on track to improve quality and patient-safety.

An initial evaluation of the HTPP, currently underway, will demonstrate participating hospitals' performance over time in comparison to hospitals not in the program and highlight the successes, barriers, changes in practice, quality improvements and investments hospitals are making. Key informant interviews conducted early in the evaluation process have highlighted some of the significant changes and investments that hospitals are making under this program. Full findings will be available in June 2016 to inform program development.

For future years of the program (beginning Year 4, 2017), OHA is proposing shifting from measures being either hospital or hospital-CCO collaboration focused to measures which integrate collaboration between hospitals and CCOs throughout their communities. This shift would be facilitated by moving to

a core and menu measure set approach, as well as modifying the payment methodology to include a challenge pool. These proposed changes are described in detail in Appendix C: Measurement Strategy.

a. Improve social determinants of health and health equity

Increase access to housing and housing supportive services for vulnerable populations

Care Coordination, Housing and Medicaid Integration: Oregon Context
Homelessness remains a complex public health challenge in Oregon. Oregon faces an unprecedented housing crisis – in 2015, Oregon's homeless population increased by 9% (from 2014), and on a single night there were 13,176 homeless individuals of which 3,991 were chronically homeless.[1] In Oregon's most populated region, Multnomah County, more than half of those counted as homeless in 2013 suffered from one or more serious physical, mental or substance abuse-related conditions. Limited services exist to address homelessness, and often available supportive housing services contain gaps, lack coordination and education to ensure services are fully used.
Individuals and families are at greater risk of poor health outcomes, including complications of chronic illness, substance use disorders, and behavioral health issues such as post-traumatic-stress disorder.[2] Individuals suffer from complications of chronic illnesses and face difficulties with basic health management. In addition to the unprecedented housing crisis in both rural and urban communities, Oregon's current health care system faces several challenges in caring for those experiencing homelessness. This largely due the fact that federal, state, and local programs often target homeless individuals or those at risk of becoming homeless using individualized objectives. Many programs have a targeted client base, lack connections to other federal, state and local programs serving similar populations. Currently, there is no vehicle through which Medicaid can pay for transitional services or supportive housing services for people who do not qualify under the state's Section 1915 waivers and state plan for eligibility and covered services.

Coinciding with Oregon's housing crisis was Oregon's Medicaid expansion. In the first two years (2014-15), 436,000 low-income adults became newly enrolled in the Oregon Health Plan (OHP) through the Affordable Care Act (ACA). Expansion dramatically altered the age and gender distribution of Medicaid members – adults now outnumber children on OHP and there are significantly more adult male members. The opportunity in Oregon:

- A significant number of Oregon's chronically homeless and individuals at-risk of homelessness are now eligible and enrolled in Medicaid;
- Leverage Oregon's successful health system transformation and our 16 coordinated care organizations (CCOs);

- Oregon's Legislature and local municipalities have invested millions in expanding affordable housing (2015 and 2016).
- Pending US Department of Justice Agreement with Oregon and the Oregon State Hospital to improve community mental health treatment and programs.

To avoid unnecessary utilization of health care services and increases in total Medicaid costs, Oregon seeks to address social service needs of high-risk, high-need individuals by ensuring development of infrastructure, partnerships and resources to deliver care in appropriate settings and provide supportive housing services.[3]

1115 Waiver Demonstration: Oregon's Strategy

To promote population health and further address social determinants of health, Oregon proposes to create a five-year pilot program that funds homelessness prevention, care coordination and supportive housing services at-risk adults, families, and adults eligible for both Medicare and Medicaid programs. Oregon will pilot locally-governed models, referred to as Coordinated Health Partnerships (CHPs) for our most at-risk populations using a combination of housing, health care integration, care transitions and supportive services to reduce Medicaid costs and improve health outcomes.

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

- Year 1: Convening and planning initiatives, regionally and statewide
- Years 1-5: Statewide investment in infrastructure development and creation of CHPs
- Years 2-5: Increasingly pay for outcomes based on evidence-based practices
- Years 2-5: Pilot and test new models of housing supportive programs among CHPs
- Years 3-5: Dissemination and spread of best practices

Coordinated Health Partnerships

Overview

Coordinated Health Partnerships (CHPs) pilot program will be funded throughout the five-year waiver renewal. The CHPs will test new models to increase collaboration and coordination among CCOs, local hospitals, community-based organizations, housing authorities, county government and public health agencies, local housing providers, behavioral health and substance use disorder (SUD) providers. The program will award grants to local CHPs to increase integration and build infrastructure among the participating entities.

The CHP pilot program will develop and advance locally designed solutions through a menu of strategies implemented by the lead entities and partnering organizations (see Figure 1 pg. 7). The CHP pilot program will achieve the following:

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

Target Population

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

- With repeated incidents of avoidable emergency use or hospital admissions;
- With two or more chronic conditions;
- With mental health and/or substance use disorders;
- Who are currently experiencing homelessness; and/or
- Individuals who are at risk of homelessness, including dual eligibles, Tribal and I/T/U constituents, and individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail).

CHPs may choose to limit the population served within their pilot application and OHA will work with CHPs to determine the number and focus of target population.

Through the CHP pilot program, Oregon seeks to target pre-adjudicated incarcerated individuals in county correctional facilities and individuals in an institution for mental diseases since these populations often experience disruptions in care when entering institutions and often experience poor health and housing outcomes when exiting these settings. Pre-adjudicated individuals comprise 61% of the county jail population; two-thirds have mental illness and/or substance use disorders, with an average length of two-week stay for pretrial (<12 days) .[4] In 2014, there were 179,332 bookings across Oregon's county jails. For the justice-involved population, failure to provide a link to health insurance and health care services upon release has a major impact on recidivism rates and the rising costs Oregon's health system

transformation aims to reduce. Oregon will work with stakeholders to determine if the pilot target population should also include pre-adjudicated juveniles.

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

Program Design

Below are an initial set of program design parameters that will apply to all CHP pilots:

- Required to provide services across three domains: homelessness prevention/transitions of care, housing transition services, and tenancy sustaining services. At a minimum, CHP pilots will be expected to implement *one program per domain area*.
- Individuals eligible for Medicaid coverage in Oregon can decide to participate in a pilot project and opt in and opt out at any time; individuals will be provided with information about their enrollment options to make an "informed choice."
- Each grantee will be required to develop their own payment methodology and strategies for financing services, within broad parameters that are consistent with the state's federal approvals for payment.
- Payments to grantee will be based on meeting process measure targets in the first 3 years and by the fifth year, payments will be made based on outcomes of members.

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

OHA's Transformation Center will convene the new partnerships to share learnings with each other. OHA's Transformation Center will facilitate Learning Collaboratives to spread best practices across Oregon and promote use of flexible services to fund medically appropriate housing supportive services.

The final design and implementation details will be based on extensive public input and involve robust collaboration among I/T/Us and tribal partners, CCOs, housing authorities, providers (including behavioral and substance use disorder providers), and organizations serving the homeless population.

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

Oregon is proposing to fund a range of care coordination and supportive housing services based on the types of services described in the June 26, 2015 CMCS Informational Bulletin.[5] Additional services may include outreach to individuals experiencing homelessness and care management services for care coordination, see Figure 1. Oregon is not requesting federal authority to use Medicaid funds to cover the cost of room and board or pay rental assistance, except for those transitioning from acute care facilities to transitional housing to receive health services (up to 60 days coverage).

Oregon is proposing that care coordination services offered by the CHPs be covered by Medicaid during the final 30 days prior to discharge for individuals undergoing treatment at the Oregon State Hospital. Care coordination would focus on providing relevant community treatment information to the state hospital for treatment and discharge planning (e.g., community services and discharge planning). As directed by the Supreme Court's Olmstead decision, individuals can be swiftly returned to an integrated setting in the community. Oregon also believes that well-coordinated short lengths of stay could support the decreased use of higher levels of care upon discharge. For example, of the (approximately) 45 patients currently on the ready-to-discharge list, about 90% have been referred to secure residential treatment.

Several research studies indicate that individuals involved in the criminal justice system are considered high utilizers of acute care services. Individuals with mental illness are 14 times more likely to be incarcerated than hospitalized.[6] A recent Miami-Dade County study of individuals with serious mental illness found that individuals with several incarcerations were high utilizers of hospital services – over a five year period, 97 individuals with serious mental illness were arrested 2,200 times and utilized 13,000 days at an emergency department or psychiatric facility. Oregon is proposing that CHPs be able to provide care coordination services to pre-adjudicated individuals while they are in jail. CHPs would have the opportunity to put resources in place to provide care coordination services for the first 30 days of an individual's incarceration in jail, which would help coordinate treatment and care planning at the beginning of incarceration (e.g., arranging proper medication) and assist in re-entry into the community, given that the average length of a county jail stay is approximately 12-15 days.[7]

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

Partnership Requirements and Integrated Network for CHP Pilots

Key community partnerships led by CCOs or Tribes and I/T/Us can build the capacity of high-need, at-risk individuals for self-support through strategies that identify homelessness and assist individuals in accessing appropriate housing that includes health related supportive services.

CCOs will be provided with the flexibility to develop their individual integrated networks based on existing delivery systems, area housing providers, and additional regional partners that will be involved in the CHP pilot. To help ensure successful CHP pilots, Oregon plans to require grantees to deploy case managers or care coordinators of varying professional status', including but not limited to social workers, counselors, behavioral specialists, nurses, resident advocates, community health workers, and peer support specialists. In addition, at a minimum, lead grantees must demonstrate partnership and commitment among county and city government, local health departments and housing agencies, hospitals, affordable housing providers, and supportive housing service providers.

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

Initial Financing and Return on Investment

Oregon is requesting federal support for one-time grants to CCOs to support capacity-building, developing community-based partnerships and infrastructure investment, as well as care management funding to target essential non-medical services.

During the Demonstration, Oregon will assess whether homelessness prevention, care coordination and supportive housing services through the CHPs result in significant reductions in total Medicaid costs among the target population, including which services may contribute to lower monthly costs on a per

member month basis (PMPM). The goal is to demonstrate that upfront investments through the CHP pilot projects will achieve cost-savings for federal and state Medicaid, producing a return on investment.

Based on several Oregon-based studies, we anticipate that the CHP pilots will result in a 10-15 percent total reduction in Medicaid costs among the population served during the waiver period, with the largest gains in savings likely transpiring in years 2-4 of the grant program.[8],[9] This is based on the assumption that reductions in overall Medicaid costs achieved through the grant program will result in efficient management of health needs in appropriate settings, reductions in acute health crises, address social service needs and promote stable housing, avoid more expensive types of utilization and improve health outcomes.

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

Upon preliminary analysis, it is expected that up to 20 percent of OHP clients (219, 132 individuals) will benefit from targeted interventions through the CHP pilot program. Many of those included in the analysis are at higher-risk of homelessness due to increased complexities in health and social determinants of health. The total Medicaid expenditures for these individuals is roughly $10.3 billion over two years. A decrease of 10 to 15 percent in Medicaid costs would lead to approximately $500 - $800 M of savings a year.

