

MEDICAID ADVISORY COMMITTEE

December 9th, 2015

9:30 a.m. – 12:30 p.m.

Oregon State Library, Room 102/103

250 Winter St. NE, Salem OR 97301

Conference line: 888.398.2342

Webinar: <https://attendee.gotowebinar.com/register/7614065613795096065>

| Time | Item | Presenter |
|-------|--|---------------------|
| 9:30 | Opening Remarks | Co-Chairs |
| 9:35 | OHA OmbudsAdvisory Council <ul style="list-style-type: none"> Recently activities and informational sessions Client-based initiatives | Ellen Pinney, OHA |
| 9:55 | Oregon Health Plan (OHP) and Coordinated Care Organizations – OHA update <ul style="list-style-type: none"> OHP determination and enrollment 2015 CCO integration | Rhonda Busek, OHA |
| 10:15 | OHA Legislative Update <ul style="list-style-type: none"> 2015 implementation update, next steps | Brian Nieuburt, OHA |
| 10:25 | OregonONEligibility <ul style="list-style-type: none"> Informational update | Sarah Miller, OHA |
| 10:50 | Break | |
| 11:00 | Basic Health Program (BHP): HB 2934 <ul style="list-style-type: none"> Review BHP Stakeholder Group recommendations | Staff, OHA |
| 11:15 | Public Health Modernization <ul style="list-style-type: none"> Informational session | Cara Biddlecom, OHA |
| 11:50 | Committee Planning for 2016 <ul style="list-style-type: none"> Review committee’s work in 2015 Identify priority policy areas for 2016 Committee calendar | Co-Chairs; staff |
| 12:20 | Closing comments | Co-Chairs |

Next Meeting:

Wednesday, January 27th: 9:00 a.m. – 12:00 p.m.

Oregon State Library bldg. -Room #102/103

Winter St. NE, Salem, OR 97301

OREGON Sept. 23rd 2015
9:00am – 12:00pm
Mt. Mazama Conference Room
1225 Ferry Street SE; Salem, OR 97301

MEMBERS IN ATTENDANCE: Janet Patin, Karen Gaffney, Rhonda Busek, Glendora Claybrooks, Kay Dickerson, Bob Diprete, Marcia Hill, Leslie Sutton, Ross Ryan and Don Erickson
MEMBERS ABSENT: Laura Etherton, Alyssa Franzen
PHONE PARTICIPANTS: Kristen Dillon
PRESENTERS: Rhonda Busek and Janna Starr, OHA; Dr. Austin, OHA; Rebekah Fowler; Darren Coffman and Jason Gingerich, OHA
STAFF: Oliver Droppers

| TOPIC | <i>Key Discussion Points</i> |
|---|--|
| Opening Remarks and Staff Update | Introduction and roll call. Staff reviewed the agenda and the list of topics to cover. |
| OHP and CCO – OHA Update | <p>Rhonda Busek and Janna Staff, Oregon Health Authority (OHA)</p> <ul style="list-style-type: none"> • Rhonda walked through recent activities and priorities of the OHA including eligibility determinations, processing, call center and the OregonONEligibility system. • Question: were 31,000 individuals terminated from OHP? Response: that’s a difficult questions to answer due to closures, changes in eligibility, individuals aging off of OHP, among other factors. • Question: does Health Systems Division have an organizational chart. Response: yes. • Janna reviewed the most recent 1115 waiver quarterly report (see meeting materials). • Question: what audience is this report intended for and is there any information in the report directly from consumers in terms of their satisfaction with coordinated care organizations and the Oregon Health Plan (OHP)? Response: the report is intended for the Centers for Medicare and Medicaid Services (CMS) but the intent is to also make the report consumer friendly. |
| Oral Health and OHP | <p>Dr. Austin, Dental Director, OHA – Oral Health and OHP</p> <ul style="list-style-type: none"> • Dr. Austin introduced himself as OHA’s new statewide Dental Director. Dr. Austin provided a brief summary of his professional background, training, and current role in OHA. His position is new within OHA. • Dr. Austin shared insights on the creation of a statewide dental advisory council, summarized what’s currently underway in OHA with respect to activities related to oral health, and highlighted several elements from the <i>2014 Strategic Plan for Oral Health in Oregon 2014-2020</i>. • Question: can you speak to the issue of access to specialty oral health services, which can be a challenge based on Medicaid coverage? Response: each dental care plan should be able to support individual OHP members with their needs for oral health specialty care. • Question: what efforts are underway specific to local varnishing programs in terms of working to improve coordination at the community level? Are you involving federally qualified health centers (FQHCs)? Response: Dr. Austin is working to connect with FQHCs and also planning to engage the Oregon Health Primary Care Association (OPCA). |

| TOPIC | <i>Key Discussion Points</i> |
|---|--|
| | <ul style="list-style-type: none"> • Question: how do you get low-income individuals educated about the importance of preventive oral health services? What programs does OHA have to promote preventive services for low-income Oregonians? Response: there are several programs in Oregon working to engage low-income individuals about the importance of receiving oral health services. |
| InterCommunity Health Network CCO CAC | <p>Rebekah Fowler, PhD, Coordinator, Intercommunity Health Network CCO Community Advisory Council (CAC) (see slides 5-13)</p> <ul style="list-style-type: none"> • Dr. Fowler described the structure of the community advisory council (CAC), provided an overview of the community health improvement plan (CHIP) and its impact to date, highlighted current CHIP work including spotlighting three CHIP activity examples, and shared several recent community engagement activities led by IHN CCO. • Question: is there a role for the CAC in helping to problem solve with respect to the CCO quality metrics and the IHN dashboard with respect to member engagement. Response: the CAC hasn't determined whether this is an aspect the council wants to prioritize but the CCO would be open to this. |
| Medicaid 12-month Continuous Eligibility | <p>Medicaid 12-month Continuous Eligibility, Committee Staff – Oliver Droppers (see slides 15-23)</p> <ul style="list-style-type: none"> • Staff reviewed the committee's preliminary recommendations and summarized the estimated program costs of the policy, if implemented, in the 2017-2019 biennium. • Question: has CMS indicated whether they are open to negotiating the reduction in the federal financial participation (FFP)? Response: no. • General discussion around the feasibility of the proposal; consensus was the proposal is good public policy. Members agreed that, ultimately, it's up to the Oregon Legislature to determine whether there's available funding to meet the required federal match if this policy were implemented. • After a brief discussion about the committee that included reflecting on its 2015 charter, the committee moved forward, unanimously adopting three recommendations and to officially submit the letter with compendium reports to the Director of OHA, Lynne Saxton. |
| Health Evidence Review Commission (HERC) | <p>Darren Coffman and Jason Gingerich, OHA (see slides 25-44)</p> <ul style="list-style-type: none"> • Darren reviewed the history of the prioritized list, described how its' methodology works, and highlighted several examples of lines from the list. • Jason walked through the process used to update the list, biennially, the impact of the Affordable Care Act (ACA) on the prioritized list in terms of the Medicaid expansion in 2014 and essential health benefits, and concluded with discussing the future of the list in Oregon. |
| Closing Comments | <p>Committee members reviewed draft minutes from June and July meetings. Two corrections were noted. Committee approved minutes with corrections.</p> |

Next MAC meeting:

January 27th, 2016

9:00 a.m. – 12:00 p.m.

Oregon State Library

250 Winter Street NE., Salem, OR 97301

2015 OHP Determination and Enrollment Project

| Main 800 number Weekly Averages | Baseline* | 11/13/2015 | 11/20/2015 | Target |
|-------------------------------------|-----------|------------|------------|--------|
| Total Daily Calls Received | 6,846 | 5,724 | 5,259 | |
| Total Daily Calls Answered | 3,310 | 2,181 | 2,506 | 90% |
| Average Wait Time (minutes) | 33 | 28 | 22 | <10 |
| Average Maximum Wait Time (minutes) | 166 | 85 | 76 | <20 |

*The baseline column represents the reporting numbers at the beginning of the project in February 2015.

| Closure Line Weekly Averages | Baseline | 11/13/2015 | 11/20/2015 | Target |
|--|----------|------------|------------|--------|
| Closure Line Calls Received | 1,221 | 1,293 | 676 | |
| Closure Line Calls Answered | 664 | 545 | 548 | 90% |
| Closure Line Average Wait Time | 21 | 39 | 5 | <10 |
| Closure Line Average Maximum Wait Time | 149 | 121 | 58 | <20 |

| Full Application Calls Weekly Averages | Baseline | 11/13/2015 | 11/20/2015 | Target |
|--|----------|------------|------------|--------|
| Full Application Calls Received | 612 | 454 | 568 | |
| Full Application Calls Answered | 340 | 261 | 441 | 90% |
| Full Application Average Wait Time | 55 | 34 | 14 | <10 |
| Full Application Average Maximum Wait Time | 132 | 134 | 76 | <20 |

| Renewal Mailings | Expected Mailing | Actual Mailing |
|---------------------------------|------------------|----------------|
| Renewal To Be Mailed - November | 0 | 0 |
| Closures To Be Mailed- November | 0 | 0 |

| Oregon Application Process | Baseline | 11/13/2015 | 11/20/2015 | Difference |
|--|----------|------------|------------|------------|
| 2015 enrollments Into Oregon Health Plan | 46,563 | 3,880 | 16,154 | |
| Applications Awaiting Determination | 26,210 | 12,604 | 12,737 | 133 |
| Applicants Waiting For IT Processing | - | 0 | 0 | 0 |
| Applicants Requiring Manual Review | 23,749 | 1,327 | 2,328 | 1,001 |

| Federal Application Process | Baseline | 11/13/2015 | 11/20/2015 | Difference |
|--------------------------------------|----------|------------|------------|------------|
| Enrolled Into Oregon Health Plan | 61,888 | 506,947 | 506,947 | |
| Applicants Waiting For IT Processing | - | 699 | 0 | -699 |
| Applicants Requiring Manual Review | 66,664 | 0 | 17 | -17 |

| Oregon Health Plan Enrollments | Baseline | 11/13/2015 | 11/20/2015 | Difference |
|--------------------------------|-----------|------------|------------|------------|
| Net Total Enrollment in OHP | 1,098,200 | 1,079,800 | 1,089,000 | 9,200 |



2015 OHP Determination and Enrollment Project

Our mission is to provide excellent customer support to all OHP members.

Last week's accomplishments:

- The ONE CORE training finished two additional sessions. Receiving positive feedback from employees regarding the training and the new system.
- Finished interim procedures for transition before Go Live date. All procedures will be shared with staff.
- Weekly ONE update huddles with all staff in place at all work sites.

Last week's challenges:

- Siebel and other system slowness or unavailability has delayed processing applications
- Continue to see a high amount of incoming paper applications
- Staff resources are needed to support the transition to ONE, while maintaining current workload.

This week's goals:

- 10,000 Closure Notices were mailed out and expecting an increase in Closure Calls on Monday. Phone Escalation plan in place to cover incoming calls while staff are in ONE Training along with a higher absent rate due to holiday week.
- Continue to work on all procedures for the different bodies of work to be revisited and updated to meet the needs of the ONE system. All procedures are to be uploaded into SharePoint for easy employee access by December 7th.

Feedback :

Thank you for your exceptional customer service and ensuring I was well taken care of during the call!

Thank you for the excellent customer service! The worker was knowledgeable, kind and treated the customer with the highest regard!

