Oregon Health Plan

Section 1115 Annual Report

07/01/2018 – 06/30/2019

Demonstration Year (DY): 17

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I. Introduction

A. Letter from Oregon's State Medicaid Director

The Oregon Health Authority (OHA) continues to advance the goals of its 1115(a) Oregon Health Plan (OHP) demonstration according to the Health System Transformation (HST) "levers" as identified in the waiver agreement and accountability plan. Highlights from the report include:

Lever 1: Improving care coordination

Oregon's Patient-Centered Primary Care Homes (PCPCH) continue to be trusted partners in setting the standard for transformative, whole-person, and evidence-based care. The Oregon Legislature established the PCPCH program in 2009. As of June 30, 2019, there were 621 PCPCH clinics (comprising 75% of all primary care locations), with 47 PCPCH practices achieving OHA's 5-STAR designation. 5-STAR distinguishes exemplary clinics that have implemented advanced transformative processes into their workflow using the PCPCH model framework and recommended best practices.

Lever 2: Implementing value-based payment models

In January, Oregon released its CCO 2.0 Request for Applications, which required CCOs to submit projected VBP data. OHA has developed multiple strategies for determining VBP roadmap compliance in 2020, including leadership interviews and data reporting. OHA will also require CCOs to develop new or expanded VBPs in five areas: hospital care, maternity health care, children's health care, behavioral health care, and oral health care.

Lever 3: Integrating physical, behavioral, and oral health care

Promoting health involves a variety of factors: psychological, social, communal, and economic conditions play a role in incorporating the whole patient experience in care integration. OHA is accelerating policy development related to health equity to remove barriers to primary care for communities experiencing health inequities.

OHA's Office of Equity and Inclusion developed the Regional Health Equity Coalition (RHEC) program to support local, community-driven, culturally-specific activities to address social determinants of health. All RHECs partner with local CCOs to promote system change and eliminate challenges in navigating complex health care systems for Oregonians facing obstacles to care.

Lever 4: Increased efficiency in providing care

OHA's Sustainable Relationships for Community Health (SRCH) program continues to bring together various organizations and sectors within the community, building capacity for foundational skills in systems change, project management, communications, data analysis, and evidence-informed strategies.

The current SRCH partnership list includes two SRCH Leadership Institute cohorts, 13 local public health organizations and one tribal health partner. This work includes co-developing shared goals, measurable outcomes, and specific actions with partners. The SRCH closed-loop referral process increases efficiency through coordination and tracking of care, and an improved referral process.

Lever 5: Implementation of health-related services

OHA upholds its commitment to promote CCOs' use of health-related services (HRS) by continually working to review and revise Oregon Administrative Rules and policies and upholding CCO financial reporting standards. OHA also shared guidance with CCOs about how to incorporate HRS in their care delivery practices.

Lever 6: Innovations through the Transformation Center

OHA's Transformation Center is the hub for innovation and quality improvement. CCOs continue to receive technical support, identify strategies, and learn about community practices through initiatives that advance the coordinated care model.

Innovative project and leadership development are promoted and organized through statewide CCO peer-learning opportunities, community health improvement plans, tobacco cessation webinars and activities, quarterly newsletters, and through sharing of best practices for addressing social determinants of health around the state.

Lori Coyner, State Medicaid Director

B. Demonstration description

In July 2012, the Centers for Medicare & Medicaid Services (CMS) approved an amendment and extension related to Oregon's 1115 Medicaid Demonstration waiver that transformed Oregon's health care delivery system to one of coordinated care. Fifteen coordinated care organizations (CCOs) – which geographically cover the entire state – now deliver physical, oral, and behavioral health services to approximately 90% of Oregon Health Plan (OHP) members. During the previous five-year demonstration, which ended June 30, 2017, Oregon sought to demonstrate the effectiveness of delivery system improvements under health system transformation.

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

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

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

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

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

- Conversion of the tribal uncompensated care payments to a Medicaid benefit;
- Clarifying the types of health-related services that meet the requirements specified in the Code of Federal Regulations;
- Allowing passive enrollment of Medicare and Medicaid dually-eligible individuals into CCOs with the option for each individual to opt out at any time;
- Specifying the demonstration will not impact American Indian and Alaska Natives' rights to exemption from managed care or the requirements to comply with the Medicaid Managed Care Regulations;
- Offering incentive payments to Patient-Centered Primary Care Homes and Comprehensive Primary Care Plus providers for enhanced fee-for-service delivery of care to Medicaid recipients; and
- Establishing minimum requirements for CCOs to collaborate and communicate in a timely and equitable manner with tribes and Indian Health Care providers.

C. State contacts

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II. Title

Oregon Health Plan
Section 1115 Annual Report
Reporting period: 07/01/2018 – 06/30/2019
Demonstration Year (DY): 17

III. Overview of the current quarter

A. Enrollment progress

1. Oregon Health Plan Eligibility

Oregon made significant system and process improvements to ensure compliance to federal requirements, improve the accuracy of eligibility determinations, and add efficiencies to application processes for both applicants and staff.

Among the most significant improvements to the Oregon Eligibility (ONE) system were:
- Enhancements completed in September 2018 to ensure compliance with Verify Lawful Presence Version 37 requirements for systematic verification of reported immigration statuses.
- Implementing more precise logic around the counting of income received by children.
- Improvements to ensure that households who report zero income are correctly verified against the Federal Data Services Hub (FDSH). Upon discovering that households that attested to having zero income were not always being verified against the FDSH, Oregon implemented staff process changes in March 2019 to improve how staff were understanding and inputting some of the application data. System changes were implemented in April 2019 to help ensure that application data was being entered correctly and electronic income verifications occurred appropriately on all cases. The slight reduction of Title XIX enrollment for April, May, and June 2019 may, in part, be a result of this correction effort.

Aggressive steps were taken during 2019 to add more trained staff resources throughout the state to assist with ongoing processing of medical applications and case changes that served to eliminate large backlogs of work.

The new business model is allowing for work to be completed within the required timeframes and with focused attention on timely customer service.

2. Coordinated Care Organization Enrollment

Through the extension of Oregon's section 1115(a) Medicaid demonstration, the Oregon Health Authority (OHA) expanded the coordinated care model to individuals concurrently enrolled in Medicaid and Medicare through a passive enrollment initiative. Dual-eligible Medicaid/Medicare members who were previously enrolled through an opt-in model were passively enrolled into coordinated care organizations (CCOs), with the option to opt out and return to fee-for-service at any time. Members enrolled with Medicare Advantage plans were matched with CCOs managing those plans, if possible, and offered choice in plans as available.

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

A new process was developed to address issues in which members were erroneously added to a different member's prime identification number. This was occurring due to multiple systems creating overlapping member IDs. Staff were trained in this process and quality improvement measures implemented to reduce errors. DHS|OHA's system-integration efforts continue to reduce these errors. This improved claims processing accuracy, protection of member health information, as well as enhanced coordination of benefits.

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

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

B. Benefits

The Pharmacy & Therapeutics (P&T) Committee developed new or revised prior authorization (PA) criteria for the following drugs:

- Biologics for autoimmune diseases;
- Long-acting beta-agonists (LABA);
- Long-acting beta-agonist/corticosteroid combinations (LABA/ICS);
- Long-acting muscarinic antagonists/long-acting beta-agonists (LAMA/LABA) and LAMA/LABA/inhaled corticosteroid (LAMA/LABA/ICS) combinations;
- Inhaled corticosteroids (ICS); calcitonin gene-related peptide (CGRP) inhibitors;
- Patiromer and sodium zirconium cyclosilicate; and
- PCSK9 Inhibitors.

The committee also retired the PA criteria for lomitapide and mipomersen.

The committee also recommended the following changes to the preferred drug list:

- Add gonadotropin-releasing hormone (GnRH) modifier class and designate all agents as non-preferred.
- Make Dulera, Tudorza, and Asmanex preferred.
- Make sumatriptan succinate syringes, zolmitriptan tablets, zolmititriptan rapid tablets and zolmitriptan nasal spray preferred.
- Make ezetimibe and evolocumab preferred.

The Health Evidence Review Commission (HERC) made no changes to the Prioritized List.

C. Access to care

Oregon Access Monitoring Review Plan

For the fee-for service system, Oregon continues efforts to operationalize activities identified in the Access Monitoring Review Plan (AMRP) through a dashboard that incorporates quarterly utilization rates for the required service categories, and quarterly beneficiary complaint rates. Primary monitoring functions spotlight specific regions of the state to compare access in those areas to the statewide baseline and threshold.

OHA is continuing to work with the nine federally recognized tribes through formal Tribal consultation and additional meetings to better incorporate their feedback into the plan. In Oregon, approximately 50% of tribal Oregon Health Plan members have chosen not to enroll in managed care plans. Oregon intends to update the AMRP with an additional public comment period and re-submit the plan to CMS.

Coordinated Care Organization Provider Delivery System Networks

The 2018 CCO contracts require all CCOs to demonstrate compliance with federal and state provider network standards. CCOs demonstrate this through submission of the Delivery System Network (DSN) and DSN Provider Capacity Reports. The contract deliverables, in combination with CCO Hospital Network Adequacy and Cooperative Agreements reporting, certify to OHA that all covered services are available and accessible to CCO members and that CCOs demonstrate adequate provider capacity.

OHA contracted with the Health Services Advisory Group (HSAG) to evaluate CCOs' 2018 DSN narrative reports. HSAG presented its findings on CCO compliance in a 2018 DSN evaluative report (available on OHA's website).

HSAG assessed the quality and completeness of each CCO's 2018 provider network. Due to the extent of CCO data and reporting inconsistencies, the DSN Provider Capacity Reports were not directly scored or aggregated. However, HSAG conducted comparative evaluations across CCOs and highlighted variations in the quality and completeness of data. HSAG also reviewed each CCO's DSN Narrative Report, assessed each category, and evaluated the elements of each category. Elements evaluated received a score ranging from 0 (*Not Met*) to 3 (*Fully Met*). Overall, the CCOs received a score of 71.6 points across aggregated DSN narrative categories, or approximately 91.8% of the maximum points possible. Five of the 15 CCOs met the requirements of all narrative categories.

Results

CCO Provider Network Strengths

- The majority of the CCOs described, demonstrated, and analyzed the delivery network and its adequacy of member access to health care services.
- Seven CCOs described the use of geocoding software to analyze the geographic distribution of providers relative to members, including member access to specialists in alignment with time and distance standards.
- Most CCOs took an interdisciplinary approach to address and resolve identified network capacity issues that affected members' access to covered services by involving the provider relations, customer service, compliance, and quality assurance departments.
- Most CCOs had mechanisms for analyzing the characteristics of members to ensure that cultural, language, disability, and special health care needs were met.
- All CCOs used technology to deliver team-based care with multiple CCOs reporting the use of internal care management, electronic medical records, and health informatics software systems to support care coordination, analytics, and utilization management.
- Most CCOs described their contractual relationships with local Aging and Persons with Disabilities offices, public health authorities, and mental health authorities that facilitate the coordination of care. The CCO narratives also described stakeholder representation and involvement at regularly scheduled interdisciplinary team meetings. Moreover, some stakeholder partners provided CCOs with a designated contact to assist with immediate care coordination needs and referrals.

Areas for Improvement

HSAG made several recommendations to enhance OHA monitoring, assessment, and reporting of network adequacy OHA has taken the following recommended actions to adjust the reporting process:

- Adjusted the required reporting template to minimize inconsistent interpretations of the elements and ambiguity around the appropriate type of supplemental documentation.
- Revised the Provider Capacity Report template to improve the accuracy of network capacity data.
- Aligned category elements with requirements, expanded the service category list, and updated citations.
- Established standardized time and distance standards and developed and implemented clear instructions and guidance on the appropriate method for CCOs to submit time and distance standard reporting.
- Utilized the standardized healthcare Provider Taxonomy Code Set to identify provider types.
- Established a standardized provider file layout with instruction manual. And, through HSAG, conducted technical assistance calls with CCOs on proper provider capacity reporting.
- Established compliance expectations for the Provider Capacity Report.

In the context of CCO 2.0, OHA also re-examined the DSN reports to ensure accurate reporting of comprehensive provider networks and clarify objectives of these contract deliverables. CCO and stakeholder input has been solicited by OHA as part of the CCO contracting process to address recommendations and opportunities for improvement.

D. Quality of care

Consumer Assessment of Healthcare Providers and Systems

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses provide OHA with access and quality data directly from Oregon Health Plan (OHP) clients. Regarding quality, the survey asks clients how often their health plan's customer service teams provided them the information or help they needed and how often their health plan's customer service teams treated them with respect. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

The latest survey was fielded in early 2019, and clients eligible to receive and complete the survey needed to be continuously enrolled in OHP from 6/1/2018 through 11/30/2018. Of the adults who responded, 70.39% reported being satisfied with their health plan. Responses for children's satisfaction reported that 83.43% are satisfied with their health plan. Fee-for-service clients reported lower rates of satisfaction than CCO members.