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

Population definition	**Number of Medicaid beneficiaries**	**Total Actual Costs (2 year period)**	**PMPM**
Repeat emergency department use/hospital use and two or more chronic conditions (>5 visits)	15,406	$971,279,942	$2,810
Repeat ED use/hospital use and mental health or substance use disorder	21,661	$912,521,030	$1,898

Individuals dually eligible for Medicare and Medicaid	76,257	$1,790,266,510	$1,082
Repeat emergency department use/hospital use only (>5 visits)	42,810	$1,502,644,206	$1,616
Chronic conditions (two or more) only	70,874	$2,485,565,343	$1,597
Mental health or substance use disorder only	131,033	$2,660,736,802	$962
Total	**219,132**	**$10,323,013,833**	

Source: OHA Office of Health Analytics

Evaluation of CHP pilot activities

Oregon will assess whether transitions of care and supportive housing services for the target populations result in improved outcomes, including:

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

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

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

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

in July 2017.ilot Domain[1]	Program	Partners	Program Goals and Potential Measures	Target Populations	List of Services
Homelessness Prevention/ Transitions of Care Support to ensure care coordination among non-medical settings; fund services to support an individual's ability to move from institutional settings to less costly community-based care settings	Select one program (at minimum): • Care coordination services for pre-adjudicated criminally justice involved (initial 30 days after entry) • Care coordination services for Oregon State Hospital (OSH) patients (admission to discharge) • Acute care transitions to less costly community-based settings	• Lead entity: ○ CCOs ○ Tribes or I/T/Us • Additional partners: ○ Local hospital(s) ○ County health departments ○ State Hospital ○ County Jails and Oregon Department of Corrections ○ Care management entities	• Reductions in ED use and psychiatric acute care hospitalizations • Decreases in inpatient admissions and total hospital days • Increases in primary care and behavioral care use including medications	Individuals with: • Repeated incidents of avoidable emergency use or hospital admissions, or nursing facility placement; or • Two or more chronic conditions; or • Mental health and/or substance use disorders; or • History of or current homelessness and/or at risk of being homeless, including: ○ Pre-adjudicated criminally justice involved ○ Oregon State Hospital (OSH) patients ○ Dual eligibles ○ Tribal members	• Ensuring that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health • Ongoing assessment of medical, mental health, substance use disorder or dental needs • Case management and coordinating the access to and provision of services from multiple agencies • Establishing service linkages with community providers
Housing Transition Services Invest in pre-tenancy services to decrease health care costs and reduce use of high-cost health care services	Pre-tenancy support services that aid an individual's ability to prepare for and transition to housing CHPs must select and implement one program	• Lead entity: ○ CCOs ○ Tribes or I/T/Us • Additional partners: ○ Primary, behavioral and SUD providers ○ Local hospital(s) ○ Local housing agencies ○ City and county agencies ○ Affordable housing providers	• Reductions in ED use and psychiatric boarding • Decreases in inpatient admissions and total hospital days • Decreased discharges to secure residential treatment facilities • Increase in transitions from recovery to permanent housing settings • Increase in access to care and quality of care after moving into housing		• Tenant screening and assessment • Assistance with housing searches and applications, move-in assistance, short-term expenses such as security deposits, other landlord-required rental or lease costs • Moving costs, basic furnishings, food and grocery supports • Adaptive aids and environmental modifications • Housing support crisis plan and intervention services • Care coordination services with medical homes, behavioral health and SUD providers
Tenancy Sustaining Services Invest in services that support the individual in being a successful tenant in his/her housing arrangement	Services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy including permanent supportive housing and family housing CHPs must select and implement one program	• Lead entity: ○ CCOs ○ Tribes or I/T/Us • Additional partners: ○ Primary, behavioral and SUD providers ○ Local hospital(s) ○ Local housing agencies ○ City and county agencies ○ Affordable housing providers ○ Other community based entities	• Reductions in ED use • Decreases in inpatient admissions and total hospital days • Increases in primary care and behavioral health • Retention in housing unit for 12 months or longer • Increase in percentage of individuals that access employment and benefits services • Increase in the percentage of individuals that transition to affordable housing (market rate housing/community housing placement) • Increase in self-sufficiency among those served		• Tenancy rights/responsibilities education; coaching and maintaining relationships with landlords • Eviction prevention (paying rent on time, conflict resolution, lease behavior requirements) • Utilities management • Landlord relationship/maintenance • Crisis interventions and linkages with community resources to prevent eviction when housing is jeopardized • Utility assistance (energy/gas) • Linkages to education/job training, employment • Care coordination services with medical homes, behavioral health and SUD providers

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

[1] Oregon Housing and Community Services (2015). Homelessness in Oregon: 2015 Point in Time County. Available from: https://www.oregon.gov/ohcs/pdfs/2015-Point-In-Time-Count-Summary.pdf
[2] Brickner, P., Scharer, L., Conanan, B., Savarese, M., Scanlan, B. (Eds). (1990). *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States.*
[3] Hwang, S., Tolomiczenko, G., Kouyoumdjian, F., Garner, R. (2005). Interventions to improve the health of the homeless. American Journal of Preventive Medicine. 29(4) 311-19.
[4] Association of Oregon Community Health Programs (2013). 2013 County Jail Survey (unpublished).
[5] CMCS Informational Bulletin. June 26, 2015. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26- 2015.pdf
[6] Steven Leifman. March 24, 2015. Ending the Criminalization of Mental Illness. Speech: Miami, Florida.
[7] A 2013 Jail Survey conducted by the Association of Oregon County Mental Health providers found that 61.5% of individuals in jail were pre-adjudicated and two-thirds of those had a mental illness or substance use disorder.
[8] Wright, B., Vartanian, K., Royal, N., Li H., & Matson, J. (2016). Formerly homeless people had lower overall health expenditures after moving into supportive housing. *Health Affairs, 35(1),* 20-27.
[9] Wright, B., Vartanian, K., Li, G., & Weller, M. (2016, February). Health and Housing: Exploring the intersection between housing and health care. *Providence Center for Outcomes Research and Education.* Portland, OR.
[10] CHP pilots must provide services across all three domains.

Improving prenatal and early childhood outcomes

Expansion of nurse home visiting services

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

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

Targeted Case Management (TCM)

Oregon plans to submit a renewal document that leaves TCM out of managed care because CMS and Oregon have been unable to determine a way to put the local and leveraged funds into the capitated rate that allows CCOs the flexibility they need in these relationships, protects the counties, and receives approval from the Financial Management Group (FMG) at CMS. Previous guidance indicated that we would need to require CCOs to pay the cost-based, per visit rate for nurse case management home visits. The state has decided to take the Nurse Family Partnership in a new direction and expand it to fill the gaps in our waiver renewal, in partnership with Public Health, and the counties.

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

Oregon is home to nine federally recognized tribes and nearly 70,000 American Indians and Alaska Natives (AI/ANs) (U.S. Census Bureau, 2013). Sixteen percent of Oregon's American Indians and Alaska Native residents are Medicaid beneficiaries (State of Oregon, 2012; U.S. Census Bureau, 2013). Medicaid is a critically important program for AI/ANs, serving as both an insurance program covering physician, hospital, and other basic health care for eligible individuals, and a source of revenue for IHS and Tribal or Urban Indian-operated clinics and hospitals. Over 50 percent (n =18,682) of Oregon's eligible American Indians and Alaska Natives are enrolled in Coordinated Care Organizations (CCOs) (OHA data, 2016).

Goals for July 2017 - June 2022:

- Ensure enhanced and improved effective consultation and collaboration between the state and Indian Health Service (IHS), Tribally Operated Health Programs and Urban Indian health organizations (collectively known as the I/T/U);
- In year 1, identify best practices for developing and funding care coordination at I/T/Us
- Facilitate care coordination agreements for I/T/Us between CCOs and other specialty care providers;
- In partnership with tribes, evaluate the 100% FMAP opportunities and potential barriers and develop a strategy for moving forward;
- Include I/T/Us as a potential lead entity(s) in the Coordinated Health Partnership pilot program;
- Continue and expand the use of the Tribal Uncompensated Care Program (UCCP);
- Evaluate the effectiveness of the UCCP; and
- Require CCOs to contract with willing I/T/U providers.

Tribal Uncompensated Care Program (UCCP)

In October of 2013, during the most recent renewal period, the Demonstration was amended to implement the Tribal Uncompensated Care Program (UCCP) to extend payments to Tribal providers for certain services previously not funded under the OHP. The Uncompensated Care Program was established to broaden the numbers of services that can be reimbursed by Medicaid funds, thereby allowing other health care funding streams to be used toward the goal of eliminating health disparities in this population.
While Oregon's UCCP moves towards being fully operational statewide, there are four clinics that are utilizing the program and others that have indicated they plan to do so. During the upcoming Demonstration period, OHA will be better able to evaluate participating facilities' staff level changes, service level changes or changes in percentages of budget represented by Medicaid payments to assess the success of initial implementation. Barriers to reimbursement through UCCP will be evaluated and addressed in collaboration between OHA and the tribes.

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

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

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

collaborate with health providers serving American Indians and Alaska Natives and improve health care and health status.

The state will require CCOs to offer contracts to IHS, Tribal and Urban Indian entities (I/T/Us), as well as to continue to provide access to specialty and primary care within their networks to IHS beneficiaries seen and referred by I/T/Us, regardless of the entity's status as contracted provider within the CCO network. The state will also encourage CCOs to partner with I/T/Us, in addition to local public health and mental health organizations and hospital systems, to ensure that the Community Health Needs Assessment include a focus on health disparities in the community and on addressing social determinants of health.

Several tribes are developing or implementing strategies to support enhanced care coordination given Oregon's health system transformation, CCO development, and recent CMS guidance on federal funding for referred services. In partnership with tribes, the state is exploring expanded opportunities for effective care coordination for AI/AN. The state will continue to collaborate with the I/T/U on delivery of care coordination services to American Indians and Alaska Natives in Oregon.