Oregon Health Plan

Section 1115 Quarterly Report



7/1/2015 – 9/30/2015

Demonstration Year (DY): 14 (7/1/2015 – 6/30/2016)

Demonstration Quarter (DQ): 1/2016

Federal Fiscal Quarter (FQ): 4/2015



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I. Introduction

A. Letter from the State Medicaid Director

From July through September 2015, the Oregon Health Authority (OHA) continued to move forward in meeting the goals of the Oregon Health Plan (OHP) demonstration.

- **Lever 1: Improving care coordination** – As of September 30, 2015, there were 589 recognized patient-centered primary care home (PCPCH) clinics in the state, surpassing Oregon’s goal of 500 clinics by 2015. This represents over 50 percent of the estimated number of primary care clinics in Oregon. The proportion of coordinated care organization (CCO) members enrolled in a PCPCH has continued to increase from the 2012 baseline of 51.8% to 81.0% as of December 2014, ranging from 60.7% to 99.0% across CCOs.
- **Lever 2: Implementing alternative payment methodologies (APMs)** – Internal analysis of the most recent quarterly CCO financial reports (for April – June 2015) shows that 55.6% of all plan payments are non-fee-for-service (FFS). This is an increase of 7.7% from the previous quarter, in which 47.9% of plan payments were non-FFS.
- **Lever 3: Integrating physical, behavioral and oral health care** – Five of the CCO incentive measures relate to physical and behavioral health care integration. Of the four measures with data available for calendar year (CY) 2014 and June 2014 – May 2015, two measures improved between those periods (SBIRT screening and follow-up after hospitalization for mental illness).
- **Lever 4: Increased efficiency in providing care** – From CY 2014 to June 2014 – May 2015, the following measures of efficient and effective care for which data were available improved (see Appendix E for details):
 - Emergency department visits per 1,000 member months decreased by 5%.
 - Potentially avoidable hospital admissions per 1,000 member months decreased for chronic obstructive pulmonary disease (18%), diabetes short-term complications (9%), and heart failure (3%). Potentially avoidable hospital admissions per 1,000 member months for adult asthma remained almost unchanged (less than 1% decrease).
 - Rate of developmental screening in the first 36 months of life increased from 43% to 48%. However, rate of adolescent well-care visits decreased slightly (from 32% to 30%).
- **Lever 5: Implementation of health-related flexible services** – Successes reported by CCOs included gym memberships and pool passes to support physical activity and wellness, rental assistance to stabilize mental health, early childhood programs to address trauma, incentives to increase adolescent well child visits, and health resilience specialists to identify member needs. CCOs expressed interest in learning about flexible services definitions and design, member communication, relationship of flexible services to rate setting, and examples of flexible services that worked at other CCOs.
- **Lever 6: Innovations through the Transformation Center** – Innovator agents work closely with CCOs and providers to develop strategies toward the new incentive metrics added in 2015 including dental sealants and effective contraceptive use.

*Leslie M. Clement,
Director of Health Policy and Analytics and Interim State Medicaid Director*

B. Demonstration description

The Oregon Health Plan (OHP) is the state’s demonstration project under Section 1115 of the Social Security Act, funded through titles XIX and XXI of the Social Security Act.

Phase I of OHP started on February 1, 1994, for Medicaid clients in the Poverty Level Medical (PLM) and Aid to Families with Dependent Children (AFDC, now known as Temporary Assistance to Needy Families/TANF) populations. One year later, Phase II added persons who are aged, blind, and disabled, and it added children in state custody/foster care.

Following the creation of the Title XXI Program in 1997, the State Children’s Health Insurance Program (SCHIP) was incorporated into the OHP, providing SCHIP-eligible people with the same benefits and delivery system available to Medicaid clients.

The OHP 2 demonstration began November 1, 2002, which established the OHP Plus and OHP Standard benefit packages, and included the Family Health Insurance Assistance Program. In 2007 and 2009, more children became eligible through expanded SCHIP eligibility and the creation of the Healthy Kids program.

On July 5, 2012, the Centers for Medicare and Medicaid Services (CMS) approved the current demonstration, Oregon’s **Health Care Transformation**, through June 30, 2017. Key features include:

- **Coordinated Care Organizations (CCOs):** The State established CCOs as the delivery system for Medicaid and CHIP services.
- **Flexibility in use of federal funds:** The State has ability to use Medicaid dollars for flexible services (e.g., non-traditional health care workers), to be used for health-related care that is authorized under managed care rules and regulations. CCOs will have broad flexibility in creating the array of services necessary to improve care delivery and enrollee health.
- **Federal investment:** The federal government agreed to provide federal financial participation (FFP) for several health care programs that had been previously supported entirely by State funds. These are called Designated State Health Programs (DSHP). Expenditure authority for DSHP is limited to \$704 million FFP over the demonstration period July 5, 2012 through June 30, 2017, allocated by Demonstration Year (DY) as follows:

| DY | Time Period | FFP Limit |
|----|------------------|-----------|
| 11 | 07/1/12-06/30/13 | \$230 M |
| 12 | 07/1/13-06/30/14 | \$230 M |
| 13 | 07/1/14-06/30/15 | \$108 M |

| DY | Time Period | FFP Limit |
|----|------------------|-----------|
| 14 | 07/1/15-06/30/16 | \$ 68 M |
| 15 | 07/1/16-06/30/17 | \$ 68 M |

- **Workforce:** To support the new model of care within CCOs, Oregon established a loan repayment program for primary care physicians who agree to work in rural or underserved communities in Oregon, and will complete training for 300 community health workers by 2015. As mandated by House Bill 3396 (2015 Regular Session), Oregon will do further evaluation and research to determine how to best recruit and retain health care providers to practice in rural and medically underserved areas of the state.

The primary goals of the Oregon demonstration are:

- **Improving health for all Oregonians:** The State is committed to fostering innovative approaches to improving population health through a focus on linking community health and services with the clinical delivery system. Population health efforts, [Public Health Modernization](#) and alignment with schools and the education system are integral to improving the health of all Oregonians by going beyond the walls of the clinics and hospitals.

- **Improving health care:** The State is working to coordinate physical, behavioral and oral health care and increase the focus on prevention and improved care. Individuals can get the care and services they need, coordinated regionally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language.
- **Reducing the growth in Medicaid spending:** The state has agreed to reduce per capita medical trend, the growth in per capita spending, by 2 percentage points by the end of the second year of the demonstration period from an assumed trend rate of 5.4 percent as calculated by federal Office of Management and Budget.

In December 2013, conforming amendments for the Affordable Care Act and the full implementation of the Tribal Uncompensated Care amendment to the 1115 Demonstration were approved.

In June 2014, the Hospital Transformation Performance Program (HTPP) was approved, and OHA and CMS concluded final negotiations regarding the measures included in the program in September 2014. This two-year program will offer hospitals incentive payments to support quality improvement.

C. State contacts

Demonstration and Quarterly Reports

Janna Starr, Operations and Policy Analyst
503-947-1193 phone
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State Plan

Jesse Anderson, State Plan Manager
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503-947-1119 fax

Coordinated Care Organizations

Rhonda Busek, Provider Services Director
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Quality Assurance and Improvement

Justin Hopkins, Compliance and Regulations Director
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503-945-6548 fax

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II. Title

Oregon Health Plan Section 1115 Quarterly Report
 7/1/2015 – 9/30/2015
 Demonstration Year (DY): 14 (7/1/2015 – 6/30/2016)
 Demonstration Quarter (DQ): 1/2016
 Federal Fiscal Quarter (FQ): 4/2015

III. Events affecting health care delivery

A. Overview of significant events across the state

| Category of event | Impact? (Yes/No) | | | Interventions or actions taken? (Yes/No) |
|--------------------------------------|---------------------|---------------|-----------------|--|
| | Demonstration goals | Beneficiaries | Delivery system | |
| A. Enrollment progress | No | No | No | |
| B. Benefits | No | No | No | |
| C. CCO Complaints and Grievances | - | - | - | |
| D. Quality of care – CCO / MCO / FFS | - | - | - | |
| E. Access | No | No | No | |
| F. Provider Workforce | No | No | No | |
| G. CCO networks | No | No | No | |

Detail on impacts or interventions

Nothing to report this quarter.

B. Complaints and grievances

Table 2 – Complaints and grievances

This information is from quarterly submissions received from the contracted health plans.

OHA has updated the complaint categories that CCOs are required to report, with 11 of 16 CCOs now reporting under the new categories. (Complaints received internally within OHA are reported separately from the CCO data and is discussed in the narrative portion of this report.)

- The following chart shows all complaints reported for the quarter using the categories required under the Special Terms and Conditions of Oregon’s current 1115 demonstration.
- Enrollment data rate per enrollee is presented in summary at the end of the chart.
- Totals for Pending, Resolved and Range Reported by CCOs are not reported this quarter.

| Complaint or grievance type | Number reported |
|--|-----------------|
| ACCESS TO PROVIDERS AND SERVICES | |
| a) Provider's office unresponsive, not available, difficult to contact for appointment or information. | 152 |

| Complaint or grievance type | Number reported |
|--|-----------------|
| b) Plan unresponsive, not available, difficult to contact for appointment or information. | 16 |
| c) Provider's office too far away, not convenient | 41 |
| d) Unable to schedule appointment in a timely manner. | 165 |
| e) Provider's office closed to new patients. | 25 |
| f) Referral or 2nd opinion denied/refused by provider. | 24 |
| ff) Referral or 2 nd opinion denied/refused by plan | 7 |
| g) Unable to be seen in a timely manner for urgent/ emergent care | 43 |
| h) Provider not available to give necessary care | 74 |
| i) Eligibility issues | 47 |
| j) Client fired by provider – This is now reported under Interaction with Provider or Plan (L) | - |
| k) Female or male provider preferred, but not available | 11 |
| l) NEMT not provided, late pick-up resulting in missed appointment, problems with coordination of transportation services | 389 |
| TOTAL: | 994 |
| INTERACTION WITH PROVIDER OR PLAN | |
| a) Provider rude or inappropriate comments or behavior | 267 |
| b) Plan rude or inappropriate comments or behavior | 48 |
| c) Provider explanation/instruction inadequate/incomplete | 194 |
| d) Plan explanation/instr. Inadequate/incomplete | 97 |
| e) Wait too long in office before receiving care | 63 |
| f) Member not treated with respect and due consideration for his/her dignity & privacy | 45 |
| g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity; interpreter services not available | 9 |
| h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity | 3 |
| i) Lack of coordination among providers | 49 |
| j) Wants to change providers; provider not a good fit | 136 |
| k) Member has difficulty understanding provider due to language or cultural barriers | 0 |
| l) Client dismissed by provider/clinic | 33 |
| TOTAL: | 944 |
| CONSUMER RIGHTS | |
| a) Provider's office has a physical barrier(s) is not ADA compliant (preventing access from street level or to lavatory or to examination room or no special adaptations or doors) | 24 |
| b) Abuse, physical, mental, psychological - -This category moved to Quality of Care # dd | - |
| c) Concern over confidentiality | 38 |
| d) Member dissatisfaction with treatment plan (not involved, didn't understand, choices not reflected, not person centered, disagrees, tooth not restorable, preference for individual settings vs. group) | 94 |
| e) No choice of clinician, or clinician of choice not available | 25 |
| f) Fraud and financial abuse (services billed not provided, service provided in two appointments that should have been provided in one.) | 12 |
| g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health marital status, Medicaid/Medicare) | 21 |
| h) Plan bias barrier (age, race, religion, sexual orientation, mental/physical health status) | 0 |
| i) Differential treatment for Medicaid clients | 9 |
| j) Complaint/appeal process not explained, lack of adequate or understandable NOA | 0 |
| k) Not informed of consumer rights | 263 |
| l) Complaint and appeal process not explained | 0 |
| m) Denied member access to medical records (other than as restricted) | 8 |
| n) Did not respond to members request to amend inaccurate or incomplete information in the medical record (includes right to submit a statement of disagreement) | 2 |
| o) Advanced or Mental Health Directive not discussed or offered or followed | 3 |
| p) Restraint or seclusion used other than to assure members immediate | 2 |
| TOTAL: | 501 |
| CLINICAL CARE | |
| a) Received appropriate care, but experienced adverse outcome, complications, misdiagnosis or | 134 |