Behavioral Health Metrics

Oregon Governor Kate Brown has recommended that the state prioritize behavioral health care and its integration into the physical and oral health care systems. Seven of the CCO incentive and state performance measures assess this integration, two of which were added in 2018. The 2018 Final Performance Report, published in July 2019, reports CCO performance on all measures.

CCO Incentive Measures

- **Depression screening and follow-up plan increased** from 58.2% in 2017 to 64.0% in 2018, exceeding the 2017 benchmark of 63.0%. Thirteen CCOs improved from 2017, and 11 CCOs exceeded the benchmark for this measure.
- **Mental, physical, and dental health assessment within 60 days for children in DDHS custody** (foster care) increased 4.3% in 2018, from 82.8 to 86.7%. The benchmark is set at 90.0%.
- **Disparity measure: Emergency Department (ED) utilization among members with mental illness** was a new incentive measure for 2018. The benchmark is set at fewer than 92.9 member-months. The statewide rate improved by 5.6% from 2017, from 106.3 member-months to 100.3 member-months. Twelve CCOs improved from 2017, and four exceeded the benchmark.

State Quality and CMS Core Measures

- **Follow-up after hospitalization for mental illness** decreased from 84.7% in 2017 to 79.5% in 2018 and fell short of the 2018 benchmark of 83.5%. Five CCOs improved from 2017, and five CCOs exceeded the benchmark for this measure.
- **Follow-up care for children initially prescribed ADHD medication** rose slightly to 65.9%, beating the Medicaid National 90th percentile of 57.1%. All but one of the CCOs reported exceeding the benchmark, and 10 organizations improved from 2017. The percentage of children who had at least two follow-up visits within 270 days after the initiation phase (i.e., continuation and maintenance of ADHD care) fell slightly, from 75.4% in 2017 to 74.4% in 2018, but still exceeded the Medicaid National 90th

percentile of 69.5%. At the CCO level, eight organizations improved from 2017, and 10 exceeded the benchmark.

- **Initiation of treatment for members with alcohol or other drug dependence** increased slightly to 37.8%, but fell short of the benchmark of 40.7%. Seven CCOs improved on this measure from 2017, and five exceeded the benchmark. Continuation and engagement of treatment (percentage of members who had two or more additional services within 30 days of their initial treatment) also increased, from 11.3% in 2017 to 13.1% for 2018, and exceeded the benchmark of 12.4%. Eight CCOs improved from 2017, and nine CCOs exceeded the benchmark.

- **Follow-up after ED visit for mental illness** was a new quality measure for 2018 and assesses the percentage of ED visits for members ages 6 and older with a principal diagnosis of mental illness who had a follow-up visit for mental illness. Of the eligible members, 60.7% received follow-up care within seven days and 72.8% received follow-up care within 30 days.

Oral Health Quality Metrics

Since 2015, Oregon has measured how well CCOs deliver dental sealants to children.

During the period of July 1, 2018, through June 30, 2019, Oregon made efforts to improve oral health integration and metrics by:

- Conducting an annual clinical training for school dental sealant programs on August 17, 2018. This provided dental hygienists with technical assistance with CCO incentive metrics for 2019 and trauma-informed care practices. Programs that were unable to attend the training in person could access an OHA-produced webinar to receive technical assistance.

- Completing presentations to targeted audiences about opioid use and registration with Oregon's Prescription Drug Monitoring Program, with the goal of making oral health providers aware of their role in decreasing opioid abuse.

- Adopting an incentive metric measuring the rate of oral evaluations for adults with diabetes in the 2019 measure set

- Conducting needs-assessment calls with CCOs to determine what technical assistance they require to meet the goals of the new incentive metric.

- Disseminating a dental health awareness toolkit to CCOs and others to emphasize the role oral health plays in overall health. The toolkit includes a brochure and poster in several languages, as well as key messages, sample tweets, and social media images to share.

- Initiation for incorporating HbA1c testing, which the Oregon Board of Dentistry recently approved for dentists' scope of practice, into services that OHP members receive, by opening Medicaid billing.

- Adoption of new administrative rules that expand telehealth to include Medicaid tele-dentistry services, allowing dental clinicians to provide expanded services in underserved areas of the state.

E. Complaints, grievances, and hearings

CCO and FFS complaints

The following data is compiled from 15 CCOs and OHA (for FFS members). The annual reporting period covers July 1, 2018, through June 30, 2019.

Oregon Health Authority

Trends

	Jul – Sep, 2018	Oct – Dec, 2018	Jan – Mar, 2019	Apr – Jun, 2019
Total complaints received	5,917	5,839	5,683	6,875
Total average enrollment	1,185,394	1,180,577	1,190,032	1,131,954
Rate per 1,000 members	4.99	4.95	4.78	6.07

Barriers

CCOs report the "Access-to-care" category continues to receive the highest number of complaints. There was an average increase in complaints by 11.6% over the four quarters of the reporting period. However, the data shows a 3.16% decrease in the fourth quarter over the average of the four quarters in this category. The "Interaction with provider or plan" category showed an increase of 32% in the fourth quarter. "Client billing issues" increased by 25% over the average. FFS data continues to show that the highest number of complaints are in the "Quality-of-service" category, with the "Client-billing issues" category the next highest.

Interventions

CCOs reported continued training to customer service representatives, provider offices and clinics to ensure all complaints are accurately recorded and reported. Some CCOs reported they have completed internal upgrades to software and processes that allow them to streamline the grievance process and ensure reporting of all complaints. These upgrades reduced the number of complaints in specific areas.

Training increased awareness about the requirement to report all expressions of dissatisfaction. CCOs report they continue to see improvements in areas where they have established committees to review issues monthly that go beyond the grievance area. Some CCOs continue to add additional staff specifically to improve communication between the provider offices and the members, and one CCO reports it has increased case management staff to improve care coordination. CCOs say they see improvements based on their continued outreach and education with provider offices and clinics. CCOs in rural areas report issues with providers leaving the area and difficulty with replacing outgoing providers, which increases complaints in some areas. To improve non-emergent medical transportation (NEMT) services, CCOs report they continue bi-weekly and monthly work monitoring and training NEMT providers.

Statewide rolling 12-month totals

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

Complaint category	Jul – Sep, 2018	Oct – Dec, 2018	Jan – Mar, 2019	Apr – Jun, 2019
Access to care	3,491	3,422	2,865	3,127
Client billing issues	299	373	522	600
Consumer rights	195	207	221	202
Interaction with provider or plan	1,103	1,082	1,184	1,958
Quality of care	476	417	443	514
Quality of service	305	338	420	456
Other	48	0	28	18
Grand Total	5,917	5,839	5,683	6,875

Related data

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

CCO and FFS Appeals and Hearings

CCO Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determination (notices) issued by CCOs during this reporting period, regardless of whether an appeal was filed. The total number of notices is listed by the type of adverse benefit determination (ABD), defined in 42 CFR §438.400(b)(1-7).

For the current April–June 2019 quarter, CCOs continue to report the highest numbers of notices for pharmacy, specialty care and outpatient care determinations. Some CCOs report increased monitoring to ensure written notices are sent to members in easily understood language and include the appropriate citations. CCOs report they are tracking for timeliness, as well as reviewing for utilization and appropriateness of care, to ensure notices are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	Jul-Sep 2018	Oct – Dec 2018	Jan - Mar 2019	Apr - Jun 2019
Denial or limited authorization of a requested service	30,820	33,284	32,590	36,276
Single PHP service area, denial to obtain services outside the PHP panel	189	90	112	132
Termination, suspension, or reduction of previously authorized covered services	146	135	144	149
Failure to act within the timeframes provided in § 438.408(b)	40	48	36	41
Failure to provide services in a timely manner, as defined by the State	182	228	288	263
Denial of payment, at the time of any action affecting the claim	17,346	29,000	22,935	18,986
Denial of a member's request to dispute a financial liability	N/A	N/A	N/A	0
Grand Total	**48,723**	**62,785**	**56,105**	**55,847**
Number per 1,000 members	56	72	64	47

CCO Appeals

The table below shows the number of appeals received by CCOs during the past year. There was a 7.8% increase in the fourth quarter over the average number of appeals for the year. Overall, the percent of ABDs overturned at the plan level held relatively steady, with a 4.36% increase in the fourth quarter. CCOs reported that specialty care and pharmacy were the areas with the highest number of appeals. CCOs report that review of overturned ABDs led to more in-depth discussions and reviews, monitoring and process changes. CCOs continue to educate providers and CCO employees to improve understanding of the appeal process. CCOs also work with members to help them find services or alternative coverage options when needed.

CCO Appeals	Jul - Sep 2018	Oct – Dec 2018	Jan - Mar 2019	Apr - Jun 2019
Denial or limited authorization of a requested service	1152	1203	1281	1358

CCO Appeals	Jul - Sep 2018	Oct – Dec 2018	Jan - Mar 2019	Apr - Jun 2019
Single PHP service area, denial to obtain services outside the PHP panel	5	3	8	2
Termination, suspension, or reduction of previously authorized covered services	8	1	8	2
Failure to act within the timeframes provided in § 438.408(b)	5	2	1	1
Failure to provide services in a timely manner, as defined by the State	0	0	0	0
Denial of payment, at the time of any action affecting the claim	335	329	363	387
Denial of a member's request to dispute a financial liability	N/A	N/A	0	0
Grand Total	1505	1538	1,661	1,750
Number per 1,000 members	1.72	1.76	1.89	1.95
Number overturned at plan level	456	481	514	573
Appeal decisions pending	8	11	12	12
Overturn rate at plan level	30.29%	31.27%	30.94%	32.74%

CCO and FFS Contested Case Hearings

The following data is compiled from 15 CCOs, six dental care organizations (DCO) and OHA (for FFS members). It is important to note that FFS members may be enrolled in a DCO for dental services. The reporting period covers July 1, 2018, through June 30, 2019.

The table below shows the outcomes of these cases, some of which were decided after a contested case hearing. There were 107 cases approved prior to hearing. Members withdrew from 118 cases after an informal conference with an OHA hearing representative, and OHA dismissed 1,344 cases that were determined not hearable. Of the cases that went to hearing, the administrative law judge upheld the OHA or CCO decision in 132 cases and dismissed 76 cases for the members' failure to appear. A total of seven cases were reversed by the administrative law judge, and six cases were dismissed due to a member requesting a hearing after the allowed time frames without good cause for the late request.

Oregon Health Plan members must exhaust their appeal rights at the CCO level and receive notice of appeal resolution (NOAR) before they can request a contested-case hearing at the state level. Requests received by OHA prior to the appeal being exhausted are dismissed as not hearable with a letter to the member explaining their appeal rights through the CCO and their hearing rights after receiving an NOAR.

Contested Case Hearing Requests Processed

Outcome Reasons	Jul – Sep	Oct – Dec	Jan – Mar	Apr – Jun	Annual total
Decision overturned after second hearing	22	32	34	19	**107**
Client withdrew request after pre-hearing conference	34	23	27	34	**118**
Dismissed by OHA as not hearable	326	347	355	316	**1,344**
Decision affirmed*	45	34	21	32	**132**
Client failed to appear*	20	21	18	17	**76**
Dismissed as non-timely	2	1	2	1	**6**
Dismissed because of non-jurisdiction	1	0	0	0	**1**
Decision reversed*	1	4	0	2	**7**
Set aside	0	1	0	0	**1**
Total	**451**	**463**	**457**	**421**	**1,792**

Resolution after an administrative hearing

Related data

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

F. CCO activities

1. New plans

There are no new CCOs or other physical, behavioral, or dental plans serving the Medicaid population. During 2018, OHA engaged in the procurement process for CCO contracts in 2020. In January 2019, OHA learned that Willamette Valley Community Health (WVCH) would not apply for a new CCO contract, which means WVCH will exit the market with the conclusion of the 2019 CCO contracts.

2. Provider networks

Columbia Pacific CCO terminated its contract with Greater Oregon Behavioral Health Inc. (GOBHI) for behavioral health services effective June 1, 2019. The CCO now manages behavioral health benefits through CareOregon with the goal of providing its members a more integrated physical and behavioral health network.

Columbia Pacific submitted written notification and other supporting documents to OHA, providing information on an upcoming change to the management of their behavioral health benefit. Columbia Pacific stated that there was no change in members' ability to continue with current providers.

The updated DSN Capacity Report provided to OHA included all necessary data fields and reflected an inventory of 1,341 total providers. 1,012 (75%) responders were identified as in-network and out-of-area. This indicates that only 330 (25%) of the provider inventory are in-network and in-area.