Expand traditional health care workers use and develop deeper cultural competence for language interpreters

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

Health Care Interpreters

Oregon is among the states with the highest language diversity.[2] More than 40 percent of OHP members have a non-English language on record. After English, the top six known spoken languages are: Spanish, Russian, Vietnamese, Chinese languages, Somali, and Arabic. OHP members speak 68 other languages *(Oregon's Health System Transformation: Annual Update, January 2016).*

In 2001, Oregon passed legislation creating a qualification and certification process for health care interpreters. However, due to the voluntary nature of the statute and the high cost of training and

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

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

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

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

Doulas

Doulas are intended to serve as an adjunct to the conventional doctor, clinic, hospital delivery system, and to provide culturally appropriate care in the right setting and at the right time to achieve the best and most cost effective outcome. In Oregon, doulas, which are certified professionals, provide personal, non-medical support to women and families throughout a woman's pregnancy, childbirth and postpartum experience. Doulas are a part of Oregon's overall strategy to improve birth outcomes funded by Medicaid by addressing health inequities in Oregon's birth outcomes. Doulas are intended to serve as an adjunct to the conventional doctor, clinic, hospital delivery system, and provide access to culturally appropriate care in the right setting and at the right time to achieve the best and most cost effective outcome. In Oregon, doulas, which are certified professionals, provide personal, non-medical support to women and families throughout a woman's pregnancy, childbirth and postpartum experience. Doulas are a part of Oregon's overall strategy to improve birth outcomes funded by Medicaid by addressing health inequities in Oregon's birth outcomes. In 2013, the rate of preterm birth in Oregon is highest for black infants (12.3%), followed by Native Americans (12.2%), Hispanics (10.2%), Asians (10.0%) and whites (8.6%). In the same year, black infants (9.4%) were about two times as likely as white infants (5.9%) to be born low birth weight during 2011-2013 (average). During 2011-2013 (average), the infant mortality rate (per 1,000 live births) in Oregon was highest for Native American infants (11.5), followed by blacks (8.3), Hispanics (4.7), whites (4.7) and Asians (4.1).[3]

[3] Sources: www.marchofdimes.org and http://kff.org/other/state-indicator/infant-mortality-rate-by-race-ethnicity/#table

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

Under federal regulations and statute, doulas are considered to be non-traditional health workers that are not licensed providers.[4] OHA is requesting to waive the federal authority requiring doulas to be supervised by an existing licensed medical provider to provide services within licensed practitioner's scope of practice. Oregon will ensure that our rules and regulations require doulas and THWs to coordinate and share information with recognized PCPCHs and CCOs, which are foundational partners in health system transformation.

Traditional Health Workers

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

[4] Federal authorities: 1905(a)(6) & 42 CFR 440.60

The state certification process requires successful completion of approved training, completion of a background check and continuing education to maintain certification. As of December 2015, 878 THWs were certified -- dramatically exceeding the 300 required in our current demonstration.

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

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

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

CCO Transformation Plan: Health Equity Elements

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

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

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

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

b. Commit to the sustainable rate of growth

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

In 2012, under an amendment to its 1115 Demonstration, Oregon implemented the use of the capitated or integrated payment for CCO members, which has provided CCOs the flexibility to offer the health and health-related services necessary to improve care delivery and member health. Health-related services are alternate, non-state plan services that promote the efficient use of resources and, in many cases, target social determinants of health. In the current demonstration, health-related services are referred to as "flexible services." OHA has since determined that a broader category of services, called "health-related services," is more appropriate; these services include flexible services *and* community benefit initiatives. Flexible services are cost-effective services offered to individuals instead of or as an adjunct to covered benefits, while community benefit initiatives are community-level interventions to improve health care quality, such as investments in provider capacity or care management capabilities.

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

To continue our progress with the integrated budget, Oregon has determined that there are additional actions that are necessary to ensure CCOs and the providers and community organizations with which they partner are positioned to drive the delivery of cost-effective, quality care and advance population health. To achieve the triple aim of better health, better care and lower costs – the core of the State's transformation objectives – OHA seeks to increase the use of cost-effective health-related services among CCOs and their network providers. In support of this goal, Oregon's demonstration renewal, CCO

contracts and rate setting methodology will address the following barriers to increase the use of health-related services:

1. Costs associated with health-related services are currently counted as administrative (not medical) expenses in the CCO capitation rate.
2. As investment in cost-effective health-related services reduces utilization of state plan services (on which the capitated rate is based), CCO rates may decline over time. As this decline occurs, there is neither funding nor incentive for CCOs to continue investing in these services.
3. When CCOs reimburse network providers on a fee-for-service basis, there is little incentive and few resources for providers to invest in health-related services.

To increase the use of cost-effective health-related services, OHA will take the following steps—all of which will be reflected in the demonstration renewal, but only one of which requires a change to the current demonstration STCs.

1. Categorize health-related services as "activities that improve health care quality" and include the costs of these services in the base of the CCO capitation rate (i.e., treat them like medical expenses for rate setting purposes). By categorizing health-related services as "activities that improve health care quality" while treating them as medical expenses, OHA will be able to separately track the costs and effectiveness of these services. (This requires a change in the current demonstration's STC 34(c).)
    a. The CCO contract language will be amended to require the CCOs to collect and report information on health-related services. This information may include data on unmet needs in the CCO's region, the health-related services utilized to address these needs, the cost-effectiveness of the services utilized, and the methodology used to determine cost-effectiveness.
2. Amend the CCO contracts to implement a reinvestment requirement that may involve the following components:
    a. A "hard medical loss ratio (MLR) standard" of 85%, where the State will recoup and share with CMS the difference between a CCO's MLR and 85% whenever the CCO's MLR falls below 85%; and
    b. A "target MLR standard" that is set and used for developing CCOs' capitation rates and is higher than the hard MLR standard (e.g., 88%). CCOs with MLRs *above* the hard MLR standard and *below* the target MLR standard may be eligible (depending on their performance on quality and cost measures) to retain some or all of the difference between their actual MLR and the target MLR, so long as the amount of the difference is reinvested in health-related services. OHA will work with CMS and CCOs to develop this reinvestment requirement.

3. Require CCOs to enter into value-based payment arrangements with network providers. Oregon's current demonstration calls for CCOs to adopt alternative payment arrangements to align CCOs and their providers with the State's transformation objectives. In this demonstration renewal, the State seeks to ensure that such arrangements are being adopted by requiring a specific percentage of CCO payments to network providers to be made through value-based payment (VBP) arrangements. Accordingly, the demonstration renewal will require the State to submit to CMS a VBP plan that describes how the State and CCOs will achieve a specific percentage of VBP payments by the end of the demonstration period, including amendments to CCO contracts. The VBP plan will also include a timeline for phased-in implementation as well as a definition of "value-based payments" that involves both the sharing of risk and the meeting of quality measures.
4. Implement a CCO performance incentive program. To further incentivize CCOs to utilize health-related services, Oregon will enhance the rate setting methodology to prevent premium slide and compensate CCOs identified as high performing (e.g., CCOs showing quality improvement and cost reduction). Three approaches to such an incentive program are described below. These approaches would require the State to develop a mechanism for measuring CCO performance. None of the approaches would replace the existing risk factor adjustments. Oregon will leverage, to the maximum extent possible, the existing cost and quality metrics included in the waiver.
    a. Margin augmentation: The State could develop rates with a profit margin range, such as 1% to 3%, as opposed to a fixed percentage of premium, which is used today. The margin percentage built into the rate would vary based on CCO-specific scoring within each rating region, where higher performing CCOs would receive higher percentages than lower performing CCOs for the following 12-month period.
    b. Base a portion of CCOs' capitated rate on quality and cost measures: The State could set aside a portion of the capitated rate and allocate it to CCOs based on performance. For example, the State could assign scores to CCOs based on their performance in cost reduction and quality improvement; CCOs with high scores in *both* areas of measurement would be allocated more dollars than CCOs with lower scores.
    c. Tiered Risk Corridor along with the hard MLR: The State could incorporate a tiered risk corridor along with the hard MLR requirement, resulting in higher performing CCOs being allowed to keep a higher percentage of surplus as opposed to lower performing CCOs that would be required to reinvest more of their surplus.

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

Sustainable rate of growth and 2% test

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

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

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

Prior to Oregon's 2012 Demonstration, health care costs were increasing unsustainably. A key goal of health system transformation has been to reduce the growth in statewide Medicaid spending, per - member, per month (PMPM). Oregon has successfully bent the cost curve and plans to continue the goal into the next waiver period. Oregon will continue to commit to maintain a sustainable rate of growth under the two percent (2%) per-member-per-month (PMPM) calculation. In reviewing national trends (Uninsured, January 2015), (Office of the Actuary, Centers for Medicare and Medicaid Services, 2014) (Office of the Actuary, Centers for Medicare and Medicaid Services) Oregon has determined that the Medicaid trend ranges from 4.5 to 5.5 percent growth. Therefore, Oregon proposes to continue to bend the cost curve at a 3.4% rate of growth. In addition, Oregon proposes to continue using the current base year of 2011 for rate development and will not rebase for the new waiver period. Oregon requests that the state work with CMS to update the return on investment calculation included in the current template to ensure that it reflects the appropriate information. OHA proposes that the calculation be updated and targeted to capture specific cost and savings outcomes. To simplify reporting, Oregon will only report on services and expenditures included in the test (e.g., Medicaid expenses for CCO enrollees). Oregon will work with CMS to identify expenditures that will be excluded from the test, including:

- Fee-for-service mental health drugs
- Fee-for-service personal service workers (PC 20)

- FQHC/RHC new and change in scope after July 1, 2011
- Primary care rate increase/rate bump (ended 12/31/14)
- Mental health habilitative
- Hospital presumptive eligibility
- Health insurer fee
- Future federally mandate changes affecting caseloads or costs
- High cost, emerging drug therapies

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

c. Expand the Coordinated Care Model

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

The Oregon legislature originally intended that those eligible for both Medicare and Medicaid, or dual eligible members, be included in new Coordinated Care Organizations as outlined in HB 3650. However, during the current demonstration, dually eligible individuals must opt in to CCOs. Over the past several years, approximately 56.8 percent of dual eligible beneficiaries have voluntarily enrolled in Coordinated Care Organizations. The state is currently conducting an evaluation to compare outcomes for dual eligible members in coordinated care to fee-for-service outcomes for the same population. Preliminary looks at Medicaid data confirm the state's belief that costs and care outcomes are better for dual eligible beneficiaries enrolled in managed care. Oregon has also had low turnover of dual eligible individuals who have been in CCOs, Currently, 99 percent of full dual eligibles in fee-for-service in the aging and disabled populations are eligible to enroll in CCOs, which include all Medicaid services in an integrated and coordinated managed care plan. For some, however, there has been a lack of clarity about their local opportunities and choices. For example, where partial enrollments for dental and/or behavioral health have taken place, beneficiaries may have received more than one proof of eligibility, at times leading to confusion about their physical health plan membership.

The state believes this can be addressed by moving to an opt-out auto-enrollment process. In this scenario, the state would automatically enroll all eligible individuals into a CCO unless the individual actively chooses not to enroll and notifies the state of this choice. CMS guidelines will be followed to ensure individuals are able to exercise their right if they choose not to be enrolled in managed care.

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

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

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

The Health Care Workforce Committee was established by the Oregon Legislature and i coordinates efforts to recruit and educate health care professionals and retain a quality workforce. This work is necessary if Oregon is to meet the demand created by the expansion in health care coverage, health system transformation, and an increasingly diverse population. In 2013, the Health Care Workforce Committee developed a strategic plan for recruiting primary care providers to Oregon[1]. The plan included three overarching goals for primary care provider recruitment, along with strategies to achieve these goals: grow our own; acquire from elsewhere (other states beyond Oregon); and empower communities to enhance their capacity around recruitment and retention. What follows is a brief description of each goal and high-level action being taken, which will continue in the years ahead during the demonstration renewal period.