| Complaint or grievance type | Number reported |
|---|-----------------|
| concern related to provider care | |
| b) Testing/assessment insufficient, inadequate or omitted | 51 |
| c) Medical record documentation issue | 7 |
| d) Concern about prescriber or medication or medication management issues (prescribed non-formulary medication, unable to get prescription filled or therapeutic alternative recommended by Provider) | 139 |
| dd) Member neglect or physical, mental, or psychological abuse | 12 |
| e) Provider office unsafe/unsanitary environment or equipment | 37 |
| f) Lack of appropriate individualized setting in treatment | 32 |
| TOTAL: | 412 |
| QUALITY OF SERVICE | |
| a) Delay in receiving, or concern regarding quality of materials and supplies (DME) or dental | 113 |
| b) Lack of access to ENCC for intensive care coordination or case management services | 0 |
| bb) Lack of access to medical records or unable to make changes | 2 |
| c) Benefits not covered | 52 |
| TOTAL: | 167 |
| CLIENT BILLING ISSUES | |
| a) Co-pays | 13 |
| b) Premiums | 5 |
| c) Billing OHP clients without an approved waiver | 197 |
| TOTAL: | 215 |
| GRAND TOTAL | 3233 |
| Enrollment numbers as of 9/30/2015 | 850,258 |
| Rate per 1000 members | 3.8 |

Trends related to complaints and grievances

The current trend rate for CCO data is from 0.23 to 8.36 per 1000 members. The higher rate may be due to an increased focus on complaint reporting in the past year. Areas where the trend and rate is higher are seen in Access to Care and Interaction with Providers, or Plans.

The OHA Client Services Unit received 8715 calls related to CCOs for this quarter. The unit received its highest amount of calls during September when, OHA issued a large number of renewal notices. The highest number of calls relating to the CCOs occurred in the Client Choice/Enrollment, General Information and Client Material categories. The Client Materials category includes requests for handbooks, ID cards, complaint forms, and other material.

The OHA Client Services unit received 6,624 calls related to Fee-for-Service (FFS) members. The highest number of calls were regarding Client Enrollment, General Information and Third Party Liability..

Interventions

While there has been an increased focus on tracking and reporting complaints in the past year, OHA staff continues to work internally on processes, as well as with the Plans to improve reporting and trending analysis going forward into 2016.

C. Appeals and hearings

Table 2.1 – Appeals and hearings – statewide report – all categories of CCO appeals and contested case hearings for the current quarter

The following table lists the total number of Notices of Action (NOAs) issued by CCOs for the quarter by NOA reason, followed by the total number of appeals and contested case hearings requested in response to these NOAs, and the range reported across all CCOs.

| Notice of Action (NOA) reason | Total NOAs issued | Total appeal requests | Range of appeal requests |
|---|-------------------|-----------------------|--------------------------|
| a) Denial or limited authorization of a requested service. | 31,535 | 1,220 | 11-283 |
| b) Single PHP service area, denial to obtain services outside the PHP panel | 185 | 11 | 0-11 |
| c) Termination, suspension or reduction of previously authorized covered services | 436 | 19 | 0-13 |
| d) Failure to act within the timeframes provided in § 438.408(b) | 2 | 0 | 0 |
| e) Failure to provide services in a timely manner, as defined by the State | 7,333 | 0 | 0 |
| f) Denial of payment, at the time of any action affecting the claim. | 33,384 | 757 | 0-319 |
| Total | 72,875 | 2,007 | 25-420 |
| Number per 1000 members | 70.46 | 2.12 | 0.37 – 3.70 |
| Number overturned at plan level | - | 518 | 4 – 147 |
| Appeal decisions pending | - | 6 | 0-4 |
| Number of contested case hearings requested | - | 820 | 8 - 141 |
| Overturned prior to hearing | - | 202 | 1 - 42 |
| Overturn rate | - | 24.6% | - |
| Hearing decision pending | - | 8 | - |
| Hearing requests per 1000 members | - | 0.86 | 0.37 – 2.17 |

Contested case hearings

The following table represents the contested case hearings that were processed during the third quarter of 2015.

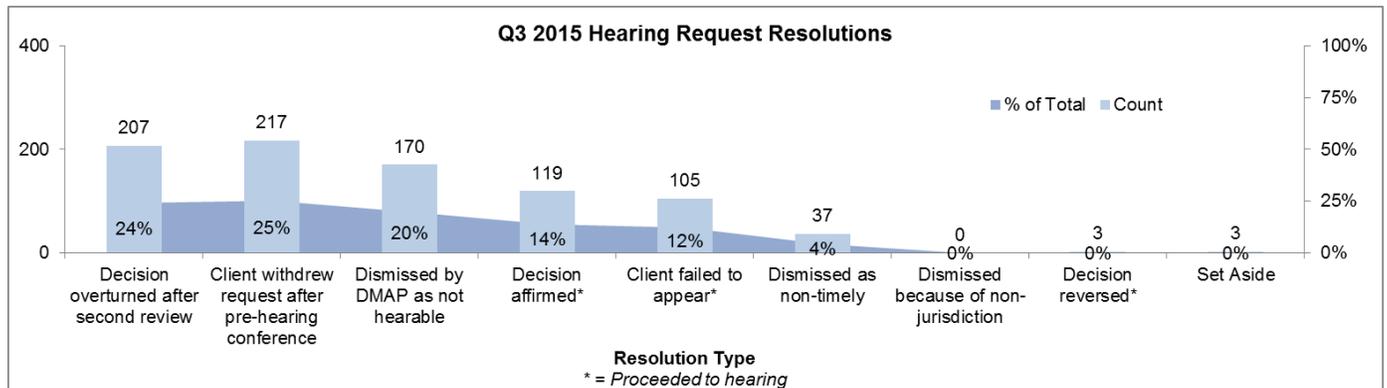
| Plan Name | Total hearing outcomes | Average plan enrollment * | Per 1000 members |
|---------------------------------------|------------------------|---------------------------|------------------|
| ALLCARE HEALTH PLAN, INC. | 33 | 49,782 | 0.6629 |
| CASCADE HEALTH ALLIANCE | 32 | 16,692 | 1.9171 |
| COLUMBIA PACIFIC CCO, LLC | 16 | 25,434 | 0.6291 |
| EASTERN OREGON CCO, LLC | 88 | 48,254 | 1.8237 |
| FAMILYCARE, CCO | 89 | 125,022 | 0.7119 |
| HEALTH SHARE OF OREGON | 132 | 235,816 | 0.5598 |
| INTERCOMMUNITY HEALTH NETWORK | 35 | 55,893 | 0.6262 |
| JACKSON CARE CONNECT | 25 | 29,832 | 0.8380 |
| KAISER PERMANENTE OR PLUS, LLC | 4 | 1,740 | 2.2989 |
| PACIFICSOURCE COMM. SOLUTIONS | 69 | 13,176 | 5.2368 |
| PACIFICSOURCE COMM. SOLUTIONS - GORGE | | 53,666 | 0.0000 |
| PRIMARYHEALTH JOSEPHINE CO CCO | 8 | 11,567 | 0.6916 |
| TRILLIUM COMM. HEALTH PLAN | 38 | 91,928 | 0.4134 |
| UMPQUA HEALTH ALLIANCE, DCIPA | 51 | 26,691 | 1.9108 |
| WESTERN OREGON ADVANCED HEALTH | 33 | 20,309 | 1.6249 |
| WILLAMETTE VALLEY COMM. HEALTH | 150 | 99,797 | 1.5031 |
| YAMHILL CO CARE ORGANIZATION | 9 | 22,905 | 0.3929 |
| ACCESS DENTAL PLAN, LLC | | 2,033 | 0.0000 |
| ADVANTAGE DENTAL | 3 | 24,358 | 0.1232 |
| CAPITOL DENTAL CARE INC | | 15,011 | 0.0000 |
| CARE OREGON DENTAL | | 2,105 | 0.0000 |

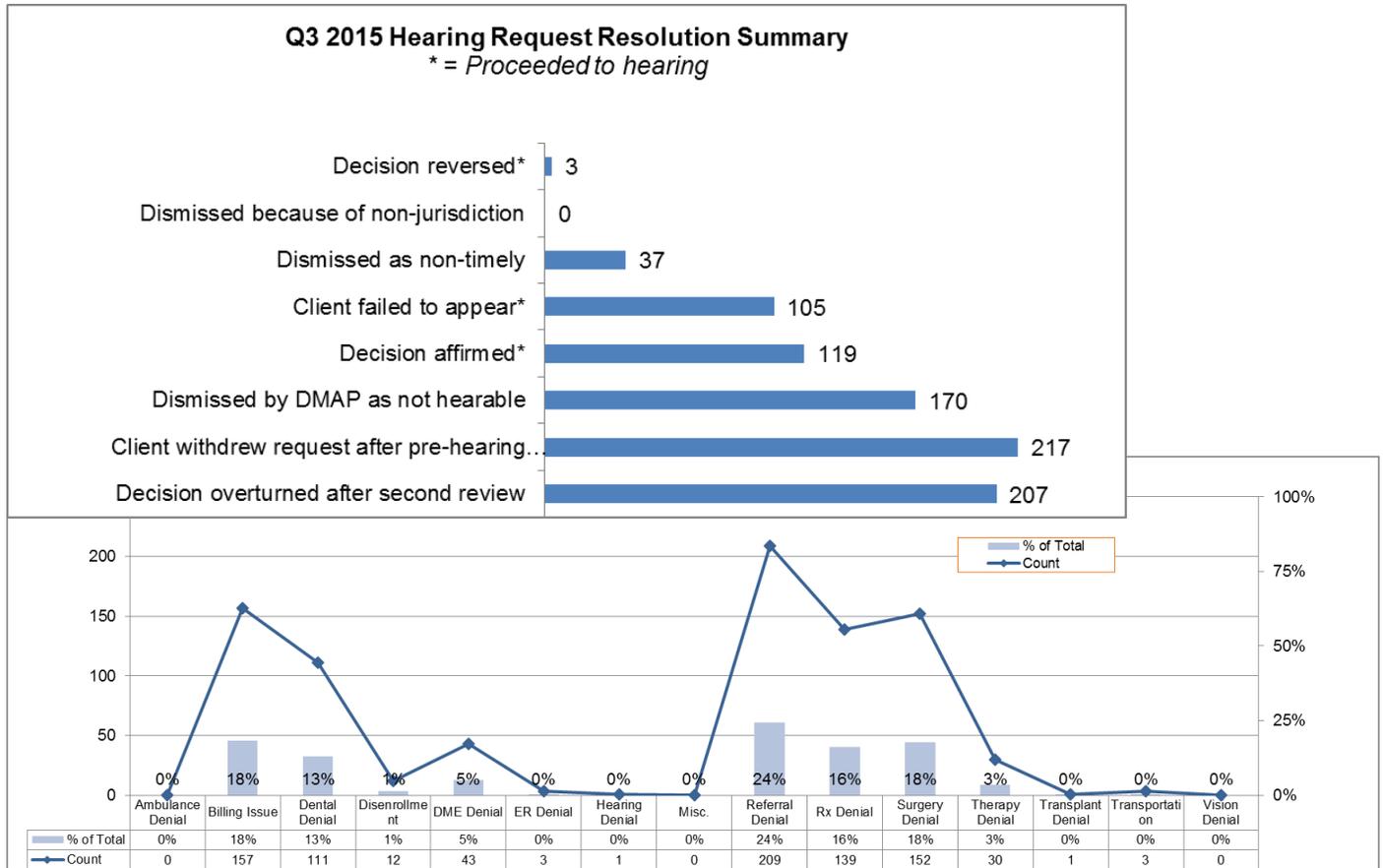
| Plan Name | Total hearing outcomes | Average plan enrollment * | Per 1000 members |
|-------------------------------|------------------------|---------------------------|------------------|
| FAMILY DENTAL CARE | | 1,982 | 0.0000 |
| MANAGED DENTAL CARE OF OREGON | | 2,078 | 0.0000 |
| ODS COMMUNITY HEALTH INC | 3 | 7,809 | 0.3842 |
| FFS | 43 | 254,648 | 0.1689 |
| Total | 861 | 1,238,528 | 0.6952 |