3. Rate certifications

OHA pays CCOs with actuarially sound capitation rates that are developed on an annual basis. Capitation rates pay an amount per month depending on the individual's OHP eligibility, age and enrollment status. In addition to CCOs, OHA also retains seven DCO contracts and an MHO contract where capitation rates are developed separately.

In April 2019, the process to develop CCO capitation rates for calendar year (CY) 2020 began. Each CCO submitted their completed Exhibit L (Financial Reporting Template) to OHA to begin the rate development and data validation processes. In June, OHA met with each CCO to discuss their financial data, the rate setting data, and the encounter data, then cross-compare the data to ensure consensus on the starting point of the base data. The discussions centered on encounter data validation and CY 2018 financials. In addition, OHA met with CCOs during the June rates workgroup. OHA requested CCOs submit questions related to CCO 2.0 and the CY 2020 rate development process verbally or in writing.

4. Enrollment/disenrollment
OHA successfully transitioned Medicare-Medicaid dual eligible clients to an opt-out process for automatically enrolling into Medicaid managed care plans that are aligned with the member's Medicare Advantage plan. This will give these members better coordination of care and benefits.

There were no other changes to the eligibility and enrollment during this time period.
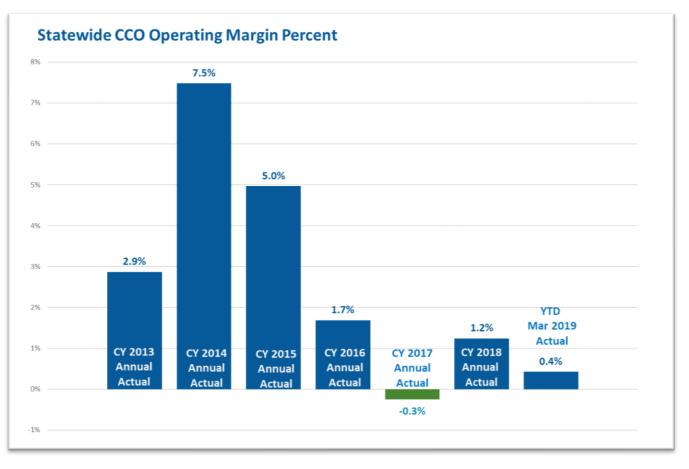
Enrollment data is listed in the actual and unduplicated enrollment table in Appendix A.

5. Contract compliance
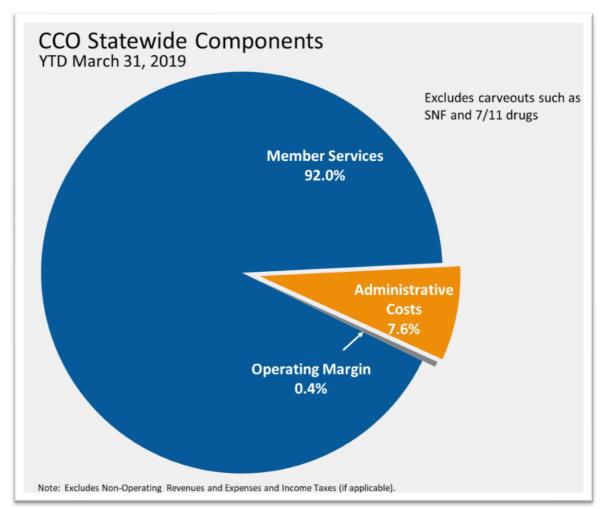There are no issues with coordinated care organization (CCO) contract compliance.

6. Relevant financial performance
As shown in the below chart, the statewide CCO operating margin was at 0.4% as of March 31, 2019, compared to 1.2% for CY 2018. For reference, the capitation rates include a 1% profit margin. CCO operating margins returned to a slightly profitable status after trending downward during 2015-2017 period.

Statewide CCO Operating Margin Percent

The CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (includes medical, behavioral, dental and health-related services, reinsurance premiums and recoveries, and other adjustments) as a percentage of total revenue. The MSR for all CCOs in aggregate was 92.0%. Administrative services accounted for 7.6% of total CCO revenue, leaving 0.4% as operating margin.

From January 1 through March 31, 2019, 13 of the 15 CCOs met or exceeded the 85% target for MSR, a key indicator for MLR, and nine of the CCOs had MSRs above 90%. Two CCOs reported MSR below 85%, Primary Health Josephine County at 84% and Yamhill Community Care at 83.2%.

CCO Statewide Components
YTD March 31, 2019

Excludes carveouts such as SNF and 7/11 drugs

Member Services 92.0%

Administrative Costs 7.6%

Operating Margin 0.4%

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

As of March 31, 2019, all CCOs met their net worth requirement. Net assets of the CCOs ranged from a low of $212 per member (Willamette Valley Community Health, LLC) to a high of $1,338 per member (Intercommunity Health Network), averaging $447 per member for the state.

7. Corrective action plans (CAP)

During the reporting period, OHA placed one CCO on corrective action:

Cascade Health Alliance (CHA) was placed on a CAP for non-compliance with their 2019 CCO contract, the Hepatitis C Risk Corridor, Oregon Administrative Rules and CFR. CHA was not timely in response to authorization requests, did not determine approvals and denials timely or appropriately, did not provide notices to members and providers, and did not provide authorized medication in a timely manner to members that qualified for treatment for Hepatitis C.

- Start date of CAP: May 20, 2019
- End date of CAP: May 20, 2020
- Action sought:
  - Immediate correction of non-compliance;
  - Development and implementation of a plan for correcting the issues identify by OHA; and
  - Submission of quarterly reports to OHA for a period of at least one year.

■ Progress during current quarter:
   o CHA provided to OHA evidence of correction of non-compliance, a CAP and two reports.

8. One percent (1%) withhold

OHA's Health Systems Division analyzed encounter data received for completeness and accuracy for CY 2018.

All CCOs except for one met the administrative performance (AP) standard for all subject months, and no 1% withholds occurred.

One CCO that did not meet the AP standard during the January 2018 subject month as submitted and approved, no 1% withhold was taken.

9. Other significant activities

There were no other significant activities reported during this demonstration year.

G. Health Information Technology

Oregon's CCOs are directed to use health information technology (HIT) to link services with core providers. They are also expected to achieve minimum standards in foundational areas of HIT and develop their own goals for the transformational areas of HIT use.

Medicaid Electronic Health Records (EHR) Incentive Program

Through the Medicaid EHR Incentive Program (also known as the Medicaid Promoting Interoperability Program), eligible Oregon providers and hospitals can receive federally funded financial incentives for adopting, implementing, upgrading, or meaningful use of certified electronic health records technology (CEHRT). Eligible provider types include physicians, naturopathic physicians, pediatric optometrists, nurse practitioners, certified nurse midwives, dentists, and certain physician assistants.

■ Since the Medicaid EHR Incentive Program's inception in 2011, 3,818 Oregon providers and 60 hospitals have received over $201 million in federal incentive payments as of June 30, 2019.

■ During this annual reporting period, a total of 1,618 providers and four hospitals received over $14 million in Medicaid EHR incentive payments.

■ Between April and June 2019, a total of 242 Oregon providers received over $2 million.

The program sunsets at the end of 2021.

Oregon Medicaid Meaningful Use Technical Assistance Program

The Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP) was in operation from spring 2016 through spring 2019 and provided technical support to Medicaid physicians, nurse practitioners, dentists, and physician assistants in certain settings. The program offered resources to help providers meet meaningful use, improve workflow, mitigate privacy and security risks, and achieve interoperability of health information exchange (HIE) to improve care coordination and service delivery.

■ Between July 2018 and June 2019, a total of 439 providers across 189 clinics received technical assistance.

- Between April 1 and May 31, 2019, a total of 87 providers across 46 clinics received technical assistance.

The program ended on May 31, 2019, having served a total of 1,269 providers across 332 clinics, with some providers receiving multiple services.

Oregon Common Credentialing Program (OCCP)

On July 25, 2018, OHA announced the suspension of the OCCP due to issues related to a lack of funding and variable stakeholder support. The OCCP was intended to be a web-based system to centralize the collection and verification of Oregon practitioner credentialing information for use by credentialing organizations. The OCCP was legislatively mandated as an administrative simplification effort to reduce the burden and duplication associated with health care credentialing and was not specific to Oregon's Medicaid program. OHA was in the testing phase of implementation.

The OCCP was intended to be solely fee-funded, and no startup funding was allocated by the legislature. As good stewards of public resources, OHA evaluated OCCP costs in light of other near-term budgetary and policy priorities and found that stakeholder support for the program had significantly diminished. Suspending the program avoided further expenditures.

OHA will continue to explore lessons learned with stakeholders and assess whether there are other opportunities to reduce administrative burdens related to credentialing. In the future, the OCCP or similar program may resurface as a priority, in which case the lessons learned, program policies, analysis, and requirements developed for the OCCP may be leveraged.

Behavioral Health

During the calendar year, OHA conducted a Behavioral Health HIT Scan, including an online survey and in-depth interviews to examine the status of HIT in Oregon's behavioral health system. The scan collected information from behavioral health entities across the state regarding HIT and HIE use, needs, challenges, and priorities. The online survey was sent to all 275 Oregon agencies operating at least one state-licensed behavioral health program, reaching a total of 874 programs. Almost half (48%) of the agencies responded, representing 60% of state-licensed behavioral health programs. The respondents showed strong engagement with the survey, with 75% agreeing to be contacted for follow-up.

The Behavioral Health HIT Workgroup was formed in August 2018 under the direction of the Health Information Technology Oversight Council (HITOC) to review the draft Behavioral Health HIT Scan and provide feedback on report recommendations and priorities. The work group met three times at the end of 2018 to discuss the survey and provide recommendations on how to expand and enhance HIT adoption and use among behavioral health providers. Recommendations were presented to HITOC at a meeting in December 2018. OHA then developed a work plan based on the recommendations from the survey and the Behavioral Health HIT Work Group.

OHA submitted a request to the Oregon Legislature during the 2019 session for funding to support the implementation of a Behavioral Health EHR Incentive Program. This request was submitted as part of the Governor's budget. The request included funding for the program itself, and for technical assistance for providers to increase capacity to asses, adopt, and utilize electronic health records. While the funding request

was not approved, the inclusion of the request in the Governor's budget request signaled support for the initiative.

The "Improving Access to Behavioral Health Information Technology Act" authorized the Center for Medicare & Medicaid Innovation (CMMI, now the CMS Innovation Center) to create a demonstration project to incentivize the adoption and use of CEHRT for behavioral health care providers. The goals are to decrease the gap in behavioral health EHR adoption and improve the coordination and quality of care for Americans with mental health, substance use disorder, and other behavioral health care needs.

HIT Commons

HIT Commons is a public-private partnership to coordinate investments in HIT technology, leverage funding opportunities, and advance HIE across the state.

The HIT Commons Governance Board met four times between July 1, 2018, and June 30, 2019. In 2018, HIT Commons established an LLC, confirmed a board of managers and approved board terms.

HIT Commons continues its focus on promoting adoption of its two web-based communications tools, the Emergency Department Information Exchange (EDIE) and PreManage.

- **EDIE** is a collaboration between the Oregon Health Leadership Council (OHLC), OHA and other partners including hospitals, health plans, CCOs and emergency department (ED) physicians. EDIE collects ED and inpatient Admit Discharge Transfer (ADT) data from hospitals and pushes notifications back to the ED in real time. The EDIE notifications provide information about the patient's care history, ED visits, known providers, care coordination, and care guidelines.
- **PreManage** is a companion software tool to EDIE. It brings the same real-time hospital event notifications (ED and inpatient ADT data) to those outside of the hospital system, such as health plans, CCOs, providers, and care coordinators.

Used statewide, both EDIE and PreManage help reduce ED utilization, improve care coordination and care management, and serve as the platform for the Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative.

PreManage is used by all of Oregon's CCOs and DCOs, most major Oregon health plans, four tribal clinics, behavioral health providers, and all of Oregon's Area Agency on Aging and Aging & People with Disabilities District offices. The Oregon Department of Human Services' Developmental Disability programs and the Oregon State Hospital are in phased rollouts.

EDIE/PreManage highlights, 07/01/2018-6/30/2019:

- Hospitals that have integrated EDIE into their EHR may now include PDMP data in their EDIE alerts.
- Hospitals that receive EDIE notifications via fax now receive a Physician Order for Life Saving Treatment (POLST) as a print-out along with the EDIE notification. As of March 2019, PreManage users may request POLST forms in their portal for assigned patients.
- Established a target for a 3% reduction in ED visits by end of 2020.
- PreManage began a rollout to skilled nursing facilities across Oregon in 2019. More than 80 out of nearly 200 are live.

Oregon Health Authority

For CCOs and their contracted clinics, the ED Disparity Measure flag in PreManage now shows when a Medicaid member with serious and persistent mental illness (SPMI). This supports better real-time care coordination for that member.