Grow Our Own

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

- Identifying additional funding for Regional Area Health Education Centers to deliver additional targeted programs to high-school age youth to encourage careers in the health care profession;
- Continued support of the Graduate Medical Education Consortium to expand the number of residency slots available to Oregonians to finish their training in the state; and
- Hold dialogue with the 12+ graduate programs for training licensed behavioral health specialists and explore ways to increase the sizes of the programs.

Acquire from Elsewhere

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

- National marketing of Oregon's current provider incentive programs: these incentive programs include a suite of differing programs that can be overlaid on one another to incentivize providers to locate in rural and underserved areas. In addition to our aggressive use of the federal Nurse Corps and National Health Services Corps, Oregon has created a tax credit for providers in rural areas, loan repayment for those who serve a high Medicaid patient population, and Behavioral Health Loan Repayment to support behavioral health providers working toward licensure adding their skills to an overall capacity for mental/behavioral health.
- Restructuring and potentially expanding the availability of loan repayment, loan forgiveness and other provider incentives to fulfill Oregon's policy objectives to ensure an adequate supply and distribution of providers in the areas and disciplines where they are needed; and
- Developing a full-scale marketing campaign (e.g., "Oregon: The State of Health") and releasing through social media and training program platforms around the nation.

Empower Communities to Enhance their Capacity around Recruitment and Retention

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

- Funding deployment of the Rimrock Model for targeted number of communities that are struggling with health care retention and recruitment within the community, and
- Ensuring coordination among OHA and the Office of Rural Health in working with CCOs and practices to take advantage of the suite of incentive programs available for workforce recruitment in Oregon.

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

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

Public Notice and Comment Process

In an effort to build on the state's health system transformation success and to continue to promote excellence in health care access, quality, and health outcomes across the state, Oregon has been

engaging key leaders and stakeholders and asking for public input on the waiver renewal. The public process has allowed Oregon Tribal and urban Indian populations, consumers, and key stakeholders the opportunity to comment on the proposed renewal of the 1115 Demonstration; this process has been public and accessible.

Oregon Health Authority staff have engaged leaders and stakeholders across the state. These contacts have included:

- Consumer and member advocacy groups, including the Substance Use Disorder (SUD) Advisory Council, Cascade AIDS Project, Central City Concern (behavioral Health, SUD treatment provider), Oregon Consumer Advisory Council
- Policy leaders, including state legislators
- Hospitals and Health Systems leaders
- Coordinated care organization leaders, including CCO Chief Executive Officers, Medical Directors and Behavioral Health Directors
- Local governments, including the Oregon Association of Community Mental Health Programs
- Health and health care committees, advisory groups, and work groups, including the Oregon Health Policy Board (public meeting), Substance Use Disorder (SUD) Advisory Council, the Medicaid Advisory Committee (public meeting) and the state Ombuds Advisory Council.

OHA held a public hearing in April at the Oregon Health Policy Board. The May 3 Health Policy Board meeting in Portland will serve as an additional public hearing and attendees can join in-person, by phone, or watch remotely. The Medicaid Advisory Committee scheduled for May 25 will serve as another public hearing on the waiver. May Public input is being taken in person at the meeting and in writing.

The State has regular consultations and meetings with the nine federally recognized Indian tribes in Oregon, urban Indian populations and Indian health providers and has provided the constituents with opportunities to comment on all proposals for renewing the OHP demonstration.

The renewal was developed in consultation and collaboration with the Governor's office, state partner agencies, and legislative committee partners.

Additional consultations and meetings are scheduled for upcoming weeks, and all logs, materials and relevant information will be presented in the renewal request to be submitted in June 2016.

Federal Authority Requests

Waiver Authority

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

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

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

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

- Provide expenditures to cover providers that do not comply with disenrollment restrictions on enrollees;
- Provide 6 to 12-months of benefits for eligible individuals, including children, when they cease to be eligible for Medicaid during the 6-12 month period after enrollment;
- Provide coverage for certain chemical dependency services for targeted beneficiaries;
- Receive federal financial participation for certain state-funded health care programs;
- Continue Uncompensated Care payments for Tribal Health Facility Program; and
- Continue to provide incentive payments to participating hospitals through the Hospital Transformation Performance Program.

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

Issue	CFR/SSA Reference
· Value based payment methodologies to reimburse on the basis of outcomes and quality, including payment structures that incentivize prevention, person-centered care and comprehensive care coordination, including requiring CCOs to make value-based payments for a minimum percentage of contracted services	42 CFR § 438.6
· The inclusion flexible, health-related, services as reimbursable to CCOs at the medical services payment rate rather than as administrative costs	42 CFR § 434.20-21, SSA § 1902 42 CFR § 438.6
· Reinvestment of CCO savings into health-related services	42 CFR § 434.50 42 CFR § 438.116
· Extension of the state's Hospital Transformation Performance Program (HTPP)	Section 1115 (a)
· Extension of the state's Tribal Uncompensated Care Program (UCCP)	Section 1115 (a)

· Care coordination for individuals 30 days from discharge from an institution for mental diseases (IMD) · Care coordination for pre-adjudicated incarcerated individuals in local correctional facilities for up to 30 days of the initial incarceration period	42 CFR 438.3, 42 CFR § 435.1009 42 CFR § 435.1010 SSA § 1115(a)
· Grants for community-based Coordinated Health Partnerships (CHPs) focusing on supportive housing services to targeted population(s); utilization of local government and other allowable funds to serve as state match; temporary rental assistance for transitional housing for up to 30 days for patients leaving an acute care setting who require health care services	42 CFR § 1905(a)
· Psychiatric telephonic consultation line pilot for adults and older adults to address Oregon's limited access to prescribing psychiatric clinicians	SSA § 1905(a)
· Doulas to provide services within the doula's scope of practice without supervision of an existing licensed medical provider	SSA § 1905(a); 42 CFR § 440.60
· Permitting enrollees dually eligible through Medicare and Medicaid to disenroll from CCOs without cause at any time	42 CFR § 438.56
· Receive federal financial participation (FFP) for certain designated state-funded health care programs	SSA § 1115(a)
· Care Coordination facilitation for American Indians/Alaska Natives, including PCCM	SSA § 1905(a)

· Expand Nurse Home Visiting and access to Targeted Case Management (State Plan)	SSA § 1905(a)

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

Expenditure Authorities

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

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

Oregon's request has been developed after similar approved requests in other states (e.g., California, New York and Massachusetts), and Oregon hopes to be given the same opportunity. CMS approval of this request will allow Oregon to move forward with our mutual reform goals to advance health system transformation and improve the social determinants of health of our most vulnerable members and build cross community partnerships to coordinate care transitions. These pilots will decrease medical

expenditures through lower emergency department use, in patient hospitalizations and residential treatment stays.

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

Financing and Budget Neutrality

Financing

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

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

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

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

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

Budget Neutrality

Oregon understands that the state must demonstrate budget neutrality for the Oregon Health Plan (OHP) Demonstration. Budget neutrality means that Oregon may not receive more federal dollars under the Demonstration than it would have received without it. The state is requesting a five-year extension

to its Section 1115 Medicaid Demonstration in order to maintain and further advance Oregon's health system transformation. This section discusses the budget neutrality test for the extension application.

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

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

Components of the Budget Neutrality Test

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

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

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

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

Requested Investments. Oregon's projected expenditures includes:

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

Historical Savings. Oregon is a demonstrated leader in delivering high quality care and containing spending growth in its Medicaid program. Oregon is requesting to continue use of the historical Demonstration savings (currently estimated at $30 billion Total Funds through demonstration year 2015). This figure reflects the savings estimates identified by Oregon and CMS through the life of the

OHP Demonstration. Administrative costs will continue to be reimbursed based on the allowed federal matching rates of 50 percent, 75 percent or 90 percent of the administrative expense and are not subject to the budget neutrality test.

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

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

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

Evaluation

2012-2017 Evaluation Overview

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

- For the Midpoint Evaluation, Mathematica Policy Research analyzed whether changes in specific outcome measures during the first 21 months of CCO implementation could be attributed to the introduction of CCOs. They identified positive effects in the area of improving primary care for all populations and no statistically significant effects in other areas. Importantly, it was noted that

early results from the extensive transformation of Oregon's Medicaid delivery system "do not suggest widespread negative results as a consequence of introducing the CCO model."[5]

- An evaluation by researchers at Portland State University (PSU) and the Providence Center for Outcomes Research and Education (CORE) suggests that CCOs meaningfully affected patterns of care in their first year of operation. Comparing self-reported and claims-based outcomes for CCO members and non-CCO comparison groups, PSU and CORE found that CCO membership was associated with better access to care, more frequent primary care use, improved ratings of care quality, increased primary care spending, and reduced spending on office visits and pharmacy.[6]
- Preliminary results from an evaluation by researchers at OHSU's Center for also suggests that CCOs meaningfully affected patterns of care in their first year. Comparing claims-based outcomes for CCO members and a commercial comparison group, it was found that CCOs were associated with an increased rate of primary care visits and a decreased rate of emergency department visits, as well as increased primary care spending and decreased emergency department spending per member, per month. Final results from this analysis are pending.

The Summative Evaluation of the 2012 – 2017 demonstration will assess the impact of CCOs overall on per capita spending, quality of care, access to care, and other key outcomes. It will improve on preliminary studies by using a longer observation period and more rigorous comparison groups. Findings will be submitted to CMS in December 2017.

Evaluation design for Demonstration waiver renewal (2017-2022)

Waiver Focus Areas

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

1. Improving population and social determinants of health.

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

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

2. Improving quality of care, access to care, experience of care, and health status, and reducing costs for members with Medicaid and Medicare eligibility (i.e., dual eligibility).
3. Integrating physical, behavioral, and oral health care.
4. Enhancing health equity.
5. Implementing health related services to improve care delivery and member health.
6. Implementing value based payments that reward quality and efficiency.
7. Improving hospital quality through the Hospital Transformation Performance Program.
8. Improving access to sustainable housing for members needing behavioral health services and other vulnerable populations.

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

Evaluation Topics: Implementation, Outcomes, and Impacts

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

- Implementation: Implementation encompasses whether activities in each focus area are being carried out as planned and how well these activities are being carried out. Assessing implementation will provide evidence about *why* the State's activities contributed (or did not contribute) to expected outcomes, such as reduced spending or increased quality of care. In addition, implementation assessment will provide rapid-cycle feedback that the State and its partners can use to improve their activities throughout the demonstration period.
- Outcomes: Outcomes represent changes in measures or indicators of progress in each focus area. For example, increased childhood immunization rates may be an expected outcome of the State's activities in the area of improving population health. The evaluation will track outcomes in each area over the course of the demonstration. Although outcomes alone are insufficient evidence that an activity *caused* a change in a measure or indicator, they provide a basic check and measure of accountability for the State's activities.
- Impacts: Impacts represent the extent to which the State's activities *caused* changes in measures or indicators in each focus area. To estimate whether a specific activity caused an observed

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

- A comparison group is a group of people who are similar to Medicaid members in terms of their observable characteristics, but are not affected by the State's activities under the demonstration. Potential comparison groups for waiver evaluation may be non-Medicaid populations in Oregon, Medicaid populations of other states, or the national population. Evaluators will use appropriate statistical techniques for matching comparison group members with Oregon Medicaid members or weighting comparison group members to ensure they match Oregon Medicaid members.
- Pre/post and interrupted time-series designs use outcomes for Medicaid members *before* the demonstration as the counterfactual, and assume that pre-demonstration trends would have continued in the absence of the demonstration. Because these designs do not account for external factors that would affect Medicaid members in the absence of demonstration activities, they are considered less rigorous than randomized controlled trials or comparison group designs.