The following chart shows the outcomes of the hearings completed this quarter.

| Outcome | Count | % of Total |
|--|------------|------------|
| Decision overturned after second review | 207 | 24% |
| Client withdrew request after pre-hearing conference | 217 | 25% |
| Dismissed by DMAP as not hearable | 170 | 20% |
| Decision affirmed | 119 | 14% |
| Client failed to appear | 105 | 12% |
| Dismissed as non-timely | 37 | 4% |
| Dismissed because of non-jurisdiction | 0 | 0% |
| Decision reversed | 3 | 0% |
| Set aside | 3 | 0% |
| Total outcomes | 861 | |

Trends





Interventions

No report this quarter.

D. Implementation of 1% withhold

During this quarter, OHA analyzed encounter data received for completeness and accuracy for the subject months of December 2014 through February 2015. All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred. Future reports may contain the following information:

Table 3 – Summary

| Metric | Frequency | |
|---|-----------|----------|
| | Quarterly | Annually |
| Actual amount paid of monthly PMPM capitation rate broken out by: | X | X |
| ■ Average/mean PMPM | | |
| ■ Eligibility group | | |
| ■ Admin component | | |
| ■ Health services component | | |

| Metric | Frequency | |
|--|-----------|----------|
| | Quarterly | Annually |
| For the first year, this will be 99% and NOT include the 1% withhold, which is reflected under incentives agreement (or policy) | | |
| Actual amount paid in incentives monthly broken out by: <ul style="list-style-type: none"> ■ Total by CCO ■ Average/mean PMPM incentive ■ The over/under 100% of capitation rate by CCO and by average enrollee PMPM | X | X |
| Best accounting of the flexible services provided broken out by: <ul style="list-style-type: none"> ■ Services that are not Medicaid state plan services but DO have encounter data (e.g., alternative providers) ■ Services that are not reflected in encounter data (e.g., air-conditioners, sneakers) | X | X |
| CCO sub-contractual payment arrangements – narrative <ul style="list-style-type: none"> ■ Description of innovative (i.e., non-FFS) reimbursement and incentive arrangements between CCOs and sub-contracted service delivery network | | X |
| Encounter data analysis <ul style="list-style-type: none"> ■ Spending in top 25 services by eligibility group and by CCO ■ To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well | X | X |

E. Statewide workforce development

Table 4 - Traditional Health Workers (THW)

| THW Program | Total number certified statewide | | Number of approved training programs | |
|--|----------------------------------|------------|--------------------------------------|------------|
| | Current Qtr. | Cumulative | Current Qtr. | Cumulative |
| Community Health Workers (CHW) | 21 | 171 | 1 | 8 |
| Personal Health Navigators (PHN) | 0 | 5 | 0 | 2 |
| Peer wellness/support specialists | 25 | 515 | 2 | 20 |
| Other THW (Douglas) | 0 | 18 | 0 | 1 |

Narrative detail on regional distribution of certified THWs and THW training programs; news about relevant recruitment efforts or challenges

One training program submitted documentation for approval in this quarter and was approved:

- Chemeketa Community College Peer Wellness Specialist Program

We were unable to collect all training program data for this quarter in time for the report. However, of the data we were able to collect, 80 THWs completed training. The racial ethnic breakdown of all certified THWs are as follows (totals do not match as some are applicants are pending):

- African American/Black: 28
- American Indian/Alaska Native: 3
- Asian: 2
- Hispanic/Latino: 8
- Pacific Islander: 1
- White: 33
- Other: 3

- Decline to Answer: 1
- Unknown: 2

THW presentations and meetings

- July 2 – ORCHWA re: dual CHW/Interpreter role
- July 13 – Health Equity Researchers of Oregon, THW Presentation
- July 16 - THW Complaint Database Review
- July 27 – THW Commission Meeting
- August 6 – Rogue Community College THW Focus Group
- August 17 - HB2024 Rules Advisory Committee – THWs and Oral Health
- Aug 24 – THW Commission Meeting
- September 8 - Chemeketa Community College, THW Training Review
- September 16 - HB2024 Rules Advisory Committee – THWs and Oral Health
- Sep 28 – THW Commission Meeting

THW-related policy

Rulemaking is underway for House Bill 2024 in the 2015 Legislative session, which requires OHA to work with coordinated care organization (CCOs) and dental care organizations (DCOs) to develop certification requirements for THWs to provide dental health education and dental disease prevention services. The final rules will be completed no later than July 1, 2016.

New background check rules are being established that may have an impact on THW background checks. Rules will be finalized by December 2015.

Health professional graduates participating in Medicaid

OHA periodically receives information about medical school, physician assistant, nurse practitioner, and dentistry program graduates from Oregon Health and Sciences University (OHSU). In accordance with STC 57.b.iii, we match this information with Medicaid provider enrollment data to ascertain what proportion of those graduates go on to serve Medicaid clients. In November 2015, OHA received an updated file of 2014-2015 graduates and results (for 295 graduates) are shown below:

Proportion of 2014-2015 graduates enrolled as Oregon Medicaid providers

| Field | November 2015 |
|-------------------------|---------------|
| Nursing (adv. practice) | 36.5% |
| Physician Assistant | 67.6% |
| Dentistry | 13.9% |
| Medicine* | 11.8% |

* This number reflects *individual* graduates as enrolled providers. However, because medical school is typically followed by at least 3 years of continued training in a residency program, with services billed under a supervising physician’s Medicaid provider number, this number does not reflect the number of graduates who are doing their residencies in Oregon at *institutions* that are enrolled as Medicaid provider facilities.

F. Table 5- Significant CCO/MCO network changes during current quarter

| Approval and contracting with new plans | Effect on | | Number affected | |
|---|-----------------|---------|-----------------|-------------|
| | Delivery system | Members | CCOs | CCO members |
| - | | | | |

| Changes in CCO/MCO networks | Effect on | | Number affected | |
|-----------------------------|-----------------|---------|-----------------|-------------|
| | Delivery system | Members | CCOs | CCO members |
| | | | | |

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| Changes in CCO/MCO networks | Effect on | | Number affected | |
|---|---|---------|-----------------|--------------------|
| | Delivery system | Members | CCOs | CCO members |
| EOCCO signed amendment effective 8/1/15 to increase enrollment limits by 3800 lives | 3800 more OHP members to be served by EOCCO | N/A | 1 | 3800 new members |
| IHN signed amendment effective 7/1/15 to increase enrollment limits by 16,000 lives | 16,000 more OHP members to be served by IHN | N/A | 1 | 16,000 new members |
| Pacific Source-Central Oregon signed amendment effective 7/1/15 to increase enrollment limits by 5000 lives | 5,000 more OHP members to be served by Pacific Source | N/A | 1 | 5,000 new members |
| Pacific Source-Columbia Gorge signed amendment effective 7/1/15 to increase enrollment limits 4500. | 4,500 more OHP members to be served by Pacific Source | N/A | 1 | 4,500 new members |

| Rate certifications | Effect on | | Number affected | |
|--|-----------------|---------|-----------------|-------------|
| | Delivery system | Members | CCOs | CCO members |
| Amendments sent to CCOs for 2015 retro-rate adjustments effective 1/1/15 | - | - | 16 | - |

| Enrollment/disenrollment | Effect on | | Number affected | |
|--------------------------|-----------------|---------|-----------------|-------------|
| | Delivery system | Members | CCOs | CCO members |
| No issues | - | - | - | - |

| CCO/MCO contract compliance | Effect on | | Number affected | |
|-----------------------------|-----------------|---------|-----------------|-------------|
| | Delivery system | Members | CCOs | CCO members |
| No compliance actions | - | - | - | - |

| Relevant financial performance | Effect on | | Number affected | |
|--------------------------------|-----------------|---------|-----------------|-------------|
| | Delivery system | Members | CCOs | CCO members |
| No issues | - | - | - | - |

| Other | Effect on | | Number affected | |
|--|-----------------|---------|-----------------|-------------|
| | Delivery system | Members | CCOs | CCO members |
| Centene acquisition of Agate (parent of Trillium Health) was finalized | - | - | 1 | - |

G. Transformation Center

The Transformation Center continues to assist CCOs through Innovator Agent leadership, learning collaboratives and technical assistance.

Key highlights from this quarter:

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

The Transformation Center facilitated three sessions for the statewide CCO learning collaborative in this period. Sessions focused on:

- Promising practices in implementing evidence-based colorectal cancer screening interventions in Oregon CCOs and clinics. A panel of providers and CCOs discussed a variety of strategies in use to increase rates of colonoscopies and use of FIT kits.
- Standardization of the Traditional Health Worker role in coordinated care with presentations from CCOs and oral health.
- Clinical and community interventions to reduce tobacco use, with presentations from CCOs, county health departments, and dental care organizations.

More information is available at www.transformationcenter.org/cco.

Quality Improvement Community of Practice

The Transformation Center launched a six month customized coaching program tailored specifically to the needs in Oregon. This monthly webinar program led by IHI began in July and focuses on peer-to-peer learning, with the cohort consisting only of CCO quality improvement leads and OHA colleagues.

The sessions cover the topics of managing the work, developing teams and managing improvement. At each session a participant presents a case study for the group to discuss and share lessons learned. Participants prepare for the sessions with reading assignments and responding to questions on the group listserv. The custom webinars are further developing relationships between the CCOs that will facilitate the sharing of lessons learned and the spread of innovation that will continue well beyond the end of the Community of Practice in December.

Community Advisory Council Learning Collaborative

During the reporting period, the Transformation Center hosted monthly conference calls for the two CAC leadership networks: one for the CAC chairs and co-chairs (who are CAC members), and one for the CCO CAC coordinators (who are primary staff of the CCOs). These networks provide ongoing leadership development for the CACs. Guest presenters from 211 Info (an information and referral service), OHA's Office of Equity and Inclusion and the Public Health Division were invited to participate on the calls, share their work and highlight available resources to support CACs.