Oregon Prescription Drug Monitoring Program Integration Initiative

The Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative, administered by OHA's Public Health Division, connects EDIE, HIE, and other HIT systems to Oregon's PDMP, which includes prescription fill information on controlled substances. This initiative aligns with broader state and federal efforts to increase the use of PDMPs to reduce inappropriate prescriptions, improve patient outcomes, and promote more informed prescribing practices.

PDMP Integration capabilities went live in summer of 2017 and the statewide subscription funding officially launched through the HIT Commons in spring 2018.

- 7,572 prescribers across 122 organizations have integrated access to Oregon's PDMP data–either through their EDIE alerts, or through one-click access at the point of care.
- 570 pharmacists at four retail pharmacy chains (across 75 sites) are also live.
- Interstate data sharing is established with PDMPs in Idaho, Kansas, Nevada, Texas, North Dakota, and Washington (web portal only in Washington). Alaska, Wyoming and California are in progress.

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

Social Determinants of Health (SDOH) and HIT

In the first half of 2018, the HIT Commons began exploring the concept of a statewide SDOH resource directory and referral network, currently referred to as the Oregon Community Information Exchange (CIE). The goal is to make it easier for health care providers and the social services sector to refer patients to an up-to-date social services resource directory, and to receive information about the outcome of the referral.

In spring 2019, the HIT Commons conducted 20 interviews with stakeholders to understand the existing SDOH landscape in Oregon. Initial recommendations were discussed at the May HIT Commons Board meeting, including a plan to conduct a statewide roadmap for an SDOH CIE network. It was agreed to formalize recommendations and present them to a larger set of stakeholders throughout summer 2019.

Oregon Provider Directory (OPD)

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

The OPD will benefit CCOs by supporting care coordination, administrative efficiencies, and serve as a resource for heath analytics. OPD will:

- Provide one place to go for accurate and complete provider data.
- Reduce burden on providers and staff time spent on data maintenance activities.

- ■ Enable better care coordination for patients and ability to meet certain meaningful use objectives by supplying complete information on providers and how to contact them.
- ■ Improve the ability to calculate quality metrics that require detailed provider and practice information.

The OPD will go-live, via a soft launch to a small set of users, in 2019. The HIT Commons is working with OHA staff and stakeholder volunteers to develop an initial use case test for the soft launch. Additional users will be added in later phases as data become more robust.

Flat-File Directory (FFD)

The FFD is Oregon's combined address book for direct secure addresses. The FFD voluntary program allows participants throughout Oregon to submit direct secure message addresses and then find or "discover" direct addresses outside of their own organizations. The addresses are compiled into one document that is distributed monthly to the participating organizations. The FFD is offered at no cost to users. To join the FFD, participants must use a fully accredited DirectTrust Health Information Service Provider, thus allowing for directed exchange to improve care coordination and administrative efficiencies.

As of June 2019, the FFD includes more than 17,500 direct addresses from 24 interoperable participating entities that represent more than 895 unique health care organizations (primary care, hospital, behavioral health, dentistry, FQHC, etc.). Over time, the FFD will transition to the OPD.

Clinical Quality Metrics Registry

Oregon's Clinical Quality Metrics Registry (CQMR) collects, aggregates, and provides clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting.

The CQMR went live in January 2019 for Medicaid EHR Incentive Program/Promoting Interoperability users to submit electronic clinical quality measures (eCQMs). In February 2019, it went live with the option to report eCQMs to CMS for the Merit-based Incentive Payment System (MIPS) and Comprehensive Primary Care Plus (CPC+) for 2018. OHA continues to engage with stakeholders through a subject matter expert workgroup and other outreach to prepare for CCOs to use the CQMR for 2019 reporting, with pilots ahead of the reporting deadlines. In addition, ongoing technical assistance is offered through a contract with Oregon Health & Science University (OHSU), to help clinics prepare for patient-level eCQM reporting (QRDA I).

H. Metrics development

OHA continued reporting on CCO and state performance measures in monthly dashboards and continued measure development and validation work. Throughout this reporting period, OHA engaged stakeholders in the measurement strategy through public committees and workgroups including the Metrics and Scoring Committee and the Metrics Technical Advisory Workgroup. Both meet monthly.

Metrics and Scoring Committee

The Metrics and Scoring Committee (MSC) met monthly during the reporting period.

At the June 2019 meeting, the Committee reviewed a letter from Governor Kate Brown urging it to include measures in the 2020 incentive measure set that are transformational and in alignment with the goals in the new

CCO contracts to begin in 2020, and to prioritize measures that support children's health, health equity, and access to behavioral healthcare.

Health Aspects of Kindergarten Readiness Technical Workgroup

From July 2018 to January 2019 the Health Aspects of Kindergarten Readiness Technical Workgroup finalized its multi-year measurement strategy, which focuses on health system behavior change, investments, and cross-sector efforts that are the drivers to improved kindergarten readiness. The MSC approved the strategy in December 2018, and the Health Plan Quality Metrics Committee (HPQMC) approved it in January 2019.

Since then OHA and Children's Institute have formed a small workgroup to develop the second part of the measurement strategy: a plan-level measure to track CCO activities to identify and address social-emotional health issues in young children. Bimonthly internal meetings for this work began in April 2019, and will continue through October 2020, with the goal of developing a measure that the MSC could choose to include in the CCO quality incentive program in 2022.

OHA has partnered with the Oregon Department of Education's Early Learning Division to apply for participation in the Center for Health Care Strategies' *Aligning Early Childhood and Medicaid,* a multi-state initiative aimed at improving the health and social outcomes of low-income infants, young children, and families through cross-agency collaboration.

Social Determinants of Health / Health-Related Social Need Measure

Both the MSC and HPQMC requested the development of a measure related to the social determinants of health / individual health-related social need. At its August 2019 meeting the MSC clarified that while long-term aims are to address the social determinants of health, initial measure development should focus on addressing individual health-related social needs. After these decisions, OHA formed an internal planning team to conduct research and staff the to-be-formed public workgroup which will make recommendations on the measure.

The next step will be to form a public workgroup to consider and develop recommendations back to the MSC and HPQMC.

Evidence-Based Obesity Measure Workgroup

During this reporting period, OHA worked on the development of an evidence-based obesity measure for use in the state of Oregon. An initial workgroup met to develop a metric that leverages evidence-based best practices and measures both process and outcome results. Membership included OHA staff from the Public Health Division and the Health Policy and Analytics Division, CCO representatives and local public health representatives.

In August 2018, the workgroup moved forward a proposal for a two-part measure. Part 1 focuses on investments in multisector interventions, and Part 2 will measure the documentation of BMI, referral to intervention and follow-up on referral.

The technical workgroup for Part 2 held several meetings between January and April 2019 to develop draft measure specifications. A feasibility review is currently underway by OHA's Health Policy and Analytics Division with consultation from partner measurement experts.

Health Equity Measurement Workgroup

During this reporting period, the Oregon Health Policy Board tasked OHA with developing recommendations for measuring health equity in Oregon's healthcare system. In October 2018, the Health Equity Measurement Workgroup convened. The workgroup was co-chaired by the director of OHA's Office of Equity and Inclusion and the director of OHA's Office of Health Analytics.

The workgroup embarked on a fast-tracked process to include a health equity measure in the HPQMC measure menu set for 2020. The workgroup developed and proposed a measure to capture the proportion of visits with spoken and sign language interpreter needs that were provided by OHA qualified and certified interpreters. The goal of the measure is to achieve meaningful access to health care services for all CCO members through quality communication and language access services, and the delivery of culturally responsive care. The measure was developed in collaboration with impacted communities and various measurement Committee members and experts.

I. Budget Neutrality

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

Reports are attached separately as Appendix D – Neutrality Reports.

J. Legislative activities

The 2019 Session of the Oregon Legislative Assembly adjourned sine die on June 30, 2019. The legislature heard three bills to provide sustained funding for the Oregon Health Plan. Two of the three measures passed, significantly closing the funding gap for years to come. OHA will continue to evaluate the third measure – an assessment on large employers who do not cover some portion of employees' health care costs – for possible consideration in a future session.

House Bill 2010 updates existing assessments on health plan premiums and hospitals and extends them for another six years to ensure long-term funding. The bill makes the following changes to existing law, effective January 1, 2020:

- The managed care (CCO) premium assessments collected by OHA will be increased from 1.5% to 2% and includes stop-loss insurance as part of the calculation.
- The bill authorizes continued collection of the assessment from CCOs through 2026. The bill also extends the hospital assessment through 2025.

House Bill 2270 increases the cigarette tax by $2 per pack and extends the tax on other tobacco products to inhalant delivery systems (e-cigarettes). Of these revenues, 90% will fund OHP and 10% will fund culturally responsive tobacco cessation and prevention services. This measure goes to a public vote in November 2020.

Of note, the OHA budget includes:

- $4.7 million to begin offering a universal newborn home visiting program to Oregon Health Plan members.

- $10 million for suicide prevention and expansion of mental health access in schools. The need for mental health access is especially great at the elementary- and middle-school levels and supports prevention of suicide by providing earlier intervention when it is most urgent.
- $19.6 million for intensive in-home behavioral health services for children. Due to a lack of intensive community-based services, many Medicaid-eligible youth are referred to residential care instead of receiving treatment in their home community. Creating and funding new intensive care opportunities in the community would increase diversity of services available to Oregon's Medicaid-eligible youth and provide alternatives to residential services.

Other 2019 legislation impacting Oregon's Medicaid program included:

House Bill 2257 defines substance use disorder (SUD) as a chronic disease rather than an acute illness and addresses access, payment, and affordability of treatment services among commercial and public payers, effective January 1, 2020. It also requires that OHA prohibit CCOs and public payers of health insurance from requiring prior authorization for reimbursement of medication-assisted treatment (MAT) for SUD during the first 30 days of treatment.

House Bill 2267 puts the Oregon Health Policy Board recommendations into state law, including requiring CCOs to have at least two community representatives on their governing board, requiring CCOs, local public health authorities, and hospitals to partner to develop shared community health assessments and improvement strategies, and establishing tribal liaisons and a tribal advisory council for CCOs. OHA's budget also includes 15 new positions to implement CCO 2.0, many of them focused on complaints and enforcement. Effective upon passage.

Senate Bill 1 allows for OHA, the Oregon Youth Authority and DHS to contract for interdisciplinary assessment teams to provide services to youth, increase statewide capacity, and prioritize evaluation, assessment, and stabilization services provided to youth. Effective upon passage.

Senate Bill 134 requires each CCO to publish on their website a document to educate members about treatment options and support resources available for members who have mental illnesses or substance use disorders. CCOs will be required to reimburse for tribal-based practices provided to American Indian and Alaska Native patients for mental health and substance abuse prevention, counseling, and treatment. OHA has acknowledged the intent to implement the reimbursement requirement upon receiving approval for that authority through future waivers. Effective January 1, 2020.

Senate Bill 1041 increases accountability and transparency in CCO finances based on best practices established by the National Association of Insurance Commissioners and provides OHA with tools to identify when a CCO's financial condition deteriorates – and to intervene if it does – to protect CCO enrollees from losing their access to health care.

K. Litigation status

Lawsuits and legal actions

Open lawsuits and legal actions related to the Oregon Health Plan, to which the State Medicaid agency (Oregon Health Authority) is a party to, are listed in aggregate. Lawsuits and legal actions include anything that is currently open in court, excluding estate recovery, during the reporting period.

Bay Area Hospital v. Oregon Health Authority

Litigation pertains to a legislatively passed assessment on hospital to support the Oregon Health Plan. According to the complaint, revisions to the assessment exempt all hospitals from the assessment except the plaintiff. The request for relief is for a declaration that petitioner is not subject to the "tax" and refund and costs of litigation are due the petitioner.

Connecticut v. Generic Drug Manufacturers and Wisconsin v. Invidior

These suits involve the State of Oregon (not the agency specifically) joining class action litigation. Purchase of pharmaceuticals by the agency for OHP clients are indicated as applicable data.

Sarepta Therapeutics Inc. v. OHA

This is a petition for judicial review of the agency's prior authorization criteria that are the rule for determination for Oregon Health Plan coverage of the prescription medication Exondys 51.

L. Public forums

Health Evidence Review Commission

The Health Evidence Review Commission (HERC) reviews clinical evidence to prioritize health spending and guide OHA in making benefit-related decisions for its health plans. HERC promotes evidence-based medical practice statewide. Public comment from HERC meetings are listed below.

August 9, 2018

The commission heard testimony on the Chronic Pain Task Force (CPTF) proposal to create a new line in the funded region of the Prioritized List to provide the coverage of treatments for five currently nonfunded conditions involving complex pain syndromes including fibromyalgia.