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

Research Questions and Data Sources

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

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

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Memorandum

To: Karen Gaffney, Co-chair
Janet Patin, MD, Co-chair
Medicaid Advisory Committee

From: Lynne Saxton LS

Date: April 27, 2016

RE: End of Year Report 2015

Thank you for your letter dated February 2, 2016. The committee completed notable work in 2015 including but not limited to:

- Comprehensive report on CHIP premium assistance submitted to the Oregon Legislature in February 2015 per Senate Bill 1526 (February).
- Received presentations from five CCO Community Advisory Councils (CACs) (March-Sept.).
- Prepared a comprehensive financial analysis of 12-month continuous eligible for adults in OHP in the 2017-19 biennium (October).

Recommendations from the committee included:

- Concluding that a premium assistance program for Oregon's CHIP population has some policy merit but was not feasible in 2015 and that the state reassess opportunities to improve Oregon's CHIP program in the future.
- Requesting 12 month eligibility policy be a part of Oregon's 1115 waiver renewal with CMS in 2017.
- Adopting transparent OHP eligibility, enrollment and redetermination performance indicators.

- Completing annual assessments of administrative costs that result from churn and potential savings to the Medicaid program, CCOs and health providers by reducing churn.

OHA's response to recommendations:

1. We accept the recommendation that a premium assistance program for Oregon's CHIP population is not feasible in 2015. This recommendation was included as part of a report submitted to and accepted by the Legislature in the 2015 session.
2. Staff assessed the feasibility of 12 month continuous eligibility with respect to Oregon's 1115 waiver renewal. As reported by Lori Coyner, OHA's Medicaid Director, on April 6th, 12 month continuous eligibility is not feasible at this time.
3. A dashboard is being developed to provide transparency to OHP eligibility, enrollment and redetermination performance indicators. Please see draft report attached.
4. OHA recognizes the value and benefit to OHP enrollees from stable coverage in OHP. At this time, OHA does not plan to conduct a longitudinal cost-benefit study.

I would like to congratulate you on the committee reaching an important milestone having appointed Don Erickson as the ex-officio member for DHS. This was an important development, as the committee has not had direct representation from DHS since the creation of OHA in 2009. This development is also a symbolic representation of the partnership of OHA and DHS in serving Medicaid Members.

We look forward to working with the Medicaid Advisory Committee in 2016.

OHP Oral Health Access Framework: Overview and Committee Work Plan

The Oregon Health Authority is uniquely positioned to work with CCOs and across divisions (Health Policy and Analytics, Health Systems Delivery, and Public Health) to coordinate activities to improve oral health outcomes for Oregonians. Recently, OHA expanded the capacity of its cross-divisional oral health program, with the hire of its first Dental Director, Bruce Austin (2015).

During the summer of 2016, OHA will commence an oral health strategic planning process to develop a coordination and alignment roadmap for oral health work across the agency: the OHA Oral Health Strategic Plan (OHA Strategic Plan). The OHA Strategic Plan will incorporate and build on:

- OHA-specific priorities and strategies in existing internal/external oral health plans, including the statewide *Strategic Plan for Oral Health in Oregon: 2014-2020* (Oregon Oral Health Coalition/Oregon Health Authority/Oral Health Funders Collaborative) and the *State Health Improvement Plan: 2015-2019* (OHA Public Health Division); and
- Emerging oral health priorities and strategies in the context of Oregon's Health System Transformation 2.0 efforts and other broad agency priorities, such as OHA's 10 priority areas, and Oregon's upcoming federal 1115 waiver renewal.

Oregon's Medicaid Advisory Committee (MAC) has the opportunity to inform OHA's ongoing strategic planning efforts with regard to oral health. Specifically, OHA has asked MAC to recommend a **framework** for defining and assessing oral health access for OHP members by addressing two foundational questions:

1. What are the key factors that influence access to oral health care for OHP members (i.e. how should Oregon define access)?
2. What key measures should OHA use to assess access to oral health services for OHP members (i.e. how should we monitor access to oral health in Medicaid)?

The committee will review this issue in May-September of 2016 and will submit its recommendations to OHA by October 1st, 2016. The Committee's recommended framework around access to oral health for OHP enrollees will be incorporated into the OHA Oral Health Strategic Plan, which will be released by the end of 2016.

Date (2016)	Task Description
May (Staff)	• Prepare background materials for May MAC meeting: Brief on access to oral health; brief on Oregon's oral health delivery system; presentation on OHA strategic planning and initiatives
May 25 (MAC Mtg.)	• Introduce OHA request to develop the framework for assessing oral health access in OHP and committee work plan; present background on oral health for adults in Medicaid, summary of oral health delivery system in Medicaid, and summary of

OHP Oral Health Access Framework: Overview and Committee Work Plan

	OHA strategic priorities and initiatives. *Committee to consider creating a Dental Work Group to advise the committee on dental access framework.*
May/June (Staff)	• Prepare background materials for June MAC meeting: National/state models to define oral health access and factors influencing access; summary of national/state metrics & measures for oral health access.
June	• *Dental Access Work Group* meeting: consider factors that help/hinder oral health access. Develop a working definition of access.
June 22 (MAC Mtg.)	• *Dental Access Work Group* present list of key factors influencing access for OHP members and working definition of access. • Present national/state model definitions and factors; presentations on model metrics/measures from active dental work groups.
July	• *Dental Access Work Group* meeting: Develop and prioritize list of key measures influencing access for OHP members.
July 27 (MAC Mtg.)	• *Dental Access Work Group* present prioritized list of key measures for committee consideration.
August	• Staff draft memo on framework for oral health access in OHP • *Dental Access Work Group meeting:* Review draft memo on framework for oral health access in OHP
September 28 (MAC Mtg.)	• Review and finalize draft committee memo on framework for oral health access in OHP for OHA

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March 2016 | Issue Brief

Access to Dental Care in Medicaid: Spotlight on Nonelderly Adults

Elizabeth Hinton and Julia Paradise

Introduction

Oral health is a critical but often overlooked component of overall health and well-being.[1] Although good oral health can be achieved through preventive care, regular self-care, and the early detection, treatment, and management of problems, many people suffer from poor oral health, which often has additional adverse effects on their general health and quality of life.[2] The prevalence of dental disease and tooth loss is disproportionately high among people with low income, reflecting lack of access to dental coverage and care. Racial and ethnic disparities in these measures are also pronounced.

Medicaid, the major health coverage program for low-income Americans, provides a uniquely comprehensive mandatory benefit package for children that includes oral health screening, diagnosis, and treatment services. In the last decade, with federal and state leadership, Medicaid and the Children's Health Insurance Program (CHIP) have made important progress in addressing gaps in low-income children's access to dental care, boosting children's use of preventive and primary dental services. However, even with a robust benefit package, securing access to dental providers and services has remained a key challenge. The situation for low-income adults in Medicaid is more complex than that for children. Dental benefits for Medicaid adults are not required by federal law, but are offered at state option, and most states provide only limited coverage – in many cases, restricted to extractions or emergency services. Further, when states have faced budget pressures, adult dental services in Medicaid have typically been among their first cutbacks.[3] It is noteworthy, too, that the Medicare program, which covers elderly adults and nonelderly adults with disabilities, provides no dental benefits.

Comprehensive coverage of dental care for children in Medicaid and CHIP, as well as the designation of pediatric dental care as one of the ten essential health benefits (EHB) under the Affordable Care Act (ACA), indicate recognition among policymakers of the importance of oral health. New opportunities now exist to establish similarly robust oral health benefits for low-income adults. Broad state flexibility to define Medicaid benefits for adults, the ACA expansion of Medicaid to nonelderly adults up to 138% of the federal poverty level (FPL), and Medicaid payment and delivery system reform are key policy levers. To help inform federal and state action concerning adult access to oral health care, this brief examines the oral health status of low-income adults, the dental benefits covered by state Medicaid programs, and low-income adults' access to dental care today.

Why adult oral health is important

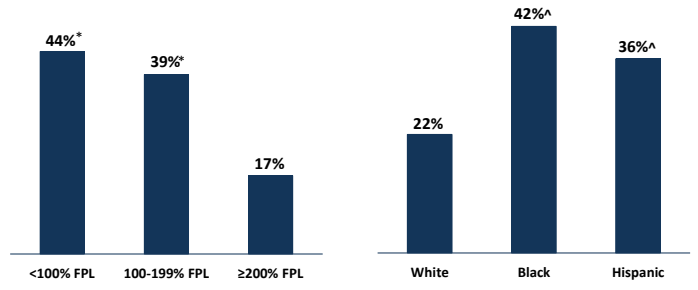
Untreated oral disease can have serious adverse impacts. Untreated oral health problems can affect appetite and the ability to eat, or lead to tooth loss, all of which can lead, in turn, to nutrition problems.[4] Untreated problems can also cause chronic pain that can affect daily activities such as speech or sleep.[5] Research has also identified associations between chronic oral infections and diabetes, heart and lung disease, stroke, and poor birth outcomes.[6] Oral health problems can also interfere with work; employed adults are estimated to lose more than 164 million hours of work each year due to oral health problems or dental visits.[7] Adults who work in lower-paying industries, such as customer service, lose two to four times more work hours due to oral health-related issues than adults who have professional positions.[8] Visibly damaged teeth or tooth loss can also harm job prospects for adults seeking work.

Dental disease prevalence in nonelderly adults

Nationally, 27% of all adults age 20-64 have untreated dental caries, but the burden of disease is not distributed evenly in the population.[9] The rate of untreated dental caries is highest (44%) among adults with income below 100% FPL ($11,880 per year for an individual in 2016) – more than twice the rate (17%) among adults with income at or above 200% FPL (Figure 1). Racial and ethnic minorities were also disproportionately affected by oral health problems. Both Black and Hispanic adults had significantly higher rates of untreated caries than Whites, largely a reflection of their higher rates of poverty.

Figure 1

Prevalence of Untreated Dental Caries Among Nonelderly Adults, by Income and Race/Ethnicity, 2011-2012



NOTES: Adults age 20-64. *Difference from ≥200% FPL is statistically significant at p<0.05. ^Difference from White is statistically significant at p<.05.
SOURCE: KFF analysis of National Health and Nutrition Examination Survey (NHANES), 2011-2012.