In addition, the CAC Steering Committee was convened bimonthly during this time to advise the Transformation Center on how best to support community advisory councils statewide. In addition, the committee met to discuss how CACs could get their Community Health Improvement Plan (CHIP) topics incorporated into contractual agreements with their CCOs, and to make recommendations for the upcoming Coordinated Care Model (CCM) Summit.

In the previous reporting period, The Transformation Center hosted a CAC Summit for CAC members. While the CAC Summit evaluation feedback was very positive overall, several CAC members experienced significant barriers to accessibility while staying at the Sunriver Resort. During the reporting period, in response to the accessibility issues encountered at Sunriver, the Transformation Center convened an OHA Accessibility Advisory Committee, consisting of community advisory council (CAC) members, Transformation Center staff, OHA Leadership and outside accessibility experts. The committee was chartered to offer recommendations for ensuring accessibility at OHA events and to provide information about how best to accommodate individuals with accessibility needs.

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More information about the CAC Learning Collaborative is at www.transformationcenter.org/cac.

Council of Clinical Innovators

This quarter, the Clinical Innovation Fellows program launched its second year with a cohort of 15 fellows. This cohort includes physical, behavioral and oral health providers, as well as public health, social work and quality improvement professionals. This year's fellows represent 12 of the 16 CCOs across the state.

In July, the fellows met for a two-day in-person meeting. The first day focused on introductions, project overviews, mentor group meetings and project charters. The second day focused on leadership, self-knowledge and influencing without authority. For the first time, the Transformation Center was able to offer continuing medical education credits for participation.

In August, the online meeting focused on establishing basic knowledge of the CCO model and connecting fellows' projects with their CCOs. The September online meeting focused on applying measurement best practices to the fellows' projects. The program also offered one-on-one consultations with the presenter of this session. Throughout this quarter, each fellow met monthly with their faculty mentor, both individually and in small groups.

The program is currently looking at funding options for sustaining the program past the SIM grant period.

More information about the Council of Clinical Innovators is available at www.transformationcenter.org/cci.

Transformation Center CCO Technical Assistance Bank

As a result of requests from CCOs and their CACs, in October 2014 the Transformation Center began offering CCOs and their CACs the opportunity to receive technical assistance (TA) in key areas to help foster health system transformation. In addition to support and technical assistance provided by other parts of OHA, each CCO was designated 35 hours of free consultation from outside consultants on contract with the Transformation Center.

- For Year One, the designated 35 hours included 10 hours of consultation to support CACs and other community-based work and the hours were accessible through September 2015. CCOs that had current projects as of August 2015 were granted an extension to use Year One hours until November 15, 2015. Any other Year One hours were forfeited after September 2015.
- For Year Two, a new allocation of 35 hours per CCO was made available starting October 2015. Requests to access Year Two hours must be made by June 2015 and Year Two hours must be used by September 2016. The Transformation Center continues to recommend that 10 of those 35 hours be used to support CACs and other community-based work.

As of September 2015, the Transformation Center had received 27 TA Bank requests from CCOs, for a total of 403 anticipated TA hours upon completion of those requests. Fifty-two percent of these requests focused on CAC development, including the community health assessment and community health improvement plan. Other requests focused on health equity, quality improvement and measurement, program evaluation and alternative payment methods (see chart below). TA Bank evaluation results for four of ten completed TA projects show that 100% of CCOs rated the TA as very valuable (80%) or valuable (20%), and 100% of CCOs rated the TA as very effective (80%) or effective (20%) (see charts below).

To continue to provide technical assistance through September 2016, the Transformation Center released a Request for Applications (RFA) for consultants to contract as technical assistance providers. The Transformation Center received feedback from CCOs through the Innovator Agents to inform the RFA process. The Transformation Center has also requested the Innovator Agents work with their CCOs to advertise the RFA to potential contractors that might be a good fit with the Technical Assistance Bank. The

RFA has resulted in 17 new contractors available to provide technical assistance on a variety of topics. The Transformation Center continues to communicate with the Office of Equity and Inclusion, Office of Health Information Technology, Public Health Division, Office of Health Policy and Research, and the Child Well-being Team to ensure coordination of OHA technical assistance for the topics listed below.

TA Bank technical assistance topics:

| | |
|---|--|
| 1. Alternative payment methods | 9. Oral health integration |
| 2. Behavioral health integration | 10. Organizational development for CCOs and/or CCO community advisory councils |
| 3. Community health improvement plan (CHIP) review, implementation and evaluation | 11. Primary care transformation, including patient-centered primary care homes |
| 4. Early learning systems and strategies | 12. Program Evaluation |
| 5. Engagement strategies for person and family-centered health care systems | 13. Project management* |
| 6. Health information technology | 14. Public health integration |
| 7. Health systems leadership* | 15. Quality improvement science |
| 8. Improving health equity | 16. Other topics upon request |

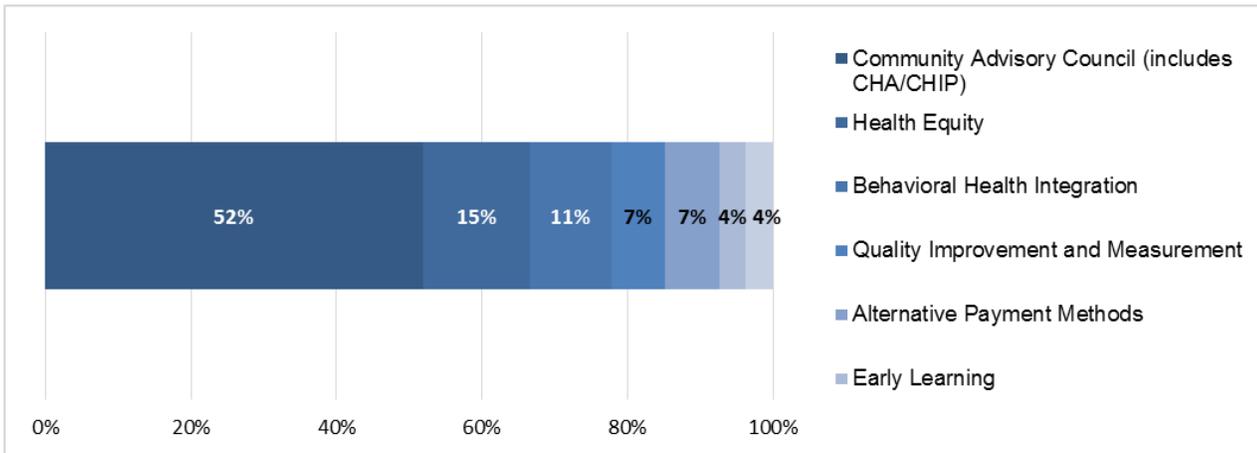
*Topics added to the Technical Assistance Bank during the RFA development process.

TA Bank projects through June 2015:

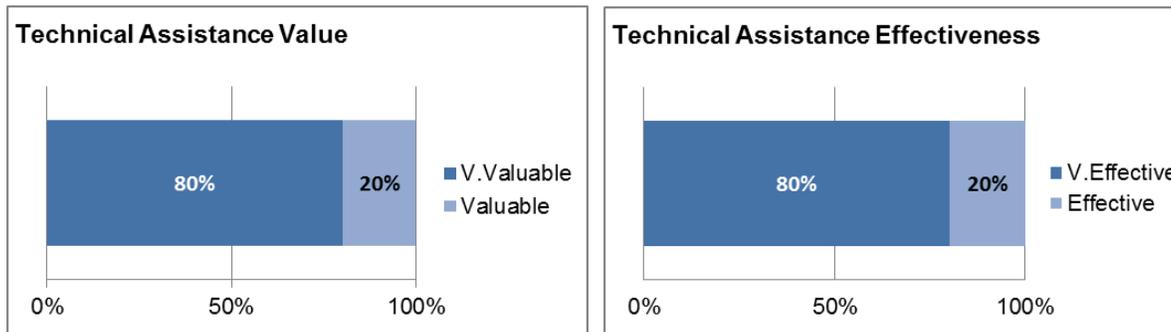
| CCO | Topic | Hours Requested |
|--|---|-----------------|
| 1. Willamette Valley Community Health | Health equity | 4 |
| 2. Intercommunity Health Network | Measurement | 11 |
| 3. FamilyCare | CAC development, CHIP implementation | 16 |
| 4. PacificSource Central Oregon | Measurement | 25 |
| 5. Eastern Oregon CCO | CAC member engagement | 5 |
| 6. AllCare | CAC member engagement | 32 |
| 7. PrimaryHealth Josephine County | CAC member engagement | 11 |
| 8. PrimaryHealth Josephine County, Jackson Care Connect, AllCare | Health literacy | 10.5 |
| 9. Jackson Care Connect | CAC development, CHIP implementation | 8.5 |
| 10. Trillium Community Health Plan | Health program evaluation | 7 |
| 11. Western Oregon Advanced Health | CHIP development | 15 |
| 12. Intercommunity Health Network | Alternative payment method training | 9.5 |
| 13. Columbia Pacific CCO | CHIP implementation | 19 |
| 14. Cascade Health Alliance | CAC member engagement | 10.5 |
| 15. Health Share | Health equity | 25 |
| 16. Willamette Valley Community Health | CAC member engagement | 16 |
| 17. Trillium | Community Health Assessment | 7 |
| 18. Eastern Oregon CCO | CHIP implementation | 30 |
| 19. Willamette Valley Community Health | Alternative payment methods | 11 |
| 20. PacificSource Central Oregon | CHIP development | 13 |
| 21. InterCommunity Health Network | Early Learning | TBD |
| 22. Jackson Care Connect | Strategic planning to address opioid issues (statewide PIP) | 18 |
| 23. Jackson Care Connect | Project management to address opioid issues (statewide PIP) | TBD |
| 24. Jackson Care Connect | Behavioral health integration | TBD |
| 25. Primary Health of Josephine County | CHIP implementation | 22.5 |
| 26. Willamette Valley Community Health | Health equity training | TBD |
| 27. PacificSource Columbia Gorge | CHIP implementation | TBD |
| Total Anticipated Hours: | | 403 |

Note: TBD = To be determined, which means a request has been submitted, and the total requested hours is still in process of being decided.

TA Bank projects by topic:



TA Bank evaluation results (for four out of ten completed TA Bank projects):



More information about the Technical Assistance Bank is available at www.transformationcenter.org/tabank.

Coordinated Care Model Summit

The Transformation Center plans to hold its third coordinated care model summit on November 17, 2015, titled “Oregon’s Coordinated Care Model: Highlighting Outcomes and Promoting Excellence.” The goals of the summit are to highlight outcomes and lessons learned, support excellence in coordinated care model implementation, and inspire future innovation in Oregon and beyond. CCOs, other public and private health care purchasers, providers and clinicians, CCOs’ CACs, community stakeholders, health leaders, lawmakers, policymakers and funders will come together to share outcomes and lessons learned from innovative strategies for implementing health system transformation.

The lunch plenary session will feature Dr. Soma Stout, the Lead Transformation Advisor with the Cambridge Health Alliance and Executive External Lead for Health Improvement with the Institute for Healthcare Improvement in a discussion about the social determinants of health and patient-centered care. A call for proposals was completed to elicit high-quality, results-oriented presentations. A draft agenda is available at

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www.transformationcenter.org/ccmsummit and the breakout sessions during the conference will focus on the following topics:

- Behavioral Health Integration
- A Culturally Competent Workforce
- Empowering Patients to Take Charge of Their Health
- Improving Health through Community Engagement
- Using Technology to Improve Health
- Oral Health Integration
- Opioids
- Improving the Patient Experience of Care
- Complex Care
- Social Determinants of Health
- Trauma-Informed Care
- Reflections from County Leaders on Oregon’s Health System Transformation

Health Equity and Health & Early Learning Conferences

In conjunction with the 2015 Coordinated Care Model Summit, half-day conferences focused on health equity and health and early learning will occur the previous day.