October 4, 2018

The commission discussed and approved a coverage guidance and corresponding Prioritized List changes encouraging the use of single fraction radiotherapy for palliation of bone metastases. They also discussed and approved a coverage guidance recommending against coverage of implantable wireless pulmonary artery pressure monitors for heart failure monitoring based on insufficient evidence of effectiveness.

November 8, 2018

The commission heard testimony to consider updating the 2015 coverage guidance on planned out-of-hospital births based on a rescan of new evidence that had become available since 2015.

January 17, 2019

The commission heard testimony on the final CPTF proposal. They also heard testimony concerning the draft coverage guidance on temporary mechanical circulatory support with Impella devices, recommended by the Evidence-based Guidelines Subcommittee (EbGS). HERC referred the coverage guidance back to EbGS for further consideration.

March 14, 2019

The commission heard additional testimony on the staff-modified CPTF proposal, with final consideration to take place at the May 2019 meeting.

May 16, 2019

The commission heard more testimony on the CPTF proposal, with staff outlining three options for consideration. HERC decided not to reprioritize the five chronic pain conditions due to a lack of established effectiveness of treatments. Based on the extensive public input, however, they modified the existing guideline on the treatment of back and neck pain to allow the use of long-term chronic opioids in those patients who have shown significant benefit and have experienced no adverse effects.

They also heard additional testimony concerning the draft coverage guidance on temporary mechanical circulatory support with Impella devices. HERC tabled approval of the coverage guidance to a future meeting, but did approve changes to the Prioritized List that provided expanded coverage of these devices beyond what was recommended by EbGS, including for certain individuals with acute coronary syndrome without cardiogenic shock and those experiencing cardiogenic shock who are candidates for transplantation or a left-ventricular assist device (LVAD).

HERC Value-based Benefits Subcommittee

Composed of commission members, providers and other stakeholder representatives, the HERC's Value-based Benefits Subcommittee (VbBS) reviews all potential changes to the Prioritized List. Interim modifications to the Prioritized List of Services are initially forwarded to the VbBS for consideration, which will often require at least two meetings to first hear the request and then have staff collect the necessary information to decide on an action. The Commission's decisions are always based on what is best for the entire OHP population and not on one individual case.

August 9, 2018

The committee heard testimony on the CPTF proposal.

October 4, 2018

Testimony for this meeting related to consideration of adding coverage for human donor breast milk for infants born prematurely, which was recommended by VbBS and approved by HERC.

November 08, 2018
Testimony for this meeting related to multiple topics on genetics testing:
- Expanding coverage for carrier screening through panel testing;
- A request to remove restrictions on who can provide genetic counseling in cases of elective testing in asymptomatic patients for hereditary cancers;
- A request to expand non-invasive prenatal screening (NIPS) to all women, not just those with a high risk of chromosomal anomalies.

Ultimately, HERC accepted the VbBS recommendations to not expand carrier screening; retain restrictions on who can provide genetic counseling; and not expand NIPS coverage to average-risk women.

January 17, 2019
Like HERC, VbBS heard testimony on the final proposal of CPTF.

March 14, 2019
Like HERC, VbBS heard additional testimony on the staff-modified CPTF proposal, with final consideration to take place at the May 2019 meeting.

May 16, 2019
Like HERC, the Committee heard more testimony on the CPTF proposal and the three options outlined by staff for consideration.

HERC Evidence-based Guidelines Subcommittee
The HERC Evidence-based Guidelines Subcommittee, elected in September 2014, is one of three subcommittees created under the HERC. EbGS looks at evidence-based guidelines on the evaluation and management of low-back pain.

July 12, 2018
EbGS received testimony related to a draft coverage guidance on the urine drug testing (UDT).

September 6, 2018
Further testimony was received related to a draft coverage guidance on the urine drug testing (UDT). EbGS recommended and HERC approved a recommendation that reasonable "soft" limits be placed on UDT for substance use disorder, harder limits be placed on UDT for opioid treatment for chronic pain based on patient risk of abuse, and no recommendation of limits was made for cases pertaining to child welfare.

November 1, 2018
Testimony related to the consideration of updating the coverage guidance on planned out-of-hospital births based on a rescan of new evidence that has become available since its completion in 2015. The following week HERC did decide to proceed with the process to update this coverage guidance.

February 7, 2019

Testimony for this meeting related to the initiation of the process to update HERC's 2015 coverage guidance on planned out-of-hospital births.

April 4, 2019

The committee heard additional testimony related to updating the 2015 coverage guidance on planned out-of-hospital births.

EbGS also heard testimony on the reconsideration of its draft coverage guidance on temporary percutaneous mechanical circulatory support with Impella devices, which was again forwarded to HERC, this time with slightly expanded coverage criteria of the same populations that were previously included.

June 6, 2019

The committee heard more testimony related to updating the 2015 coverage guidance on planned out-of-hospital births with committee discussion of the topic planned to continue through at least December.

HERC Health Technology Assessment Subcommittee

The HERC Health Technology Assessment Subcommittee develops medical technology assessments where technology assessments from trusted sources do not exist or require the consideration of additional evidence. Medical Technology Assessments include a new search of the current peer-reviewed research on the topic. HERC coverage guidance may be based on evidence-based guidelines developed by HTAS.

September 27, 2018

Testimony for this meeting related to a draft coverage guidance on FDA-approved next generation sequencing (NGS) tests for tumors of diverse histology. At the conclusion of this meeting the development of the coverage guidance was tabled until further evidence anticipated from randomized controlled trials are completed, which may be available as early as 2019.

November 15, 2018

Testimony for this meeting related to recently passed legislation that directed HERC to develop evidence-based guidelines on patient characteristics and appropriate procedure in the use of newly authorized extended stay centers (ESCs) to be associated with ambulatory surgical centers (ASCs). These ESCs will allow patients to receive care in an ASC/ESC up to a combined 48 hours, compared to the 24-hour maximum currently allowed in ASCs.

February 21, 2019

There was no public testimony heard at this meeting as the committee approved the release of a draft ESC report for a 30-day public comment period.

April 18, 2019

No public comment was received to review, and the committee forwarded their report to HERC, which includes a guideline that recommends that the presence of an ESC should not expand the surgical risk profile or the

procedures permissible in an ASC. Rather, ESCs should be utilized for patients who need extra time for managing pain or bodily functions, who do not have a caregiver at home, or who may require extended travel time to return home after a surgical procedure.

Note that no additional meetings of HTAS are planned as of this time and that the development of all coverage guidance and multisector intervention reports will be initiated in EbGS for the foreseeable future.

Chronic Pain Task Force

The HERC Chronic Pain Task Force (CPTF) is an ad hoc group representing pain care providers and the patients they treat. It was created to help HERC staff form a proposal on potential changes to the Prioritized List related to the treatment of nonpalliative, noncancer chronic pain other than back pain. This proposal is expected to focus on the use of nonpharmacologic treatments not currently covered under the Oregon Health Plan (OHP) for certain conditions involving chronic pain and potential limits of pharmacological treatments, such as opioids, that have evidence of harm. This proposal will be taken to the Value-based Benefits Subcommittee and then HERC for consideration in early 2019 as part of the biennial review of the Prioritized List.

September 20, 2018

Testimony for this meeting related to the CPTF proposal originally presented at August VbBS meeting. This testimony focused on the use of long-term opioid therapy.

December 5, 2018

Further testimony was heard on the CPTF proposal, which again focused on the use of long-term opioid therapy. The revised proposal sent back to VbBS at the end of this meeting included an individualized opioid tapering plan that did not necessarily taper down to zero for patients with certain conditions who were stable.

Genetics Advisory Panel

The Genetics Advisory Panel (GAP) assists in developing recommendations on the potential coverage and prioritization of specific genetic testing, including potential coverage of gene panel testing, exome and genomic testing, and mitochondrial genome testing.

October 10, 2018

The panel heard testimony that advocated the coverage of non-invasive prenatal screening (NIPS) for all pregnant women. The panel said they will continue to monitor ACOG guidelines to see if they change their guidelines in favor of screening in a broader population.

Testimony was also received on the coverage of whole exome sequencing, which was not on the agenda, and the panel will plan to discuss this at a future meeting when they can review the evidence.

Medicaid Advisory Committee

The Medicaid Advisory Committee (MAC) is a federally mandated body that advises the State Medicaid Director on the policies, procedures, and operation of Oregon's Medicaid program (OHP) through a consumer and community lens. The MAC develops policy recommendations at the request of the governor, the legislature and OHA.

July 25, 2018

The committee heard updates on the Oral Health Program and discussed the initial draft of MAC guidance document for CCOs, which explains how to use Health Related Services to provide housing-related services for members.

September 26, 2018

The committee was given updates on the CCO Incentive Measure Program implemented in January 2019. Mike McCormick from DHS Aging and People with Disabilities gave a basic 101 presentation on the goals of the Long-term Services and Supports (LTSS) system and coordination.

October 24, 2018

The committee received an update about the Department of Homeland Security's proposed changes to the federal public charge rule, which governs how the government determines whether an immigrant is likely to become a public charge. Staff from OHA, and the Oregon Governor's office shared additional information about the rule and how it could affect Oregon's Medicaid program.

December 5, 2018

The committee received Medicaid staffing updates. Dana Hittle was introduced as the new interim Deputy Medicaid Director, with recruitment underway for the Medicaid Director.

Metrics and Scoring Committee

The Oregon legislature established the Metrics and Scoring Committee (MSC) to recommend outcomes and quality measures for CCOs.

July 20, 2018

The committee received updates on CCO 2.0 and an overview of the process to date. The committee was asked to vote on 2018 incentive measure program changes that would identify a set of modifications to be implemented for any CCO experiencing extraordinary capacity changes now or in the future.

August 17, 2018

The committee reviewed the CCO Metrics 2017 Final Report and most recent performance. Discussions and initial selections for 2019 benchmarks and improvement target floors occurred.

September 21, 2018

The committee received substantive updates on health aspects of kindergarten readiness measures and finalized decisions on 2019 benchmarks and improvement target floors.

October 19, 2018

The committee received written public testimony related to the specifications for the screening, brief intervention, and referral to treatment measure (SBIRT drug and alcohol screening) from a primary care provider.

November 16, 2018
The committee heard oral public testimony from several CCOs noting concerns about changes to the depression screening and follow-up measure specifications made by the measure steward.

December 14, 2018
The committee received public testimony as below:
- PacificSource Community Solutions CCO gave testimony about concerns with the changes to the depression screening and follow-up measure specification changes from the measure steward; this was also raised by a provider.
- Eastern Oregon CCO provided testimony related to concerns about the effective contraceptive use measure.
- Georgetown University Center for Children and Families (Georgetown CCF) and the Marion and Polk County Early Learning Hub each wrote in support of the Health Aspects of Kindergarten Readiness Technical Workgroup proposal.

April 19, 2019
The committee heard testimony regarding a health equity measurement that would result in increased access to appropriate level of services, patient safety and physician compliance.

May 17, 2019
The committee heard testimony regarding Health Aspects of Kindergarten Readiness, Social Determinants of Health, Health Equity Measures and obesity.

June 21, 2019
The OHA Health Policy & Analytics Division director read a letter to the committee from Oregon Governor Kate Brown, which addressed CCOs' integral role in transforming health care and ensuring access to high quality health care. The letter directed OHPB and OHA to commit to key goals of improving the behavioral health system, increasing value and pay for performance, focusing on social determinants of health and health equity; and maintaining sustainable cost growth and ensuring financial transparency.

Health Aspects of Kindergarten Readiness Technical Workgroup
The Children's Institute, in collaboration with the Oregon Health Authority and with technical expertise from the Oregon Pediatric Improvement Partnership, convened the Health Aspects of Kindergarten Readiness Technical Workgroup in 2018. The purpose of this technical workgroup is to explore measures of the health sector's role in kindergarten readiness for potential use in the CCO Metric Quality Incentive Program.

July 27, 2018
The workgroup was given an update and refresher on health equity and social determinants of health. Comments about metrics were focused on changing individual behaviors in order to improve metrics.

August 27, 2018

The workgroup reviewed a slide presentation about its timeline and work plan for developing and delivering final measure recommendations to the Metrics and Scoring Committee in November 2018. The workgroup was surveyed on how to get stakeholder input on workgroup recommendations.

September 11, 2018

The workgroup reviewed background on health system transformation, CCO incentive measures and kindergarten readiness definitions.

October 26, 2018

The workgroup discussed measurement strategy proposals under consideration for recommendation to Metrics and Scoring Committee and reviewed components for final report and recommendations.

November 5, 2018

The workgroup finalized measurement strategy proposal for Metrics and Scoring Committee and report content.

December 14, 2018

The workgroup received written testimony from a provider regarding development of a measure on social emotional health.