Medicaid's role in covering low-income adults

In 2014, Medicaid covered nearly 28 million low-income nonelderly adults. The program covers 4 in every 10 nonelderly adults under the poverty level.[10] As of February 2016, 31 states and DC had adopted the Affordable Care Act's (ACA) Medicaid expansion, which provides Medicaid eligibility to nearly all adults with income at or below 138% FPL ($16,394 per year for an individual in 2016); 19 states have not adopted the Medicaid expansion. The uninsured rate among low-income adults remains high, especially in non-expansion states.[11] Across non-expansion states, the median Medicaid income eligibility for parents is 44% FPL, and adults without dependent children, except pregnant women and people with disabilities, are excluded from Medicaid no matter how poor they are. An estimated 2.9 million adults with income below 100% FPL fall into the "coverage gap" across non-expansion states – without access to Medicaid coverage and unable to qualify for subsidies in the Marketplace.[12]

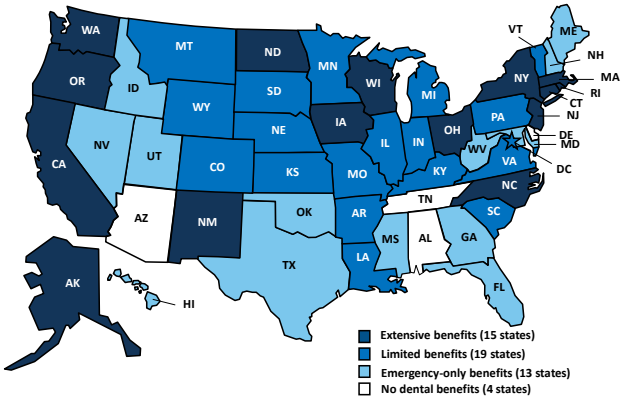
Medicaid dental benefits for adults

States have considerable discretion in defining Medicaid adult dental benefits because these services are optional, not mandatory, under federal Medicaid law. Adult dental benefits are a state option across the board – for adults who qualify for Medicaid under pre-ACA law and also for adults newly eligible for Medicaid under the ACA expansion. States must provide Alternative Benefit Plans (ABPs) for Medicaid expansion adults, modeled on one of four "benchmark" options specified in the law, including an option for coverage approved by the HHS Secretary. All ABPs must include the ten essential health benefits (EHBs) established by the ACA.[13] Notably, the EHBs include pediatric dental benefits, but not adult dental benefits.[14] Many states have used the Secretary-approved coverage option to conform the benefits they provide for expansion adults with their benefits for adults in traditional Medicaid, modifying them as necessary to comply with the EHB requirements. Of the 31 states and DC that have adopted the Medicaid expansion, all but two states provide the same dental benefits for expansion adults that they do for the traditional adult Medicaid population. The two exceptions are Montana and North Dakota. Montana provides limited dental benefits for its traditional Medicaid adult population, but none for Medicaid expansion adults; North Dakota provides extensive dental benefits for traditional Medicaid adults, but none for expansion adults.

Almost all states (46) and DC currently provide some dental benefits for adults in Medicaid (Figure 2 and Appendix). However, just as commercial dental plans typically do, many state Medicaid programs set a maximum on their per-person spending for adult dental benefits or impose caps on the number of certain services they will cover. The scope of Medicaid adult dental benefits varies widely by state. As of February 2016, 15 states provided extensive adult dental benefits, defined as a comprehensive mix of services including more than 100 diagnostic, preventive, and minor and major restorative procedures, with a per-person annual expenditure cap of at least $1,000. Nineteen states provided limited dental benefits, defined as fewer than 100 such procedures, with a per-person annual expenditure cap of $1,000 or less. The remaining 13 states with any adult dental benefits covered only dental care for pain relief or emergency care for injuries, trauma, or extractions. Four states provided no dental benefits at all.[15] Even in states that provide some dental benefits, adult Medicaid beneficiaries may face high out-of-pocket costs for dental care, making it difficult or impossible to afford.

Figure 2

Medicaid Coverage of Adult Dental Benefits, February 2016



SOURCE: *Medicaid Adult Dental Benefits: An Overview*, Center for Health Care Strategies, Inc., February 2016, http://www.chcs.org/resource/medicaid-adult-dental-benefits-overview/

As optional Medicaid services, adult dental benefits are also subject to being cut. Many states change their benefits from one year to the next. In particular, when states are under budget pressures, adult dental benefits in Medicaid have been cut back and, when their economies improve, states often move to restore them. For example, in 2009, California eliminated coverage of non-emergency dental services for adults. In 2014, the state restored many of the benefits, including preventive and restorative care, periodontal services, and dentures. Similarly, Illinois eliminated coverage of non-emergency dental services for adults in 2012, but

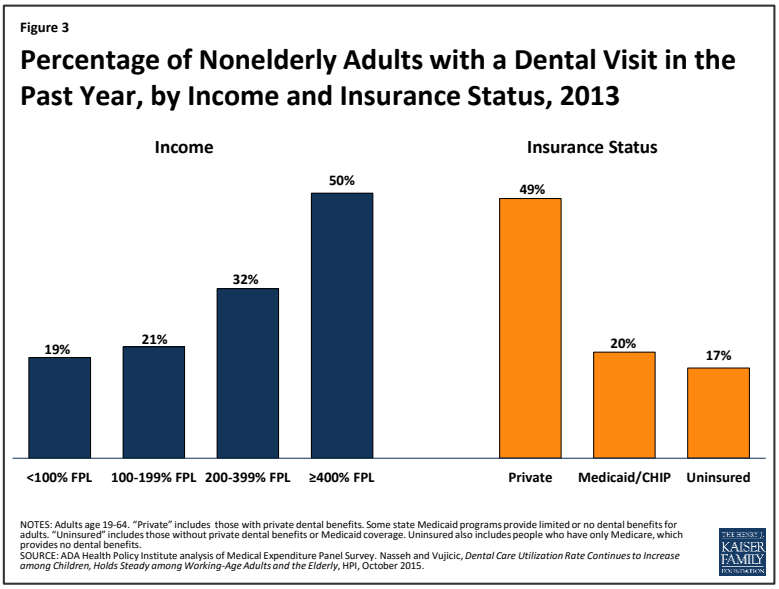
expanded services again in 2014 to include limited fillings, root canals, dentures, and oral surgery services.[16] Research has shown that when states reduce or eliminate adult dental benefits, unmet dental care needs increase, preventive dental service use decreases, and emergency department use for dental problems increases.[17 18 19]

Adult access to dental care

Access to and use of dental care among low-income adults depends on a number of variables. Medicaid eligibility for low-income adults, Medicaid coverage of dental benefits, the availability of dental providers, and beneficiary and provider awareness of the importance of preventive dental care all bear on whether low-income adults obtain dental services. Particularly in the absence of dental benefits, cost is the main barrier to access to dental care for low-income adults.[20] Paying for services out-of-pocket is difficult, if not impossible, on their strained budgets. Over time, persistent lack of access to dental care or connection with dental providers may result in low expectations for oral health among low-income adults, reinforcing existing disparities. And if consumers are unaware of the need for regular checkups or cannot afford them, they may wait until they experience oral pain to seek care.

Dental Care Utilization and Unmet Need

Regular dental care is important to maintaining good oral health. Low-income adults are less likely to have seen a dental provider within the last year than higher-income adults. In 2013, only about 1 in 5 adults with income below 200% FPL had a dental visit in the past year, compared to 1 in 3 of those with income of 200-399% FPL, and 1 in 2 adults with income above 400% FPL (Figure 3). Similarly, adults with private dental coverage were more than twice as likely as adults with Medicaid/CHIP or uninsured adults to have seen a dental provider within the last year. (Note: "Uninsured" includes adults without private dental benefits or Medicaid and nonelderly Medicare-only adults who do not have private supplemental dental benefits.) In 2013, 49% of adults with private coverage had a dental visit in the last year, compared to 20% of adults with Medicaid/CHIP and 17% of uninsured adults. Children in Medicaid/CHIP, for whom dental benefits are mandatory, were much more likely than adults in Medicaid to have had a dental visit (42%).[21] The low visit rate for adults with Medicaid/CHIP coverage, compared to both children with Medicaid/CHIP and adults with private insurance, reflects, in part, the limited adult dental benefits covered in many state Medicaid programs.

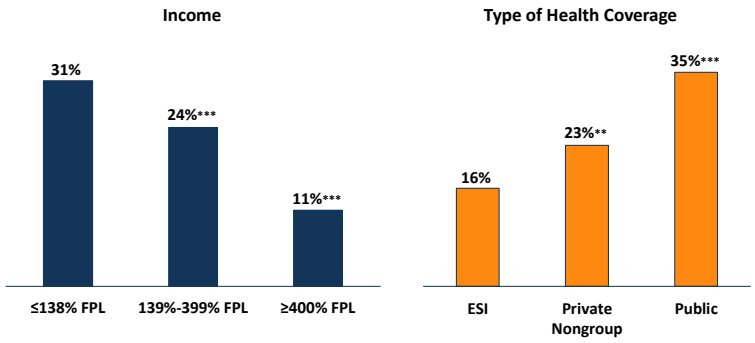


In recent research, dental care emerged as the service for which insured adults were most likely to report unmet need due to cost. This was especially true for low-income insured adults[22] (Figure 4). Nearly one-third (31%) of full-year-insured nonelderly adults with income at or below 138% FPL and one-quarter (24%) of those

between 139% and 399% FPL reported an unmet need for dental care due to cost, compared to 11% of full-year-insured adults with income at or above 400% FPL. Also, nonelderly adults with public insurance, including those with Medicaid/other state coverage and those with Medicare, were more than twice as likely to report an unmet need for dental care due to cost as adults with employer-sponsored insurance (35% vs. 16%) – again, likely reflecting limited Medicaid adult dental benefits in many states.

Figure 4

Unmet Need for Dental Care Due to Cost in Past 12 Months Among Full-Year Insured Nonelderly Adults, March 2015



NOTE: Adults age 18-64. "Public" includes Medicaid/other state (including CHIP) and nonelderly adults with Medicare. **/***Difference from reference group is significant at p<.01/.001.
SOURCE: Health Reform Monitoring Survey, Quarter I, 2015. See Shartzer and Kenney, *QuickTake: The Forgotten Health Care Need: Gaps in Dental Care for Insured Adults Remain Under ACA*, Urban Institute, September 24, 2015.

Provider Availability and the Role of Health Centers

As of January 1, 2016, there were nearly 49 million people living in over 5,000 dental health professional shortage areas (HPSAs) across the country. HPSAs are defined primarily in terms of the number of dental health professionals relative to the population.[23] Although there is some debate about whether a national shortage of dentists exists, most experts agree that there is a geographic maldistribution of dentists and a shortage of office-based dentists available to treat low-income and special needs populations, including people in nursing homes and other residential institutions. In addition, dentist participation in Medicaid is limited, as a large percentage of dentists accept no insurance and many dentists who do accept private insurance do not accept Medicaid.[24] Medicaid beneficiaries often have difficulty finding a dental provider. The reasons dentists generally cite for not participating in Medicaid are low reimbursement rates, administrative burden, and high no-show rates among Medicaid patients.