The OHA Office of Equity and Inclusion is hosting a conference that focuses exclusively on the implementation of health equity, diversity and inclusion policies and strategic equity initiatives throughout Oregon’s health system. The conference will bring together OHA leadership, CCOs and health systems; providers and health care stakeholders; community-based organizations; community stakeholders; and other organizations and groups that address social determinants of health to focus on these key areas:

- Upstream approaches to achieving health equity;
- Community-led decision-making for organizational change and policy;
- Social determinants of health and opportunities for collaboration throughout the state; and
- Developing equity leadership skills among executives, administrators, providers and clinicians in Oregon’s health system.

The OHA Child Well-being Team and the Early Learning Division of the Oregon Department of Education are inviting CCO and Early Learning Hub representatives to come together to:

- Identify collaborative opportunities to support early learning & children’s health;
- Inspire and strengthen cross-sector connections; and
- Learn about existing CCO/Hub initiatives, projects and policies that can be replicated in other regions of Oregon.

Table 6 - Innovator Agents – Summary of promising practices

Innovator Agent learning experiences

| | |
|-----------------------|--|
| Summary of activities | The Innovator Agents convene a monthly in-person meeting to share information and learn from others in OHA as well as outside experts. Meetings this quarter included discussions about the impact of new benefits, the integration of new services into CCOs (NEMT and TCM), the mapping of Behavioral Health services throughout Oregon, and Traditional Health Workers. Additionally Innovator Agents met with Early Learning staff, Public Health staff, and the Housing Integrator for Oregon Housing and Community Services to share information and strategize how to continue work towards health system transformation. |
|-----------------------|--|

| | |
|--------------------------------|---|
| Promising practices identified | These meetings allow Innovator Agents to build and sustain relationships with executive leadership across OHA and other state divisions. The Innovator Agents meet with the OHA Director each month to share her vision for the role of the Innovator Agents in the new OHA organizational structure and how OHA will continue to support the CCOs. |
| Participating CCOs | 16 |
| Participating IAs | 9 |

Learning collaborative activities

| | |
|--------------------------------|--|
| Summary of activities | <p>The Innovator Agents attended several learning collaboratives and forums this past quarter, including the “Engaging Beneficiaries with Medicaid & Medicare and Long-Term Services and Supports (LTSS): Strategic Approaches and Partnerships” Fall Forum and the Oregon Oral Health Coalition and Fall conference entitled “Oral Health in the New Age of Aging, Perspective on Epigenetics, Gerontology and Chronic Diseases.” The LTSS Fall Forum included presentations on disability competent care, improving patient engagement utilizing the Patient Activation Measure, the ADA and the Olmstead Act, amongst many other topics.</p> <p>During Q3 2015, Innovator Agents also had representation at the EDIE/Pre Manage Summit on implementation and data, which focused on the use of data, updates and education on the Emergency Department Information Exchange (EDIE) and PreManage, how it’s been useful thus far throughout the state and within other states utilizing the system.</p> <p>Innovator Agent representatives assisted Transformation Center staff in planning for the Flexible Services Learning Collaborative scheduled for October 2015.</p> |
| Promising practices identified | Innovator Agent engagement with learning collaboratives are a key strategy to ensuring that innovations are identified and shared across CCOs. For example, information from the LTSS Fall Forum on Patient Activation Measures was shared with key CCO staff. |
| Participating CCOs | 16 |
| Participating IAs | 9 |

Assisting and supporting CCOs with Transformation Plans

| | |
|--------------------------------|--|
| Summary of activities | During Q3 2015, Innovator Agents provided support to their CCOs with Transformation Plans by reviewing OHA feedback of their 2015-2017 Transformation Plans and assisting as needed with modifications. Innovator Agents continue to connect CCO staff with research and other resources as they seek to implement their Transformation Plan strategies. |
| Promising practices identified | Dental Integration: Innovator Agents help create a linkage with oral health providers and advocates with existing CCO structures to develop intentional partnerships and strategies to promote the integration of oral health into the CCOs. |
| Participating CCOs | 16 |
| Participating IAs | 9 |

Assist CCOs with target areas of local focus for improvement

| | |
|-----------------------|---|
| Summary of activities | Innovator Agents supported conversations between their CCOs, the State and community partners about a range of topics, including implementation of APMs, health equity and disability awareness, and behavioral health/physical health integration. |
|-----------------------|---|

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| | |
|--------------------------------|--|
| | Trauma Informed Care: There is a growing knowledge base within the CCOs and their community partners around the effects of trauma. Where needed, IAs have assisted in strategy development, community education, training, and supporting the development of Trauma Informed Care. |
| Promising practices identified | Each month CCOs have an opportunity for peer-to-peer education and support through a learning collaborative held during the Quality and Health Outcomes Committee meeting. Promising practices are identified and shared during this time. During Q3 2015, learning collaboratives on Colorectal Cancer Screening, Provider Vitality, and the use of Traditional Health Workers were held. |
| Participating CCOs | 16 |
| Participating IAs | 9 |

Communications with OHA

| | |
|--------------------------------|--|
| Summary of activities | <p>Innovator Agents meet regularly with leaders across OHA to strategize on how to collaborate and to stay informed about OHA programs and policies. For example, this quarter the Innovator Agents met with the Housing and Community Services Integrator to discuss potential grant opportunities, the Office of Equity and Inclusion to give feedback on an outreach plan, and State Public Health staff to review their reorganization efforts and its impact on CCOs.</p> <p>Additionally, Innovator Agents communicate routinely with Health Systems Division staff on specific issues and concerns. During Q3 2015 the rollout of new benefits and challenges with implementation were discussed.</p> |
| Promising practices identified | Regular and frequent communication with the Health Systems Division staff helps the Innovator Agents support continuous quality improvement efforts within OHA related to Oregon's health system transformation implementation. |
| Participating CCOs | 16 |
| Participating IAs | 9 |

Communications among Innovator Agents

| | |
|--------------------------------|---|
| Summary of activities | <p>Innovator Agents spent considerable time during Q3 2015 composing an electronic survey evaluating the Innovator Agent program. This required significant collaboration and teamwork to produce a product that offers respondents an opportunity to provide objective feedback.</p> <p>Additionally, the Innovator Agents regularly connect with each other to answer questions, share information and practices across CCOs.</p> |
| Promising practices identified | Regular meetings by phone and monthly in-person meetings have provided a critical link between Innovator Agents and have also helped to keep them aligned with the Transformation Center and OHA. Since each Innovator Agent is located within their region and do not (in general) work out of a state office, these regular connections have provided direction and essential support. |
| Participating CCOs | 16 |
| Participating IAs | 9 |

Community advisory council activities

| | |
|-----------------------|---|
| Summary of activities | Innovator Agents continue to support the Community Advisory Councils (CACs) through regular attendance at meetings and consultation with CAC leaders about strategies for continued growth of the CACs. The Innovator Agents are also attending CAC Community Health Improvement Plan (CHIP) workgroup meetings as these projects move forward. |
|-----------------------|---|

| | |
|--------------------------------|---|
| | Innovator Agents attend all CAC meetings and many have a standing report on the agenda to update the council on OHA-related items. This serves to establish a critical link between the CAC and OHA and increases CAC members' knowledge about Medicaid policies and organization change occurring within OHA. |
| Promising practices identified | As CACs mature and evolve, they have a greater understanding of how to effectively fulfill their role and function. For example, many CACs are actively engaged in creating work plans and completing activities in support of the CHIP. Some are preparing for the next iteration of their CHIP. Counties, hospitals, CCOs, and other community partners are actively collaborating on these processes. Innovator Agents are central to connecting the partnerships, identifying common data sources, and linking with the CCO's CHIP and CAC. |
| Participating CCOs | 16 |
| Participating IAs | All 9 Innovator Agents attend the CAC meetings associated with their CCO(s). |

Rapid-cycle stakeholder feedback (to identify and solve barriers; assist with adapting innovations; simplify and/or improve rate of adoption; and increase stakeholder engagement)

| | |
|--------------------------------|---|
| Summary of activities | <p>At the direction of their CCO, each Innovator Agent pursues specific issues related to challenges and barriers to health system transformation. Topics raised in Q3 2015 ranged from specific operational issues (such as billing codes) to reporting challenges (such as duplicate or unclear reporting requirements) to policy or rulemaking questions. In this area, the Innovator Agent role functions primarily as the bridge between the CCO perspective and the OHA perspective, and endeavors to facilitate an efficient and effective solution if possible.</p> <p>Additionally, with the goal of advancing education and greater stakeholder engagement, an Innovator Agent made a presentation on the CCO Quality Metrics and Opportunities for Public Health Engagement to the Conference of Local Health Officials Health Communities.</p> |
| Promising practices identified | <p>The role of the Innovator Agent to assist with integration of new services and adopting innovations can be an effective tool to increase stakeholder engagement and movement towards change. Examples include:</p> <ul style="list-style-type: none"> ■ Integration of Targeted Case Management into the CCO: The Innovator Agents are actively involved with their local health departments, CCOs, and OHA leadership on the integration of county leveraged fund programs such as Targeted Case Management. Community partners are engaged in local planning while OHA provides further clarity on policy and program direction. ■ Three Innovator Agents are also involved in a multi-disciplinary workgroup to map a process for Lactation Consultation to be included and reimbursed as a CCO service to OHP members. The first meeting of this group was held on August 24. ■ Two IAs continue participation on OHA's Application and Redetermination workgroup to ensure that member and community feedback is reflected in state efforts to improve the member experience in obtaining and maintaining their Medicaid coverage. |
| Participating CCOs | 16 |
| Participating IAs | 9 |

Database implementation (tracking of CCO questions, issues and resolutions to identify systemic issues)

| | |
|--------------------------------|---|
| Summary of activities | The Issue Tracker is being revised to capture additional information about Innovator Agent presentations. |
| Promising practices identified | The Issue Tracker continues to be helpful for documenting issues and steps toward resolution. |
| Participating CCOs | 16 |
| Participating IAs | 9 |

Information sharing with public

| | |
|--------------------------------|--|
| Summary of activities | <p>Activities in support of information sharing with the public during Q3 2015 included a presentation to the Oregon Department of Developmental Disability Services, consultation with the Oregon Aging and People with Disabilities Office, and a variety of meetings with local Public Health entities.</p> <p>Additionally, Innovator Agents participated in the Behavioral Health Town Halls, conducted by legislative and OHA leadership around the state to gather first-hand information from consumers of the behavioral health system in Oregon. Innovator Agents have been involved in the state- and community-level coordination, community outreach and engagement, and have attended the events themselves.</p> |
| Promising practices identified | Communicating with CACs and CHIP workgroups is a good way to more broadly disseminate information to community members. |
| Participating CCOs | 16 |
| Participating IAs | 9 |

Table 7 - Innovator Agents – Measures of effectiveness

Measure 1: Surveys rating IA performance

| | |
|---|---|
| Data published for current quarter? Type? | <p>Innovator Agents designed a survey intended to capture feedback about the original intent of the Innovator Agent program, its successes, challenges, and possibilities for the future.</p> <p>Vetted by OHA leadership, the electronic survey will be distributed in October 2015 to a wide range of people representing CCOs, including CCO staff, community organizations and CAC members. Evaluation and summary of responses will be available in Q4 2015.</p> |
| Web link to Innovator Agent quality data | - |