Health Plan Quality Metrics Committee

Senate Bill 440 (2017) mandated publicly funded health plans such as Medicaid and the Public Employees Benefit Board (PEBB) to align their quality metrics by selecting from a common menu of quality measures. SB 440 created the Health Plan Quality Metrics Committee (HPQMC) and specified that the Metrics and Scoring Committee (MSC) would become a subcommittee that informs the larger committee. The MSC continues to select the specific incentive measure and benchmarks for the CCOs. The HPQMC finalized the 2019 measures, and it includes 51 measures and 20 developmental measures.

At the October, November, and December Health Plan Quality Metrics Committee meetings, the committee finalized its 2018-2019 workplan, continued work on prioritizing measure domains and gaps, and heard from stakeholders regarding recommendations for the 2020 aligned measure set. The final measure set was voted on by committee in March 2019 and published in April 2019. Stakeholders providing recommendations include the Health Aspects of Kindergarten Readiness Technical Workgroup, Evidence-Based Obesity Metric Workgroup, and Integrated Behavioral Health Alliance. The Metrics and Scoring Committee provided its recommendations in January 2019.

IV. Progress toward demonstration goals

A. Improvement strategies

To meet the goals of the three-part aim, Oregon's coordinated care model and fee-for-service delivery systems rely on six key levers to generate savings and quality improvements and accelerate spread across the delivery system. These levers drive Oregon's transformation. Along with the actions that OHA will take in the form of

the stimuli and supports described below, they comprise a roadmap for achieving Oregon's vision for better health, better care and lower costs.

- Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through Patient-Centered Primary Care Homes.
- Lever 2: Implementing value-based payment models to focus on value and pay for improved outcomes.
- Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care.
- Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources.
- Lever 5: Implementation of health-related services aimed at improving care delivery, enrollee health, and lowering costs.
- Lever 6: Testing, accelerating and spreading effective delivery system and payment innovations through peer-to-peer learning, the spread of best practices, and innovation through the Oregon Health Authority's Transformation Center

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

Certified Community Behavioral Health Clinics

During this past year, OHA completed the second of two years participating in the Certified Community Behavioral Health Clinic (CCBHC) demonstration program, after being granted one additional quarter by Congress. Following a one-year planning grant (2015- 2016), the CCBHC demonstration program was launched in Oregon on April 1, 2017, and was originally set to end March 31 but was extended through June 30, 2019. Today, the demonstration and payment methodology continue to garner federal support that may allow for additional continuity.

CCBHCs must meet numerous federal requirements, such as the ability to directly provide outpatient mental health and substance-use disorder (SUD) services to the full age range, regardless of payer. There are also nine Oregon CCBHC Standards, which enhance or expand on the federal requirements.

For this demonstration period, Oregon continued to pay a daily rate to participating clinics, using the selected the Prospective Payment System (PPS) model and through federal legislation was granted an extension to participate for three additional months, through June 30. The rate for each CCBHC is unique to each organization and was developed based on analysis of cost reports submitted to OHA during the planning grant. Among the key milestones for this annual period:

1. State-led and clinic-led metrics for Demo Year 1 report completed.
2. Report to Congress, 2018 released by Mathematica/SAMHSA.
3. All on-site compliance visits were completed with OHA.
4. State Plan Amendment drafted.
5. Survey released on integration.
6. Final technical assistance/statewide gathering in May on sustainability post-demonstration.

Patient-Centered Primary Care Homes

Patient-Centered Primary Care Homes (PCPCH) program staff conducted 87 site visits to primary care clinics. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address identified barriers.

As of June 30, 2019, 621 clinics were recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Forty-seven PCPCHs have been designated as 5-STAR, the highest tier in the PCPCH model.

The Transformation Center partnered with the Oregon Rural Health Practice Network on a telelearning series to assist CCOs in adding PCPCHs to their network and provide support to already recognized PCPCHs to increase their tier level. Fourteen clinics participated in the six-module virtual learning collaborative series, and six clinics used additional technical assistance hours offered.

Tribal Care Coordination

Federal Medical Assistance Percentage Savings and Reinvestment Program
This program allows the state to claim 100% federal match for services that would otherwise be paid at the normal federal/state Medicaid recipient match rate for services rendered to American Indian/Alaska Native (AI/AN) members outside of an Indian Health Service (IHS) or tribal 638 facility. To be eligible for 100% federal match, the care received outside of the IHS/tribal facility must be requested and coordinated by the IHS/tribal facility.

OHA has entered into contracts with seven tribes to direct state savings back into tribal health programs. Payments to tribes began in August 2018 and continue on a quarterly basis. Efforts are underway to design and implement a methodology to determine the state savings from capitation payments made to CCOs when AI/AN members' care is coordinated by the tribe.

CareOregon Contract
To further assist in efforts to expand coordination of care for tribal members, OHA has contracted with CareOregon to provide care coordination services for the roughly 17,000 AI/AN members not enrolled in a CCO (approximately 53% of OHP's AI/AN population). The contract was recently renewed for a second year.

Indian Managed Care Entities
OHA received a proposal from Oregon's nine federally recognized tribes announcing their intent to form an Indian Managed Care Entity (IMCE), potentially based on the Primary Care Case Management Model. The tribes and the Urban Indian Health Program (UIHP) have also requested technical assistance with IMCE implementation. This proposal is still currently in the planning phase, and efforts are expected to continue into 2019 to design and execute a plan to create one or more IMCEs to help the tribes and UIHP coordinate care on behalf of their tribal communities.

Work continues in partnership with the tribes and the Native American Rehabilitation Association of the Northwest (NARA) to facilitate establishment of this program for those who may be ready to implement by July 1, 2020.

Tribal consultation

OHA continues to implement and abide by the Tribal Consultation and Urban Indian Health Program Confer Policy, which has created many more opportunities to provide information to the tribes/UIHP and offer time for consultation/confer. The number of identified critical events and tribal consultations continues to increase, as OHA staff are better attuned to tribal impact of their work across the agency. OHA has implemented a tracking system to ensure agency-wide compliance with the policy.

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

Comprehensive Primary Care Plus

Oregon was selected as a CPC+ region and began implementation January 1, 2017. The Transformation Center manages the Medicaid fee-for-service implementation. Per-member, per-month care management fees are a key component of the CPC+ payment model. In 2018 OHA launched the second key component, a performance-based incentive payment that is paid based on practice performance on quality and utilization metrics. In 2018 each practice that submitted data received an average of $12,500.

The Oregon CPC+ payers continue to have monthly facilitated meetings to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers are moving forward with data aggregation through the existing HealthInsight Oregon Reporting Portal. CPC+ specific measures are being added to the portal and will be available to practices in early 2019.

Value-Based Payment Innovations and Technical Assistance

During this annual reporting period, the Transformation Center worked with stakeholders and national value-based payment (VBP) experts to develop a VBP Roadmap for CCOs. The CCO VBP Roadmap is a required deliverable of Oregon's 1115 waiver and, beginning 2020, will include annual and five-year statewide VBP targets for CCOs and their contracted providers.

As stipulated in the CCO VBP Roadmap, CCOs were required to have at least 20% of projected annual payments to contracted providers in contracts that include a VBP component in Category 2C ("Pay for Performance") or higher (as defined by the Health Care Payment Learning and Action Network's "Alternative Payment Model Framework White Paper Refreshed for 2017"). Applicants submitted projected VBP data as part of their response to the CCO 2.0 request for applications, and these data will serve as a basis for comparing CCOs' actual VBP penetration in their respective markets.

CCOs will report in multiple ways on their progress toward meeting VBP targets and requirements. CCO executive leadership will engage in the first of the annual VBP interviews with OHA in the summer of 2020, to describe their VBP activities, discuss strategies for mitigating adverse effects of VBPs on marginalized populations, and report implementation plans for their VBP care delivery area pilots. The first data template is due early 2021 and will include CCOs' preliminary VBP data from 2020, stratified by categories as well as required foundational payments for infrastructure and operations to PCPCH clinics. Finally, CCOs will submit comprehensive payment arrangement data every fall that reflects the previous year. In combination, these comprehensive CCO reports will provide both qualitative and quantitative data detailing progress toward the OHA's VBP targets and other VBP requirements.

By 2024, at least 70% of each CCO's provider payments must be in the form of a VBP in Category 2C or higher, and at least 25% of the CCO's provider payments should include downside risk (fall within Category 3B or higher). As part of their work toward achieving their VBP targets, CCOs must also develop new or expanded VBPs in five care delivery areas: hospital care, maternity health care, children's health care, behavioral health care, and oral health care. In addition to these targets, CCOs will be required to make monthly infrastructure and operations payments (Category 2A) to all their PCPCH clinics.

Federally Qualified Health Center (FQHC) / Rural Health Clinic (RHC) Alternative Payment Model (APM)

The Advanced Payment and Care Model (APCM), otherwise known as the FQHC/RHC APM, continues to transition from an alternative payment methodology to a value-based payment (VBP) method that places a portion of the health center's per-member per-month (PMPM) revenue at-risk. This is being accomplished through collaborative workgroups consisting of OHA, the Oregon Primary Care Association (OPCA), and participating FQHCs and RHCs. Workgroups have been focused over the past year on operationalizing components intended to transition the APM to VBP:

Upon the FQHC/RHC submission of the quarterly Care STEPs report, OHA will place all Care STEPs in a database and query for any member not engaged with a billable FQHC/RHC encounter or a Care STEP over the prior eight quarters. The resulting members are reported to health centers on the *Non-Engaged Closure Report* and disenrolled from their health center.

Quality Pool

A portion of CCO global budgets is tied to performance and quality. To receive these funds, commonly referred to as the "quality pool," CCOs must meet performance or improvement targets on a set of 17 quality measures. The Health Plan Quality Metrics Committee and the Metrics and Scoring Committee choose the measures.

OHA reviewed two options regarding the quality pool for 2018 considering a higher rate of growth in 2018 and 2019. In 2018, CCO rates grew at 5.3%, and in 2019 the CCO rates grew at 0.1%. This is based on historical membership and does not include projected caseload changes.

OHA expects that revenue will not continue at the 2018 level and will be exploring a tiered structured program for the 2019 quality pool that evaluates efficiency and rate of growth performance.

Hospital Transformation Performance Program

The Hospital Transformation Performance Program (HTTP) has been retired and there is no information to report since last year's annual report to CMS.

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

Health Equity Committee

The Health Equity Committee (HEC) is a subcommittee of the Oregon Health Policy Board formed in 2017 and charged with accelerating the development of policy related to health equity and ensuring health equity is considered in all policy.

The Health Equity Committee is staffed and supported by the OHA's Office of Equity and Inclusion. HEC members are professionals and individuals representative of communities experiencing health inequities, including, but not limited to: racially and ethnically diverse populations, linguistically diverse populations, immigrant and refugee populations, LGBTQ populations, the aging population, people with disabilities, rural communities, economically disadvantaged populations, transient populations, geographic diversity, and intersections among these communities.

The HEC is in its second year of existence, with members who reside in every corner of the state. In 2019 the committee has continued to work on providing:

- Analysis, guidance and recommendations to OHPB on policy, using an equity lens such as supporting the implementation of CCO 2.0 – from policy to practice.
- Assessment and actionable recommendations to OHA's progress toward achieving defined health equity goals, including the development of best practices to support recruitment and retention of diverse participants to OHPB committees and the development of a definition for Health Equity.
- Collaboration with other OHPB committees to develop goals to integrate and advance equity.

Regional Health Equity Coalitions (RHECs)

OHA's Office of Equity and Inclusion (OEI) developed the Regional Health Equity Coalition program to support local, community-driven, culturally specific activities to reduce disparities and address social determinants of health. Once funded, coalitions select the region and populations they focus on. Each RHEC conducts community-needs assessments to identify priority issue areas to concentrate their efforts and ultimately inform their strategic plans. Both the strategic plans and OEI deliverables provide guidance on annual work plan activities.

RHECs are autonomous, community-driven, cross-sector groups whose backbone organizations are non-governmental in nature. The RHEC model works by building on the inherent strengths of local communities to meaningfully involve them in identifying sustainable, long-term, policy, system and environmental solutions to increase health equity for communities of color[i], and those living at the intersection of race/ethnicity and other marginalized identities.

The coalitions are currently prioritizing issues related to: chronic disease, corrections/criminal justice reform, education, healthcare, housing, institutional racism, immigration, and leadership development for diverse populations. All coalitions have connections to their local CCOs, and many provide technical assistance and training to them.

The RHEC model is unique in that it:

1. Recognizes the impact of structural racism on the health and well-being of communities of color,
2. Meaningfully engages impacted communities to lead the work, and
3. Honors community wisdom by ensuring policy and system change solutions build upon community strengths.

The RHECs represent 11 Oregon counties and the Confederated Tribes of Warm Springs. Two new capacity-building grants were awarded in 2018, which are supporting the development of the first RHECs in Eastern Oregon covering Malheur and Umatilla Counties, as well as the first group fully focused on a tribal population. These grantees are piloting the RHEC model with the health equity work they are leading, and this funding offers an opportunity to complete foundational RHEC activities.