Medicaid dental services may be delivered and paid for on a fee-for-service basis or by comprehensive or dental-only managed care plans that contract with the state. Of the 39 states with comprehensive Medicaid managed care in 2015, 29 states reported that they cover adult dental benefits. Of these states, 10 states reported carving-out adult dental benefits to Medicaid fee-for-service or prepaid health plans.[25]

Although most dental care is provided in solo or small office-based dental practices, community health centers are an important source of dental care for Medicaid beneficiaries and others in low-income, medically underserved communities. In 2014, health centers across the country served 22.5 million patients, a large majority of them Medicaid beneficiaries (46%) and uninsured patients (28%).[26] The ACA made a major investment in health center growth, establishing a five-year $11 billion Health Center Trust Fund (which has since been extended through 2017), and providing $1.5 billion in new funding for the National Health Service Corps, which supplies many of the medical and dental providers who staff health centers. Health centers can also contract with private dental practices to provide oral health services to health center patients. Between the ACA trust fund dollars and increased patient revenues generated by expanded coverage for low-income people under the ACA, health centers in all states have been able to expand their service capacity; a recent survey of health centers found that those in Medicaid expansion states were significantly more likely than those in non-expansion states to have expanded their dental and mental services capacity since the start of 2014.[27] In 2014,

over three-quarters of health centers provided dental care, and about 15% of all health center patient visits were for dental services.[28]

One strategy with potential to increase access to dental care in low-income communities is to develop a more diverse oral health workforce, because minority providers are more likely to work in minority communities and to provide care to the underserved.[29] Programs like the National Dental Pipeline Program have increased enrollment of under-represented minority students at participating dental schools. In addition, dental school accreditation standards have been revised to improve diversity among dental school faculty and students.[30]

Expanding the Supply of Dental Care: Scope-of-Practice & New Provider Types

In addition to dentists, dental hygienists, who specialize in preventive care and oral hygiene, are an integral part of the dental workforce. Dental hygienists work in a variety of settings (e.g., private offices, schools, nursing homes) in accordance with varying state requirements for dentist supervision, based on each state's practice acts or regulations. To expand access to dental care, some states have amended their scope-of-practice rules to allow dental hygienists to furnish services without the presence or direct supervision of a dentist. Accompanying changes may be needed in some states' Medicaid reimbursement policies and systems to permit dental hygienists to bill the program directly for services provided to Medicaid beneficiaries.

Some states have broadened the dental workforce further by introducing new midlevel dental provider types. Conceptually, midlevel dental providers play a role similar to that of nurse practitioners and physician assistants in the medical care context.[31] They are part of the dental professional team and perform routine preventive and restorative services in a variety of settings.[32] Three states – Alaska, Minnesota, and Maine – have recognized and licensed a new type of midlevel provider known as a dental therapist, to help improve access to care, especially for underserved populations. Education requirements, roles, and supervision requirements for midlevel dental providers vary across states. For example, Minnesota requires that at least 50% of the caseload of dental therapists and advanced dental therapists be Medicaid beneficiaries or underserved populations.[33] Emerging research on midlevel dental providers indicates that they provide high-quality, cost-effective care.[34]

Other strategies for optimizing current dental care capacity are also developing. Effective January 1, 2015, California began requiring the Medicaid program to reimburse for services delivered by dental hygienists in consultation with remote dentists, a practice known as “teledentistry.”[35] This law was passed years after the state began the Virtual Dental Home Demonstration Project, a pilot program designed to test the “virtual dental home” model to expand access to care in dental shortage areas. In this model, telehealth technology is used to link allied dental professionals working in the community – registered dental hygienists in alternative practice, registered dental hygienists, and registered dental assistants – with dentists located in dental offices or clinics. The community-based providers collect patient information, including medical histories and x-ray images, and this information is then sent to the collaborating dentist. A treatment plan is developed, and the community-based provider furnishes the services they are authorized to provide in the community, and patients requiring more complex services are referred to a local dentist.[36]

Dental Delivery System

Important changes in two key realms are poised to affect the delivery of dental care in the coming years. The first relates to the organization of service delivery. Movement toward more integrated, "whole-person" care and more accountable systems of care (e.g., Accountable Care Organizations) is leading to arrangements in which providers who have not traditionally done so are now sharing patient information and collaborating in care planning. Currently, states and delivery systems (e.g., managed care plans) are focused primarily on integrating behavioral health care with general medical care, but some systems are taking steps to integrate dental care as well.[37] Interestingly, early research indicates that ACOs that provide dental services are more likely to include a health center and are much more likely to have contracts with Medicaid.[38]

The second realm of change is clinical care itself. A different paradigm for oral health care is emerging that departs from the traditional fee-for-service, procedure-driven model that prevails today, and instead involves care planning based on individual patient characteristics and risk factors, and payment tied to quality and outcomes, not volume.[39] This approach is essentially a model of prevention and chronic care management, in which patient risk is assessed, and preventive care, early intervention, close monitoring, and care management are targeted to individuals with or at high risk for disease. The aim is to improve oral health outcomes by providing services based on individual patient risk and need. Rethinking systems of care and broad health system accountability may improve access to and utilization of dental care as well as the impact of Medicaid spending for dental services.

Looking ahead

Improving the oral health of low-income adults involves efforts to expand coverage, strengthen benefits, promote oral health, and improve access and care delivery. State Medicaid programs can play a major role in this area and have important levers for making advances. States that have not yet expanded Medicaid under the ACA have an opportunity to cover millions of poor adults who lack other affordable health coverage options. Independent of the Medicaid expansion, improving state economies may enhance the prospects for expansion of adult dental benefits in Medicaid programs. The progress that states have made in increasing children's access to and use of dental care, by building stronger provider networks, leveraging accountability through contracts, and investing in care coordination efforts, provides a foundation for similar action for adults in Medicaid.[40] States are also expanding the dental workforce by removing scope-of-practice barriers and through targeted efforts among dental schools to increase diversity among dental students, as under-represented minority students are more likely to provide care to the underserved. Finally, state Medicaid programs are implementing a host of payment and delivery reforms in pursuit of higher-quality care, better patient outcomes, and reduced costs. A central emphasis of these new approaches is more integrated care, sometimes encompassing an expanded range of health and social services and supports, as well as innovative workforce and other strategies for expanding access. With growing recognition that oral health is essential to overall health and well-being, these new models of care present potential for increasing access to dental care and improving dental care and outcomes for both children and adults in Medicaid.

Appendix

Table 1: Oral Health Access in the States – Selected Measures					
	Medicaid Income Eligibility Limits for Adults (as % of FPL):[1]				
State	Parents (in a family of three)	Childless Adults	Percent of Adults** ≤138% FPL Reporting "Poor" Condition of Mouth/Teeth, 2015[2]	Scope of Medicaid Adult Dental Benefits[3]	Percent of Medicaid Children who received preventive dental visit in 2013[4]
Medicaid Expansion States:					
Alaska	143%	138%	14%	Extensive	42%
Arizona	138%	138%	25%	None	46%
Arkansas	138%	138%	32%	Limited	50%
California	138%	138%	20%	Extensive	37%
Colorado	138%	138%	10%	Limited	51%
Connecticut	155%	138%	14%	Extensive	60%
Delaware	138%	138%	19%	None	46%
DC	221%	215%	6%	Limited	50%
Hawaii	138%	138%	12%	Emergency-Only	44%
Illinois	138%	138%	20%	Limited	52%
Indiana	139%	139%	20%	Limited	38%
Iowa	138%	138%	9%	Extensive	50%
Kentucky	138%	138%	21%	Limited	43%
Louisiana*	138%	138%	27%	Limited	48%
Maryland	138%	138%	18%	Emergency-Only	53%
Massachusetts	138%	138%	15%	Extensive	54%
Michigan	138%	138%	20%	Limited	40%
Minnesota	138%	138%	17%	Limited	38%
Montana	138%	138%	21%	Limited	48%
Nevada	138%	138%	13%	Emergency-Only	45%
New Hampshire	138%	138%	17%	Emergency-Only	56%
New Jersey	138%	138%	15%	Extensive	47%
New Mexico	138%	138%	17%	Extensive	51%
New York	138%	138%	12%	Extensive	41%
North Dakota	138%	138%	14%	Extensive	29%
Ohio	138%	138%	9%	Extensive	21%
Oregon	138%	138%	20%	Extensive	40%
Pennsylvania	138%	138%	20%	Limited	40%
Rhode Island	138%	138%	15%	Extensive	41%
Vermont	138%	138%	19%	Limited	59%
Washington	138%	138%	18%	Extensive	55%
West Virginia	138%	138%	27%	Emergency-Only	46%
Non-Expansion States					
Alabama	18%	0%	19%	None	52%
Florida	34%	0%	26%	Emergency-Only	NR
Georgia	37%	0%	24%	Emergency-Only	50%
Idaho	26%	0%	14%	Emergency-Only	56%
Kansas	38%	0%	21%	Limited	46%
Maine	105%	0%	21%	Emergency-Only	40%
Mississippi	27%	0%	20%	Emergency-Only	48%
Missouri	22%	0%	25%	Limited	NR
Nebraska	63%	0%	13%	Limited	52%
North Carolina	44%	0%	15%	Extensive	49%
Oklahoma	44%	0%	18%	Emergency-Only	47%
South Carolina	67%	0%	21%	Limited	51%
South Dakota	52%	0%	18%	Limited	41%

Table 1: Oral Health Access in the States – Selected Measures					
	Medicaid Income Eligibility Limits for Adults (as % of FPL):[1]				
State	Parents (in a family of three)	Childless Adults	Percent of Adults** ≤138% FPL Reporting "Poor" Condition of Mouth/Teeth, 2015[2]	Scope of Medicaid Adult Dental Benefits[3]	Percent of Medicaid Children who received preventive dental visit in 2013[4]
Tennessee	101%	0%	16%	None	49%
Texas	18%	0%	24%	Emergency-Only	53%
Utah	45%	0%	13%	Emergency-Only	52%
Virginia	39%	0%	28%	Limited	48%
Wisconsin	100%	100%	21%	Extensive	25%
Wyoming	57%	0%	20%	Limited	41%
US	**138% (median)**	**138% (median)**	**19%**	**NA**	**48% (median)**

NOTES:
NR- Not Reported
* LA's Governor signed an Executive Order to adopt the Medicaid expansion on 1/12/16, but coverage under the expansion is not yet in effect. For purposes of this analysis, LA is considered an expansion state.
**Adults age 18 and older
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Medicaid Adult Dental Benefits: An Overview

Access to oral health care for low-income adults is a persistent challenge in the United States. As many states expand Medicaid coverage for adults through the Affordable Care Act (ACA), there are new opportunities to expand much-needed dental coverage and avoid the dangerous and costly consequences of untreated dental disease.