Measure 2: Data elements (questions, meetings, events) tracked

| | |
|---|--|
| Data published for current quarter? Type? | <p>Examples of meetings and events attended by Innovator Agents during Q3 2015:</p> <ul style="list-style-type: none"> ■ Weekly phone calls with Innovator Agents ■ Weekly phone call with Transformation Center, OHA ■ Monthly in-person meeting ■ Representation at the monthly CCO workgroup meetings ■ Representation on numerous OHA committees ■ Attendance at three conferences addressing a variety of issues (Long Term Care, Health Information Sharing, Oral Health Integration). ■ Representation at a Limited English Proficiency training ■ Representation at town halls and focus groups, including the |
|---|--|

| | |
|--|---|
| | Regional Telehealth focus group and the Behavioral Health town halls. |
| Web link to Innovator Agent quality data | - |

Measure 3: Innovations adopted

| | |
|---|---|
| Data published for current quarter? Type? | Innovator agents work closely with CCOs and providers to develop strategies toward the new incentive metrics added in 2015 including dental sealants, effective contraceptive use. |
| Web link to Innovator Agent quality data | Projects presented at the Innovation Café are available at: http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx |

Measure 4: Progress in adopting innovations¹

| | |
|---|--|
| Data published for current quarter? Type? | CCOs have sought Technical Assistance through the Transformation Center and are taking action to implement the learnings, including subject matter such as evaluating the impact of programs that target social determinant issues, designing and implementing Alternative Payment Methodologies. Innovator Agents shared the projects presented at the Innovation Café in June with CCO staff who were not able to attend. |
| Web link to Innovator Agent quality data | Technical Assistance projects are described in a separate section of this report. Projects presented at the Innovation Café are available at: http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx |

Measure 5: Progress in making improvement based on innovations¹

| | |
|---|--|
| Data published for current quarter? Type? | Incentive payments for 2014 performance were distributed during this quarter, resulting in a heightened focus on 2015 performance targets and improvement. Clinical Advisory Panels and Board of Directors, along with CCO quality improvement staff, are highly engaged in identifying interventions to improve performance. |
| Web link to Innovator Agent quality data | Link to the 2015 Incentive Measures: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx Oregon’s Health System Transformation 2014 Final Report is available at: http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf |

Measure 6: CCO Transformation Plan implementation

| | |
|---|--|
| Data published for current quarter? Type? | Innovator Agents assisted with the completion of the 2014-2015 Technical Assistance Bank hours for their respective CCOs and educated CCOs about the process for accessing hours available for 2015-2016. As CCOs mature, the Transformation Plans are becoming more integrated into the CCO administration and structure. Increasingly CCOs are organizing their strategic planning efforts to incorporate the Transformation Plan domains. |
| Web link to Innovator | Transformation Plan Reports available online: |

¹ This item will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

| | |
|--------------------|---|
| Agent quality data | http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx |
|--------------------|---|

Measure 7: Learning collaborative effectiveness

| | |
|---|--|
| Data published for current quarter? Type? | <p>An increasing number of stakeholders participate in the Transformation Center’s learning collaboratives. For example, stakeholder participation in the Statewide CCO Learning Collaborative has maintained an average of 72 attendees at the seven sessions in the first three quarters of 2015 (compared to an average of 70 participants in 2014 and 61 participants in 2013).</p> <p>Participant evaluations for the first three quarters of 2015 indicate an increased percent of participants who found sessions valuable or very valuable (94% in 2015 compared to 90% in 2014) and a similar percent who planned to take action based on the learning collaborative (51% in 2015 compared to 52% in 2014).</p> |
| Web link to Innovator Agent quality data | <p>Oregon’s Health System Transformation 2014 Final Report is available at: http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf</p> |

Measure 8: Performance on Metrics and Scoring Committee metrics

| | |
|---|---|
| Data published for current quarter? Type? | <p>Incentives for the 2014 CCO performance on metrics were disbursed this quarter, which serve to reinforce positive behavior and motivates future performance amongst providers and CCOs.</p> <p>Innovator agents work closely with CCOs and providers to support development of strategies toward the new incentive metrics added in 2015 including dental sealants, effective contraceptive use.</p> |
| Web link to Innovator Agent quality data | <p>Oregon’s Health System Transformation 2014 Final Report is available at: http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf</p> |

Other evaluation results from Transformation Center learning collaborative can be found in Section V, Table 9.

H. Legislative activities

No report this quarter.

I. Litigation status

Nothing to report this quarter.

J. Two-percent trend data

See [Appendix C](#).

K. DSHP terms and status

See [Appendix D](#).

IV. Status of Corrective Action Plans (CAPs)

Table 8 – Status of CAPs

No report this quarter.

V. Evaluation activities and interim findings

In this quarter, Providence Center for Outcomes Research and Education (CORE) delivered a plan for conducting the second round of surveys and interviews to assess adoption of the coordinated care model among CCOs, other payers, and providers. CORE also delivered an analytic report and coded data set from a project that analyzed specific activities CCOs are carrying out to transform the delivery system. Evaluation of OHA’s PCPCH program and Behavioral Health Home Learning Collaborative continued, and Oregon Health & Science University’s Center for Health Systems Effectiveness (CHSE) made progress analyzing claims and encounter data to determine whether the effects of Medicaid transformation may have “spilled over” to non-CCO patients.

Table 9 - Evaluation activities and interim findings

In the tables below, relevant OHA and CCO activities to date are reported by the “levers” for transformation identified in our waiver agreement and Accountability Plan.

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 (PCPCH)

Evaluation activities:

As part of its evaluation efforts, the PCPCH Program is looking in-depth at 15 to 30 recognized clinics considered to be top-performing or exemplary practices. Researchers will interview key staff at each practice to determine which aspects of the PCPCH model are most important to successful practice transformation. In this quarter, researchers reached out to sites that were selected for interviews and conducted interviews onsite at the clinics.

Interim findings:

As of September 30, 2015, there were 589 recognized clinics in the state (surpassing Oregon’s goal of 500 clinics by 2015). This represents over 50% of the estimated number of primary care clinics in Oregon.

- PCPCH enrollment is a CCO incentive metric. The statewide baseline (for 2012) for this measure is 51.8%.
- CCO performance metrics (see Appendix E) show that the proportion of CCO members enrolled in a PCPCH increased from the 2012 baseline of 51.8% to 81.0% as of December 2014, ranging from 60.7% to 99.0% across CCOs.
- It is notable that CCOs have sustained this increase despite the significant growth in Medicaid enrollment due to the Affordable Care Act.

Improvement activities:

Oregon’s Patient-Centered Primary Care Institute (PCPCI) provides technical support and transformation resources to practices statewide, including learning collaborative opportunities.

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The current contract with PCPCI was closed out in this quarter and a new contract was executed. In the coming year, PCPCI will:

- Expand its role as a resource hub. PCPCI will provide Web-based and in-person learning events, convene communities and identify gaps and barriers to inform policy, and develop new programming to support primary care transformation.
- Design and pilot a regional primary care extension program. PCPCI will facilitate the planning, testing, and implementation of a regionally-based infrastructure which accelerates the ongoing development of comprehensive primary care.
- Align resources: PCPCI will facilitate communication and coordinate collaboration among related initiatives, including the Million Hearts[®] initiative, payment reform, alignment of metrics, and OHA activities led by the Transformation Center, PCPCH program and others.

Lever 2: Implementing alternative payment methodologies (APMs) to focus on value and pay for improved outcomes

Evaluation activities:

In this quarter, work continued on the Hospital Transformation Performance Program (HTPP), Oregon's incentive measure program for hospitals. The advisory committee for the program met twice, and a technical advisory group was established. 2016 measures and benchmarks for the CCO incentive measure program were also finalized by the advisory committee for the CCO program. See Appendix E for details.

Interim findings:

Internal analysis of the most recent quarterly CCO financial reports (for April – June 2015) shows that 55.6% of all plan payments are non-fee-for-service (FFS). This is an increase of 7.7% from the previous quarter, in which 47.9% of plan payments were non-FFS. As noted above, OHA continues to work with CCOs on improving APM reporting.

Improvement activities:

OHA continued to contract with Oregon Health & Science University's Center for Evidence-based Policy (CEbP) to provide technical assistance to CCOs with developing and implementing APMs. Assistance provided by CEbP will consist of focused work with two or three CCOs and more general resources and webinars for the remaining CCOs and other payers and providers. CCO proposals were submitted and reviewed during the reporting period. Grants will be awarded during the next reporting period. The CEbP submitted a report, in conjunction with the technical assistance application process, "Coordinated Care Organizations Alternative Payment Methods Readiness Assessment Report," to OHA. The report assessed the status of APM implementation in the state and outlined information, tools, strategies, and best practices to plan and implement effective APMs to assist CCOs and other entities within Oregon.

In this quarter, two CCOs received technical assistance with APMs from OHA's Technical Assistance Bank. In early July, a senior consultant from Bailit Health presented an overview of APMs and some recommendations for next steps to leadership of the Intercommunity Health Network (IHN). Also in this quarter, Bailit Health delivered a report to Willamette Valley Community Health evaluating existing APM activity and recommending APM approaches to align behavioral and oral health incentives

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

Evaluation activities:

The Behavioral Health Home Learning Collaborative (BHHLHC) is supported by Oregon's Adult Medicaid Quality Grant and assists organizations that are integrating primary care into their behavioral health settings.

The Oregon Rural Practice-based Research Network at OHSU (ORPRN) continued data collection for its evaluation of the project, including both qualitative and quantitative components.

In this quarter, ORPRN analyzed two sets of the Behavioral Health Integration Capacity Assessment (BHICA) for each of the participating sites. A third set will be completed in November and December to track changes in organizational capacities over the course of the Collaborative. ORPRN completed the focus groups to learn how team members at each site understand how behavioral health homes fit within the PCPCH model and began to conduct exit interviews of key informants. A transcriptionist was contracted to transcribe the recordings of the kick-off meetings, focus group discussions, and exit interviews for coding and analysis.

The project manager and ORPRN contractors consulted with OHA staff managing the advisory committee that is developing recommendations on standards for a Behavioral Health Home certification under the Patient-Centered Primary Care Homes system, providing preliminary findings from the BHHLC. ORPRN and OHA staff gave three presentations on the BHHLC at state and regional conferences and one Grand Rounds presentation at Oregon Health Sciences University. The evaluation of the project will be completed by the end of January 2016.

Interim findings:

Five of the CCO incentive measures relate to physical and behavioral health care integration. The narrative below compares progress on the measures from the 2011 baseline to CY 2014, the period June 2014 – May 2015, and the CCO incentive target for 2015 (see Appendix E for details). Of the four measures with data available for CY 2014 and June 2014 – May 2015, two measures improved between those periods. One of the three measures in the 2015 incentive measure set was above the target for 2015. Please note: final CY 2014 performance was updated for three of the measures (SBIRT, follow-up after hospitalization for mental illness, and mental, physical, and dental health assessment for children in DHS custody) due to measure specification changes.