Partnerships with CCOs

All RHECs interface with their local CCOs in various ways. Some RHECs have CCOs involved as members of their general coalition membership[1], while others are part of RHEC leadership/steering committees[2]. These partnerships provide opportunities for CCOs to build capacity and skills related to health equity through technical assistance, training and other ongoing learning activities provided through interactions with coalitions. These opportunities will become increasingly valuable with CCO 2.0 work, especially as it relates to social determinants of health and health equity work.

Roadmap to Oral Health

Oregon continues to integrate oral health into whole patient care for Medicaid members. During 2019, Oregon built on former efforts driving this work, including several key policy changes. Innovative efforts included a decision by the Oregon Health Policy Board to add oral health integration performance indicators to the contract with coordinated care organizations; the reopening of Patient-Centered Primary Care Home (PCPCH) standards for updating; and the Oregon Board of Dentistry's decision to add HbA1c testing to the scope of practice for dentists.

Key efforts to improve oral health integration for Medicaid members during the April–June 2019 quarter are:
- Working with PCPCH staff to develop recommendations for oral health integration to present to the PCPCH standards committee.
- Reviewing CCO applications to evaluate their ability to improve oral health integration for Medicaid members.
- Opening the process to develop performance indicators for oral health integration for Year 2 of the new CCO contract.

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[1] A person who consistently attends general coalition meetings; provides input and guidance on the coalition's strategic priorities and activities; and is aware of the aim, priority issues and current activities of their RHEC.

[2] A person who consistently participates in a leadership capacity to make decisions on coalition actions.

Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources

Innovator Agents

During the demonstration year, innovator agents assisted with gathering feedback and input for OHA about proposed policies from CCOs, community advisory committees (CACs) and communities. They continued to provide information to these same partners about the CCO 2.0 application process, dates for deliverables and important policy updates.

Most CCOs, CACs and communities developed new Community Health Assessments and Community Health Improvement Plans. Innovator agents led and participated in community-planning meetings, provided information and feedback, and assisted with connecting CCOs and communities to technical assistance.

CCOs developed their second Transformation Quality Strategy plans, which replaced the former CCO Transformation Plan and Quality Assessment and Performance Improvement deliverables. Innovator agents assisted by participating in work groups, connecting CCOs with appropriate technical assistance and providing CCOs with feedback on their plans.

Public Health Modernization

In March 2019, OHA published the 2019 Public Health Accountability Metrics Annual Report. Oregon demonstrates it is improving health and effectively using public dollars through a modern public health system. This report shows that the 2017 legislative investment in public health modernization is strengthening capacity for improving childhood immunization rates. As a result of local use of public health modernization dollars Oregon exceeded the 25% benchmark for Vaccines for Children clinics participating in the Assessment, Feedback, Incentives and eXchange (AFIX) quality improvement program, increasing from 14% to 28% in a single year.

OHA published an addendum to the evaluation of the 2017 legislative investment. The addendum focuses on progress reported by eight regional partnerships that are funded to implement new systems for communicable disease prevention. The addendum describes in detail how each regional partnership is reducing communicable disease risks within the community.

As a result of early successes, including those reflected in the reports listed above, Oregon's legislature invested an additional $10 million in public health modernization for the 2019-21 biennium. These funds will be used by state, local and tribal public health authorities to continue to modernize systems for communicable disease control, with an emphasis on eliminating health disparities and building systems to respond to emerging health threats.

Sustainable Relationships for Community Health Program

Sustainable Relationships for Community Health (SRCH) teams are composed of CCOs, local public health authorities and community-based organizations. The goal of SRCH is to bring together different organizations and sectors within a community to complete a shared systems-change project that will be sustained beyond the grant period. In the process of completing SRCH grants, teams build strong relationships, define roles in ongoing partnerships and programs, and build capacity for foundational skills in systems change, project

management, communications, data analysis and evidence-informed strategies. SRCH is designed to align with OHA's agency-wide goals and public health modernization and is an actionable strategy that can be used to meet the triple aim of health systems transformation.

To build leadership and staff capacity prior to receiving the SRCH grant funding, OHA developed the SRCH Leadership Institute for local public health and health system partners to build relationships, identify project and policy opportunities, and build core capacities for health systems transformation. In FY18-19, 13 local public health organizations and one tribal health partner participated in two cohorts of the SRCH Leadership Institute. Over the course of multiple two-day Leadership Institutes, each team of local public health and health system partners co-designed sustainable health systems changes that improve health outcomes, promote equity and contain costs. This work included co-developing a shared goal, measurable outcomes and specific actions with partners. All SRCH Leadership Institute teams learned techniques that are critical to establishing, nurturing and sustaining partner relationships to improve health outcomes.

In May 2019, OHA's Public Health Division released the Request for Grant Funding for another cohort of SRCH grantees for 2019-2020, with priority given to consortia who have participated in the SRCH Leadership Institutes. Three SRCH grantee teams led by Hood River Public Health, Tillamook Public Health and InterCommunity Health Network CCO, along with partners from Local Public Health Authorities (LPHAs), Oregon's federally recognized tribes, Urban Indian Health Programs, CCOs, RHECs, clinics, community-based organizational partners delivering self-management programs (SMPs), were awarded funding and will be joined by the Public Employee Benefit Board and its three health plans. These teams will develop and strengthen relationships, co-design strategies to formalize infrastructure and/or arrangements between health system partners and community-based organizational partners (e.g., closed loop referrals, memorandums of understanding), implement quality improvement processes, and collect, analyze and share data in order to reduce some of the leading causes of death and disability in Oregon.

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

Health-Related Services

CCOs receive a global payment for each member, which provides CCOs the flexibility to offer health-related services (HRS) to improve the health of Oregon's Medicaid population. Under Oregon's 1115 Medicaid Demonstration Waiver for 2017–2022, OHA continues its commitment to promote CCOs' use of HRS to achieve the triple aim of better health, better care, and lower costs for all Oregonians. OHA published a frequently asked questions document about how to use HRS.

OHA staff reviewed CCOs' 2018 HRS policies and will share opportunities with CCOs to update their policies to align with Oregon Administrative Rules for 2019. Staff are also reviewing spending data and will give feedback to each CCO on appropriateness of HRS expenditures. The Oregon Rural Practice-based Research Network (ORPRN) held interviews with CCOs, clinics and health systems partners to inform technical assistance to CCOs, including work group calls and a peer-learning convening about how CCOs are implementing HRS.

Health Care Interpreters

The Health Care Interpreters Program administered by OHA's Office of Equity and Inclusion is critical to achieve health equity for patients with Limited English Proficiency (LEP), deaf and hard of hearing patients, and their families. About 15.25% of the state's population is estimated to speak non-English languages (U.S. Census estimates, 2017) and about 4.8% has hearing disability (U.S. Census estimate, 2016). The development of a sustainable HCI workforce that can serve as part of a health care provider team is an important strategy for improving LEP individuals' access to health care, quality of care received, enrollee health, and overall health care costs.

Program Level Activities:

The HCI program in collaboration with the HCI Council sets competency criteria for:

- Approving HCI training curriculum and programs, and
- Recognition and registration of spoken and sign language HCIs as qualified and certified state-approved interpreters.

Oregon's growing LEP, deaf and hard of hearing populations make the continuous training and recognition of HCIs an important priority. The HCI program is responding to this by continuing to train interpreters across the state to ensure a sustainable supply of trained interpreters.

OEI also worked with the HCI Council to develop the program's first five-year strategic plan. The two subcommittees of the HCI Council have been reorganized to focus on the following broad strategic priorities:

- Improving and expanding training options to be collaborative, affordable, and geographically accessible.
- Streamlining the registration process based on existing successful models.
- Working with stakeholders to promote a livable wage for HCIs.
- Recruiting, supporting, and capacitating HCI Council membership.
- Advocating for a more equitable HCI program through education and legislation.
- Strengthening partnerships and collaboration through community outreach and information sharing

OEI completed an update of the Oregon Administrative Rules to address problems with renewing HCI letters for current HCI Registry enrollees.

OEI proposed for adoption a health equity metric that is based on measuring the need for and utilization of trained HCIs by CCOs and their provider network.

Traditional Health Worker Program

The Traditional Health Worker (THW) program works to promote the roles, integration, and utilization of the traditional health workforce in Oregon's health system transformation, which includes Community Health Workers, Peer Wellness Specialists, Family Support Specialists, Youth Support Specialists, Personal Health Navigators, Peer Support Specialists and Doulas.

The THW program, in partnership with stakeholders, tribal organizations, community-based organizations, CCOs, THW statewide training organizations, and health systems, strives to ensure that Traditional Health Workers are uniquely positioned to work with communities to identify and address the underlying causes of health problems and health inequities for some of the Oregon's most vulnerable populations.

Key focus areas for the THW program during were pursuing strategies to integrate THWs into CCOs, advancing community engagement opportunities, and developing and implementing ongoing strategies that assure the delivery of high-quality, culturally competent care, which is instrumental in achieving Oregon's triple aim. THW's workforce provides critical services in mobilizing patients, managing and coordinating care, assisting in system navigation, and health promotion and coaching.

OHA's Office of Equity and Inclusion continues to support the training and certification of THWs by:
- Enrolling certified workers on the state public registry,
- Approving quality statewide training programs,
- Developing processes and procedures to facilitate seamless integration of THW workforce in the health system, and
- Providing technical assistance to stakeholder partners regarding the integration and utilization of THWs in Oregon's health system.

On September 30, 2018, the OHA and the Oregon Doula Association published a statewide doula needs assessment report. The report highlighted and addressed strategies for advancing health equity for childbearing families in Oregon.

On November 30, 2018, OHA the Oregon Community Health Workers Association published a statewide Community Health Worker's needs-assessment report. This report highlighted how community health workers are integral members of the Oregon's health workforce.

Both needs assessments also brought to light barriers and challenges to integrating and utilizing these THWs into Oregon's health care systems.

In May 2019, OHA supported grant funding for Oregon's nine tribes to conduct a community-based participatory project and support the delivery of a Family Peer Delivered Services Foundations training that is culturally specific to tribal community members and will meet OHA's competency requirements. This work will be done in collaboration and consultation with representatives from the identified Oregon tribes who will act as cultural experts and advise the development of culturally respectful and inclusive training.

Traditional Health Worker Training Programs
Between July 2018 and June 30, 2019, OHA approved 16 training programs, including renewal and Continuing Education Units (CEUs). There are 63 OHA-approved foundational training and CEU programs.
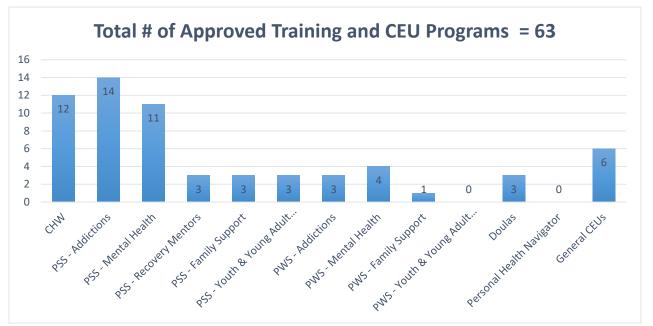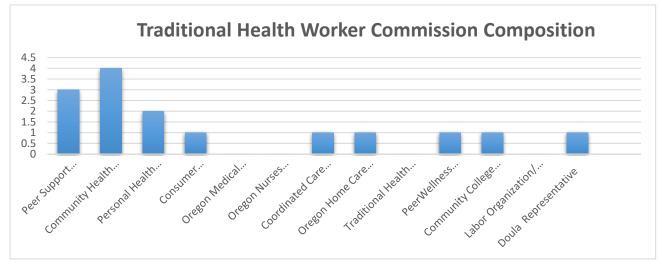
Table 2 - Traditional Health Worker Training Programs

Total # of Approved Training and CEU Programs = 63

Bars: CHW 12, PSS - Addictions 14, PSS - Mental Health 11, PSS - Recovery Mentors 3, PSS - Family Support 3, PSS - Youth & Young Adult... 3, PWS - Addictions 3, PWS - Mental Health 4, PWS - Family Support 1, PWS - Youth & Young Adult... 0, Doulas 3, Personal Health Navigator 0, General CEUs 6

Table 3 - Traditional Health Worker Commission Composition

Traditional Health Worker Commission Composition

Bars: Peer Support... 3, Community Health... 4, Personal Health... 2, Consumer... 1, Oregon Medical... 0, Oregon Nurses... 0, Coordinated Care... 1, Oregon Home Care... 1, Traditional Health... 0, PeerWellness... 1, Community College... 1, Labor Organization/... 0, Doula Representative 1

Stakeholder Engagement

From July 1, 2018 through June 30, 2019, the THW program coordinator provided a series of presentations and technical assistance to THW training program participants, CBOs, FQHCs, CCOs and other stakeholders and partners. These presentations focused on certification, background check process, Medicaid enrollment, and the public registry process.