Scope of the Problem

Low-income adults suffer a disproportionate share of dental disease, and are 40 percent less likely to have a dental visit in the past 12 months, compared to those with higher-incomes.[i] Forty-two percent of low-income adults ages 20 to 64 have untreated tooth decay, and more than one-third of those 65 or older have lost all of their teeth.[ii] Adults who are disabled, homebound, or institutionalized have an even greater risk of dental disease.[iii]

Poor oral health can elevate risks for chronic conditions such as diabetes and heart disease, as well as for lost workdays and reduced employability.[iv] It can also lead to the preventable use of costly acute care. A recent study identified $2.7 billion in dental-related hospital emergency department visits in the U.S. over a three-year period. Thirty percent of these visits were by Medicaid-enrolled adults, and over 40 percent were by individuals who were uninsured.[v]

Challenges to Oral Health Care Access and Utilization for Low-Income Adults

Inadequate Dental Coverage: While comprehensive dental coverage is mandatory for children enrolled in Medicaid, dental benefits for Medicaid-eligible adults are optional. States have considerable flexibility in determining the scope of dental services covered. As a result, Medicaid adult dental coverage varies tremendously across states, and is limited in some cases to emergency services such as tooth extractions, or to specific populations such as pregnant women.[vi] In response to fiscal challenges, many states reduced or eliminated Medicaid dental coverage over the past decade,[vii] with a concurrent 10 percent decline in oral health care utilization among low-income adults.[viii]

Insufficient Provider Availability: Medicaid enrollees often have difficulty finding Medicaid-contracted dental providers. Only 20 percent of dentists nationwide accept Medicaid, citing burdensome administrative requirements, missed appointments, lengthy payment wait times, and low reimbursement rates as barriers to participation.[ix,x]

Individual Barriers: Disparities in dental access and utilization for low-income adults are often exacerbated by challenges in making work or child care arrangements and/or obtaining transportation to appointments as well as covering the cost of required copayments. Additional issues that may pose barriers include: (1) a lack of awareness of dental benefits; (2) gaps in oral health literacy; (3) the perception that oral health is secondary to general health; and (4) primary care providers who may not encourage oral health care.[xi,xii]

Medicaid Coverage of Adult Dental Benefits: Medicaid Base and Expansion Populations

The ACA provides new opportunities for states to leverage federal dollars and extend dental access to low-income adults through Medicaid expansion. A state can offer a dental benefits package to its expansion population that is either the same or different than what is provided to its base Medicaid population.[xiii] Dental benefits covered by state Medicaid programs typically fall into three general categories:[xiv]

- ***Emergency Only***: Relief of pain under defined emergency situations.
- ***Limited***: Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the American Dental Association (ADA); per-person annual expenditure for care is $1,000 or less.
- ***Extensive***: A comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the ADA; per-person annual expenditure cap is at least $1,000.

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Nearly all states (46) and the District of Columbia offer some dental benefit to their base adult Medicaid population. Thirty-three states cover services beyond defined emergency situations (e.g., uncontrolled bleeding, traumatic injury), and among those, 15 offer extensive services. The majority of states currently expanding Medicaid – 29 out of 31 – plan to offer the same dental benefits package to both their base and expansion populations.[xv]

EXHIBIT 1: **State Medicaid Coverage of Adult Dental Benefits by Type of Beneficiary Population (Base or Expansion)**[xvi]

Dental Benefits Category	Offered to Medicaid Base Population	Offered to Medicaid Expansion Population
No dental benefits	4 states: AL, **AZ, DE**, TN	4 states: AZ, DE, MT, ND
Emergency-Only	14 states: FL, GA, **HI**, ID, ME, **MD**, MS, MO, **NV**, **NH**, OK, TX, UT, **WV**	5 states: HI, MD**,** NV, NH, WV
Limited	18 states: **AR**, **CO**, **DC**, **IL**, **IN**, KS, **KY**, LA, **MI**, **MN**, **MT**, NE, **PA**, SC, SD, **VT**, VA, WY	10 states: AR, CO, DC, IL, IN, KY, MI, MN, PA, VT
Extensive	15 states: **AK**, **CA**, **CT**, **IA**, **MA, NJ**, **NM**, **NY**, NC, **ND**, **OH**, **OR**, **RI**, **WA**, WI	12 states: AK, CA, CT, IA, MA, NJ, NM, NY, OH, OR, RI, WA

Notes: Bolded states have decided to expand Medicaid eligibility under the ACA. DC is included as a state. Montana and North Dakota offer different categories of benefits to their Medicaid base vs. expansion populations. Idaho offers limited Medicaid dental benefits beyond emergency care to pregnant woman and adults with disabilities and/or other special health care needs. Maryland's contracted managed care organizations provide a limited dental benefit to adult Medicaid beneficiaries who are enrolled in managed care.

State Strategies to Increase Dental Coverage and Access for Adults

States are engaging in a variety of strategies to promote adult coverage and access to oral health care. These include tailoring oral health literacy campaigns to educate eligible adults about coverage options; developing coalitions of likeminded partners to build political support; and expanding the dental workforce to include mid-level providers such as dental therapists, who can be trained and licensed to perform preventive care and routine restorative procedures.[xvii]

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[i] The Kaiser Commission on Medicaid and the Uninsured (2012). "Oral Health and Low-Income Nonelderly Adults: A Review of Coverage and Access." Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/03/7798-02.pdf.

[ii] National Center for Health Statistics, Centers for Disease Control and Prevention (2011). "Selected Oral Health Indicators in the United States, 2005-2008." Available at http://www.cdc.gov/nchs/data/databriefs/db96.htm.

[iii] The Institute of Medicine (2011). "Improving Access to Oral Health Care for Vulnerable and Underserved Populations." Available at: http: //www.hrsa.gov/publichealth/clinical/oralhealth/improvingaccess.pdf.

[iv] National Academy for State Health Policy (2008). "Medicaid Coverage of Adult Dental Services." Available at http://www.nashp.org/sites/default/files/Adult Dental Monitor.pdf.

[v] V. Allareddy, S. Rampa, M. Lee, V. Allareddy, and R. Nalliah. "Hospital-based Emergency Department Visits Involving Dental Conditions: Profile and Predictors of Poor Outcomes and Resource Utilization. *Journal of the American Dental Association*, 145, no.4 (2014): 331-337.

[vi] Health Policy Institute, American Dental Association (2014). "More than 8 Million Adults Could Gain Dental Benefits through Medicaid Expansion." Available at http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0214_1.ashx.

[vii] National Conference of State Legislatures (2014). "Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators." Available at: http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf.

[viii] Note: This decline was from 2002-2010. Health Policy Institute, American Dental Association (2013). "Dental Care Utilization Declined among Low-income Adults, Increased among Low-Income Children in Most States from 2000 to 2010." Available at http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0213_3.ashx.

[ix] Subcommittee on Primary Health and Aging (2012) "Dental Crisis in America: The Need to Expand Access." U.S. Senate Committee on Health, Education Labor and Pensions. Available at: http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf.

[x] National Conference of State Legislatures, op cit

xi The Kaiser Commission on Medicaid and the Uninsured (2012), op cit.

[xii] Ibid.

[xiii] S. Chazin, V. Guerra, and S. McMahon. *Strategies to Improve Dental Benefits for the Medicaid Expansion Population.* Center for Health Care Strategies. February 2014. Available at http://www.chcs.org/media/CHCS-Revised-Adult-Dental-Benefits-Brief__021214.pdf.

[xiv] Ibid.

[xv] Ibid.

[xvi] Ibid.

[xvii] Ibid.

Despite considerable progress in pediatric oral health care achieved in recent years, tooth decay remains one of the most preventable common chronic diseases of childhood. Tooth decay causes significant pain, loss of school days and may lead to infections and even death. CMS has been working with State and Federal partners as well the dental provider community, children's advocates and others to improve access to pediatric dental care for children eligible under Medicaid and the Children's Health Insurance Program (CHIP).

Use of Dental Services by Children

According to data collected for CMS's Early Periodic and Screening, Diagnostic and Treatment (EPSDT) benefit, approximately 38 percent of Medicaid eligible children received a dental service in 2008 (see Table 1). While this is an improvement over the 27 percent of children who received a dental service in 2000, it remains below the Healthy People 2010 goal of 56 percent of children having a dental visit within a year. Importantly, however, 17 States had dental service utilization rates above the average rate in Medicaid. Likewise, the use of preventive dental services also varied by States, with 10 States having at least 40 percent of children receiving a preventive dental visit in 2008. These finding are an indication that some States have identified ways of overcoming the barriers they face in improving access to oral health services.

Data from the Medical Expenditure Panel Survey (MEPS) show Medicaid performance on access to dental services in a broader context.[1] One study found that a larger percent of children with public coverage had at least one dental visit in a year than children without any coverage. While promising, these rates are still below those of privately insured children. This study also was useful in identifying children who may have greater problems accessing dental services than other children. For example, younger children (ages 2-5) and children in households where English is not the primary language, were less likely to have a dental visit in a year than their respective counterparts.

Challenges & Opportunities

The challenges to ensuring that Medicaid/CHIP eligible children receive the oral health services they are entitled to are varied. States note that enrolling sufficient dental providers and creating a dental home are continuing challenges. Administrative issues and low reimbursement rates are noted by providers as being a barrier to their participation in these programs.

To better understand how States are addressing these challenges, CMS reviewed eight States that were identified as having innovative practices and/or higher than average utilization rates.[2] From these reviews, we confirmed what we suspected: there is no "one size fits all" solution to improving access to dental services. In fact, it appears that States that use multiple activities-- including collaboration, reducing administrative barriers, and an increase in fees, have been able to improve access.

In addition to the barriers mentioned above by providers, children in Medicaid/CHIP may not have a dentist in their neighborhoods or lack transportation. They may face language barriers that make it difficult to access or receive services. Some families may not understand the importance of taking their children to a dentist for a check-up or of obtaining preventive care when there are no apparent problems. Moreover, some parents may not be aware that their children are eligible to receive dental services.

Despite the many challenges, opportunities do exist to improve access to oral health services for children. Some States are collaborating with State provider organizations, dental schools, health departments and others as a way of increasing access. Collaborations can be effective in educating dentists about Medicaid and CHIP programs, assisting them in enrolling as a provider in the program and helping the provider's staff navigate the unique Medicaid and CHIP administrative requirements such as confirming eligibility and filing claims. A number of States have increased provider rates as part of their strategies to increase children's oral health access, although fiscal conditions are an obstacle to many States increasing rates. In addition, working together to educate beneficiaries about the importance of oral health and reinforcing that message through multiple channels (e.g., Head Start programs) can provide States with opportunities to reach families and provide consistent information.

[1] "Findings on Children's Health Care Quality and Disparities." June 2009. *Agency for Healthcare Research and Quality (AHRQ).* <http://www.ahrq.gov/qual/nhqrdr09/nhqrdrchild09.pdf>28 September 2010.

[2] Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports (October 2010) http://www.cms.gov/MedicaidDentalCoverage/