The THW program provided three presentations at stakeholder conferences, including the Oregon Community Health Workers Association annual conference, Northwest Primary Care Association's annual conference, Oregon Peer Delivered Services Coalition annual summit, Peerpocalypse annual conferences, and the CHW Unity Conference 2019 with focused discussions on THWs and their integration into Oregon's health care systems.

The THW program also supported the Oregon Administrative Rule revisions for THW rule 410-180-0350. The rule now includes Family Support Specialist and Youth Support Specialist THW types, as well as the training and certification process for these types.

From May 2018 through November 2018, OHA worked with the U.S. Government Accountability Office on *Mental Health: Leading Practices for State Programs to Certify Peer Support Specialists,* a report to congressional committees. GAO selected the states in part based on the state's certification program being well-established (at least two years old), use of SAMHSA funding for peer support, and stakeholder recommendations. The six selected states — Florida, Georgia, Michigan, Oregon, Pennsylvania, and Texas — are among the 41 states and the District of Columbia that, as of July 2016, had programs to certify Peer Support Specialists.

In December 2018, the THW program coordinator worked with the Health Systems Division on a proposed State Plan Amendment that would put fewer restrictions on how Oregon uses Medicaid funds for peer-delivered services.

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

Transformation Center activities
The Transformation Center continues to offer CCOs and clinics technical assistance in key strategic areas.

Behavioral health integration
The Transformation Center staffs the Regional Behavioral Health Collaborative (RBHC), a partnership with behavioral health leaders and stakeholders in the Portland area to improve behavioral health outcomes through collective action across organizations responsible for behavioral health. The initial focus of the RBHC is peer-delivered services and substance use disorder activities that can make an impact in 12–24 months. Three topic-specific work groups — communities of color, youth and families, and medical community collaboration — are identifying goals, strategies, implementation plans and measures of success for the first year of the RBHC. The medical work group is developing a resource document for medical settings engaging peers in caring for patients struggling with substance use disorder. The other two work groups are finalizing their strategies.

The center supported technical assistance to eight CCOs for furthering behavioral health integration. Topics included integration across a community; value-based payment; efficient workflows; an embedded behaviorist model; quality and outcome measures that can be reported by clinics; and how to do a population health needs assessment and compare with services available.

Oral health integration
One CCO completed an oral health integration project with a consultant through the Transformation Center. The CCO worked with stakeholders to develop a workplan for oral health integration.

Population Health

Community Advisory Councils

The Transformation Center continues to provide targeted supports to CCO community advisory councils (CACs) for CAC member recruitment and engagement. With guidance from the CAC learning collaborative, the Transformation Center hosted the annual CCO community advisory council (CAC) conference. The event was attended by 130 people, representing all 15 CCOs and 33 of the 37 CACs. All evaluation respondents said the event was valuable in supporting their work.

The center continued to host monthly calls with CAC leaders on recruitment and engagement, community health improvement plan implementation, health equity and effective CAC meetings.

Children's health complexity
The Transformation Center launched technical assistance for CCOs on using children's health complexity data. This data is provided by OHA's Office of Health Analytics in partnership with the Oregon Pediatric Improvement Partnership (OPIP). Support includes 10 hours for each CCO to work with OPIP, as well as technical assistance to OHA to use the data to enhance care coordination for the fee-for-service Medicaid population. Five CCOs have requested assistance.

Community Health Assessment and Community Health Improvement Plans
Transformation Center staff held one CCO CHP training in January. Seven CCOs have now received the training, which focuses on best practices in CHA/CHP development.

CCO incentive metrics technical assistance

Adolescent well-care visits
The Transformation Center held a webinar about starting pediatric-to-adult transition programs in clinics. The session was led by a pediatrician and included a toolkit and national resources. Forty-one people attended, and 100% of evaluation respondents rated it valuable or very valuable.

Controlling high blood pressure
The Transformation Center contracted with a local Million Hearts® champion to provide:
- A webinar on CCO- and system-level support for increasing rates of controlled blood pressure (43 people participated or watched the recording from 14 CCO regions, with all evaluation respondents indicating they planned to take action as a result);
- Follow-up technical assistance calls with three CCOs; and
- ACME-accredited webinar for clinicians on controlling high blood pressure. Fifty-five people have watched live or accessed the recording. All evaluation respondents said it was valuable or very valuable.

The center also contracted with Oregon Rural Practice-based Research Network (ORPRN) to provide technical assistance on quality improvement to clinics using high blood pressure control as the learning tool. The 21 participating clinics met regionally for a full-day training in QI and best practices, and they received five hours of follow-up technical assistance to work on their improvement projects.

Effective contraceptive use
Effective contraceptive use technical assistance activities included:

- A training for one CCO's community members and providers on culturally responsive strategies for engaging the Latino community in sexual and reproductive health, and a webinar for all CCOs to discuss learnings;
- A CCO-customizable metrics brief to support clinic staff in understanding and documenting the effective contraceptive use measure; and
- A webinar for CCO staff on the implementation of policy expanding the scope of pharmacists to directly prescribe hormonal contraception in Oregon.

Emergency department use among members with mental illness

Four CCOs used the 20 hours of technical assistance offered for this metric. Projects included a community convening to inform a collaborative approach to addressing needs of members with severe and persistent mental illness; building staff capacity to improve systems of care and data-informed decision-making; and standardizing care plans across the community using PreManage.

Cigarette smoking prevalence

Tobacco cessation technical assistance activities included the following.

- Tailored tobacco cessation benefits communications for members for seven CCOs.
- An online provider training in the Five A's, brief intervention, and cessation counseling during pregnancy. It includes no-cost CMEs. Of the 44 evaluation respondents, 93% rated the training as excellent or good.
- A half-day CCO learning collaborative on reducing tobacco prevalence. Thirty-one CCO staff and partners attended, representing 12 CCOs. Content included data and partnership with public health, and evidence-based clinical and community-based interventions. Ninety-one percent of evaluation respondents said the opportunity was valuable.
- Two in-person trainings on implementing Oregon's Freedom from Tobacco policy, which requires residential mental health and addictions providers licensed by OHA to maintain properties that are free from tobacco use. Seventy-one people participated.
- A community of practice (six sessions) and webinar series (five sessions) focused on treating tobacco dependence in behavioral health settings. Presenters were from the University of Colorado School of Medicine. Participants represented 16 organizations.

Developmental screening and follow-up

A contractor developed and facilitated five webinars with accompanying tip sheets and guides. Three webinars for CCOs focused on improving the referral and follow-up process for children with potential delays. Two webinars for primary care practices focused on follow-up to developmental screening and referring to and coordinating with Early Intervention.

Diabetes (HbA1C and a new oral health visit metric)

The Transformation Center held technical assistance needs-assessment calls with CCOs regarding two measures: rates of poorly controlled HbA1C and rates of adults with diabetes who receive a dental evaluation. Five CCOs participated in the calls, expressing interest in TA to help with patient engagement, HIT/data access and analysis, and care coordination.

Timeliness of postpartum care

The Transformation Center held a spring online learning series for CCOs, tribes, clinics and partners on the timeliness of postpartum care CCO incentive metric. The series included six webinars focused on the metric itself, data, barriers and peer sharing of innovative strategies. Sixty-six people attended (or watched the recording of) at least one of the sessions.

Cross-cutting supports

Innovation Café: Strategies for Addressing Social Determinants of Health

The 2019 Innovation Café focused on sharing innovation and best practices to address social determinants of health (specifically housing, trauma, early learning/early childhood education, and food insecurity). This full event brought together more than 300 people from multiple sectors, including all 15 CCOs. Attendees presented 45 projects in discussion-based rounds. All evaluation respondents planned to act as a result of attending.

CCOs Advancing Health Equity Workshop

A one-day peer learning event supported CCOs' health equity work, with nearly 80 attendees representing all 15 CCOs. Over 90% of evaluation respondents said the event was valuable. Topics included health equity strategic planning, using a national framework to engage staff and board members on health equity, using data to advance health equity, language access for members, utilizing community health workers, and cultural competency training for staff.

Transformation and Quality Strategy technical assistance

CCOs submitted their first Transformation and Quality Strategy (TQS) progress report and second annual TQS. Center staff facilitated a CCO work group that made recommendations on the 2019 deliverables and assessment methods; held webinars for CCO staff to review updates; and managed the review process.

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

The Transformation Center coordinated three statewide CCO learning collaborative sessions, which focused on children's health complexity data, best practices for caring for members with hepatitis C, and the National Diabetes Prevention Program. More than 90% of evaluation respondents rated the sessions as valuable for supporting their work.

Patient-centered counseling trainings

The center held 11 patient-centered counseling trainings for Medicaid providers. Evidence-based content included motivational interviewing, FRAMES and Five A's for tobacco cessation counseling, and examples drew from CCO metrics. No-cost CME credits were available. Two hundred and forty-one people attended. Evaluation respondents rated the value, effectiveness and trainer quality as 100% positive. Nearly all (99.5%) respondents planned to take action as a result. Respondents to a post-training survey indicated they were more comfortable discussing sensitive topics with patients than they were prior to the training.

Innovations database

The center updated its innovations database with reports and new data from across the CCO system. Staff produced 11 reports in response to requests about topics including housing as a social determinant of health,

maternal health, end-of-life care, trauma-informed care, base rate development for behavioral health, and culturally competent tobacco cessation projects.

Council of Clinical Innovators

The Transformation Center convened the Council of Clinical Innovators for a daylong learning event focused on addressing social determinants of health in health care settings. Participants included 30 alumni and their guests, and 100% of evaluation respondents rated the event as valuable or very valuable for supporting their work. The council includes alumni and faculty of the Clinical Innovation Fellows program.

Early childhood health coordination

This year, Transformation Center staff:

- Engaged early learning stakeholders on the CCO 2.0 policy options;
- Collaborated with the Office of Health Analytics to produce a CCO metrics update for early learning hubs and provide outreach regarding the Health Aspects of Kindergarten Readiness Technical Work Group;
- Facilitated three meetings with partners about an Oregon oversample for the 2020 National Survey of Children's Health; and
- Held an online peer learning session for initiatives that coordinate referral and follow-up. Evaluation responses were mixed, with some requests for an in-person, in-depth session.

Transformation in Action newsletter

The Transformation Center launched a quarterly newsletter to feature stories about CCOs' innovative work, highlight evidence-based best practices, and celebrate successes. More than 400 people have subscribed.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

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

2. State reported enrollment table

Enrollment	April 2019	May 2019	June 2019
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	951,105	947,718	947,169
Title XXI funded State Plan	90,022	90,186	90,414
Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A

Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A
Enrollment current as of	April 30, 2019	May 31, 2019	June 30, 2019

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total number of clients	Member months	Percent change from previous quarter	Percent change from same quarter of previous year
Expansion	**Title 19**	PLM Children FPL > 170%	0	0	0.00%	0.00%
		Pregnant Women FPL > 170%	0	0	0.00%	0.00%
	Title 21	SCHIP FPL > 170	60,254	155,756	-22.70%	-48.63%
Optional	**Title 19**	PLM Women FPL 133-170%	0	0	0.00%	0.00%
	Title 21	SCHIP FPL < 170%	86,076	225,427	14.00%	41.78%
Mandatory	**Title 19**	Other OHP Plus	156,899	449,837	-0.30%	0.44%
		MAGI Adults/Children	734,528	2,053,137	1.02%	-1.03%
		MAGI Pregnant Women	11,729	27,556	-4.27%	-16.82%
		QUARTER TOTALS	**1,049,486**			

OHP eligible and managed care enrollment

		Coordinated Care				Dental Care	Mental Health
OHP Eligibles*		**CCOA****	**CCOB****	**CCOE****	**CCOG****	**DCO**	**MHO**
October	969,970	851,327	890	44,260	3,663	510	32,732
November	972,026	848,186	650	44,242	3,661	505	32,825
December	971,635	843,109	631	44,168	3,641	507	32,828
Quarter average	971,210	847,541	724	44,223	3,655	507	32,795
		87.27%	0.07%	4.55%	0.38%	0.05%	3.38%

*Total OHP Eligibles include: GA, ACA expansion, CX Families, OAA, ABAD, CHIP, FC and SAC.

Due to retroactive eligibility changes, the numbers should be considered preliminary.

**CCOA: Physical, Dental and Mental Health; CCOB: Physical and Mental Health; CCOE: Mental Health only; CCOG: Mental and Dental

B. Complaints and grievances

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

C. CCO appeals and hearings

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

D. Neutrality reports

Reports are attached separately as Appendix D – Neutrality Reports.

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