- SBIRT (screening for unhealthy drug and alcohol use) increased from the 0.0% baseline in 2011 to 6.3% in CY 2014 and 7.4% in June 2014 – May 2015. The measure was below the target of 12% for 2015. SBIRT ranged from 0.3% to 15.5% across CCOs in June 2014 – May 2015. The SBIRT measure now includes adolescents ages 12-17.
- Follow-up after hospitalization for mental illness increased from the 65.2% baseline in 2011 to 71.8% in CY 2014, but decreased slightly to 70.3% in June 2014 – May 2015. The measure exceeded the target of 70.0% for 2015. The measure ranged from 55.7% to 81.2% across CCOs in June 2014 – May 2015. The follow-up after hospitalization for mental illness measure now includes follow-up services occurring on the same day of discharge.
- Screening for clinical depression and follow-up plan was 27.9% in CY 2014. The measure was below the target of 25.0% for 2015. The measure ranged from 3.3% to 68.1% across CCOs in CY 2014, with some of the variation likely due to challenges capturing data from electronic health records. The measure is updated annually, and is not available for June 2014 – May 2015.
- Mental, physical, and dental health assessment within 60 days for children in DHS custody decreased slightly from 27.9% in CY 2014 to 27.7% in June 2014 – May 2015. The measure was below the target of 90% for 2015. The measure ranged from 14.0% to 39.1% across CCOs in June 2014 – May 2015. Previously reported data for this measure only included mental and physical health assessments; performance dropped when the dental assessment requirement was instated.

Follow-up care for children initially prescribed ADHD medications increased from 52.3% in 2011 to 57.7% in CY 2014 and 59.6% in June 2014 – May 2015 for initiation phase, and decreased slightly from 61.0% in 2011 to 60.8% in CY 2014 for continuation and maintenance phase (an update for continuation and maintenance phase is not available for June 2014 – May 2015). In June 2014 – May 2015, the measure

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ranged from 47.6% to 78.7% across CCOs for initiation phase. Please note that this measure has been removed from the incentive measure set for 2015 given strong CCO performance (above the 90th percentile nationally), but OHA continues to monitor and report on the measure as part of the quality and access test.

Improvement activities:

The Behavioral Health Home Learning Collaborative (BHHLC) works with organizations that are integrating primary care into their behavioral health settings. During this quarter, regular practice coaching continued, typically twice per month, providing individualized technical assistance for each site. In September, BHHLC provided a webinar on the rules governing confidentiality and information exchange between behavioral and medical practitioners. The project manager and ORPRN contractors consulted with OHA staff managing the advisory committee that is developing recommendations on standards for a Behavioral Health Home certification under the Patient-Centered Primary Care Home system, providing preliminary findings from the BHHLC. Four of the nine organizations participating in the collaborative now provide integrated physical health services within the behavioral health facility to a growing panel of clients. Other sites are making progress toward increasing physical health services through co-location or care coordination with partners. The BHHLC will continue practice coaching, learning sessions, and webinars through December 2015.

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

Evaluation activities:

Assessing the spread of coordinated care in Oregon

Providence Center for Outcomes Research and Education (CORE) began preparation for a second round of surveys and interviews to assess spread of the coordinated care model among CCOs, commercial health plans, hospitals, and provider organizations. The surveys will assess the extent of transformation across 11 domains identified by OHA, CORE, and Oregon Health & Science University's Center for Health Systems Effectiveness (CHSE):

- Cross-sector partnerships
- Community involvement in governance
- Integrated and shared health care data
- Using data for population health management
- Integrated physical, behavioral, and dental care
- Better coordination (right care in the right place)
- Prevention and social-determinants-of-health-informed care
- Workforce transformation and diversification
- Ownership of risk
- Integrated risk
- Aligning incentives and value

CORE conducted initial surveys and interviews in February – April 2015 and delivered a baseline study assessing the extent of transformation among payers and providers in June 2016. In this quarter, CORE delivered a plan for conducting a second round of surveys and interviews that will enable them to assess the rate of transformation over a one-year period and address additional research questions about the motivations and mechanisms that result in transformation. CORE plans to conduct the second round of surveys and interviews in February – May 2016 using the panel of organizations from the first survey. Organizations with especially high or low transformation scores will be selected for interviews to identify factors that led to

transformation or challenges achieving transformation. In addition to questions included in the first round of interviews, CORE will address the following questions:

- What kinds of factors motivated organizations to adopt specific elements of the coordinated care model?
- How did organizations implement specific elements of the coordinated care model? Mechanisms may include outreach and education, financial incentives, or mandates for staff and contractors; investment in new staff, systems, or technologies; and other mechanisms.

Findings from the surveys and interviews will be included in a State Innovation Model (SIM) Grant evaluation report from CHSE and CORE to be delivered September 2016.

CCO document analysis

CORE delivered an analytic report and coded data set from a project to identify and categorize specific activities each CCO is carrying out to transform the delivery system. For the project, CORE reviewed and entered data on activities described in a variety of documents that CCOs submit to OHA, including transformation plans, community health improvement plans, and Transformation Fund grant reports. CORE then analyzed the data to describe where CCOs are focusing their effort and what kinds of successes and challenges CCOs are experiencing. Key findings from the report are summarized below. OHA will update the coded data set from the project as new documents are received. The data will be analyzed to evaluate CCOs' transformation activities, assess contract compliance, identify and spread promising practices, and better support CCOs.

Tracking “spillover” from Medicaid’s coordinated care model

CHSE made progress on its analysis of health care claims and encounters data to determine whether the effects of Medicaid transformation may have “spilled over” to non-CCO patients. Spillover may occur if clinics that are working to improve care management and coordination for Medicaid patients also adopt these improvements for other patients. As a first step in its analytic plan, CHSE analyzed the extent to which clinics in Oregon specialize in serving Medicaid patients; that is, whether some clinics serve a high percentage of Medicaid patients while others serve a low percentage of Medicaid patients, or whether percentage of Medicaid patients is relatively uniform across clinics. This step will enable CHSE to assess the association between Medicaid and utilization, spending, and quality measures for Medicaid and non-Medicaid patients. Findings from the surveys and interviews will be included in a State Innovation Model (SIM) Grant evaluation report from CHSE and CORE to be delivered September 2016.

Interim findings:

CCO document analysis

Key findings from CORE’s analysis of CCO documents include:

- CCOs focused heavily on physical, mental, and dental integration and workforce development.
- Relative to other areas, CCOs focused less on HIT transformation and APMs. This may be related to high upfront investments needed to support HIT transformation, since APMs often require performance data.
- Common barriers to transformation included provider and workforce capacity, challenges with outreach to the Medicaid population, obtaining demographic and health disparities data, and startup times for collaborating with other organizations.
- Overall, CCOs achieved three quarters of their goals for activities in their transformation plans.

Measures of efficient and effective care collected by OHA

From CY 2014 to June 2014 – May 2015, the following measures of efficient and effective care for which data were available improved (see Appendix E for details):

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- Emergency department visits per 1,000 member months decreased by 5%.
- Potentially avoidable hospital admissions per 1,000 member months decreased for the following conditions: chronic obstructive pulmonary disease (18% decrease), diabetes short-term complications (9% decrease), and heart failure (3% decrease). Potentially avoidable hospital admissions per 1,000 member months for adult asthma remained almost unchanged (less than 1% decrease).
- Rate of developmental screening in the first 36 months of life increased from 43% to 48%. However, rate of adolescent well-care visits decreased slightly (from 32% to 30%).

Please note that hospital readmissions and rates of screenings that serve as measures of efficient and effective care not listed above are not available from the period June 2014 – May 2015 and will be available in a future report.

Improvement activities:

Sustainable Relationships for Community Health (SRCH) Program

In February 2015, OHA's Public Health Division awarded five grants to local consortia consisting of CCOs, local public health authorities, and chronic disease self-management program providers. From February through September 2015, grantees participated in a series of three institutes designed to establish improved referral and programmatic relationships to improve health outcomes for pre-diabetes, diabetes, and hypertension. After the first two institutes, grantees created plans around quality improvement for closed-loop referrals and payments/reimbursements for self-management programs, using tools and best practices for provider engagement and data collection. Grantees improved efforts around data collection and measurement concepts; identified relevant performance measures; and identified tools for developing data collection and measurement plans. During the third institute in August 2015, grantees established new processes for data sharing across organizations and established a shared vision for commitment. Grantees created joint agreements and coordinated key performance indicators to implement the work related to pre-diabetes, diabetes, and hypertension moving forward. SRCH grantees shared their lessons learned and experiences with grantees and contractors from across Oregon at the annual Grantees and Contractors meeting in September 2015. A formal evaluation for the SRCH project launched at the beginning of September 2015 and will be complete by January 2016. Results of the evaluation will be disseminated out to partners and key stakeholders to inform current and future work with self-management in Oregon. These efforts are funded by the Centers for Disease Control and Prevention, and align with Oregon's CCO incentive measures and statewide performance improvement project.

Summary of Health Information Technology (HIT) initiatives

OHA's Office of Health Information Technology (OHIT) continues to make progress on state HIT initiatives and ensure that our efforts align with and support CCO needs through various activities that include stakeholder support and programmatic activities. Major HIT activities in July – September include:

- Bringing real-time hospital event notifications to CCOs and care teams.
- Engaging CCOs in the development of technical assistance for Medicaid practices related to their EHRs and meaningful use.
- Launching telehealth pilots in five communities.
- Passing critical legislation that improves OHA's ability to advance HIT in Oregon.

The biggest success in HIT for Oregon stakeholders this year, has been the increased adoption of PreManage, the HIT tool that brings real-time hospital notifications to CCO and primary care coordinators. OHA is pleased to be a co-sponsor for this effort and is responsible for coordinating CCO use of the tool. All 59 Oregon hospitals are now contributing admit, discharge, and transfer (ADT) data (both emergency department and inpatient data) to the Emergency Department Information Exchange (EDIE). CCOs, health plans, and providers can subscribe to PreManage to access the EDIE data and better manage their

populations who are high utilizers of hospital services. Currently, several health plans and about half of CCOs are using (or in process of launching) a PreManage subscription, and nearly 100 clinics in Oregon are subscribers. A September learning collaborative included many anecdotes about the value of PreManage and EDIE, including:

- Support for emergency department doctors working with patients seeking opioids.
- CCO care coordinators finally able to reach homeless members because they have the real-time information when a member is in the ED and can reach out in person and divert to primary care.
- Primary care clinics who have seen incredible reductions in readmissions by connecting with hospitals through PreManage.

The EDIE Utility Governing Committee (of which OHA is a member) is considering ways to assess the impact of these tools and report on progress.

OHIT convenes the Health Information Technology Advisory Group (HITAG) comprised of CCO representatives to guide HIT activities that support CCOs. HITAG met in July 2015 to provide input on the upcoming activities of meaningful use technical assistance, which OHA plans to launch through a contractor in Winter 2015/2016. HITAG met in September 2015 to share lessons learned from early CCO users of PreManage, helping spread information to CCOs considering PreManage.

In 2015, the Oregon Legislature passed long-anticipated legislation to formalize and support OHA's HIT efforts, improving OHA's ability to advance the necessary HIT to support CCOs and the spreading coordinated care model. Oregon originally addressed HIT in House Bill (HB) 2009 (2009 Regular Session) with the establishment of the HIT Oversight Council (HITOC), setting forth a strategic, policy, and coordination role for OHA. HB 2294 (2015 Regular Session) updates the HIT statute to account for changes since 2009 and has three major components:

1. Establishes the Oregon HIT Program within OHA.
 - Grants OHA authority to provide optional HIT services to support health care statewide (*e.g.*, beyond the Medicaid program).
 - Authorizes fees to cover the costs of operating OHA's HIT services. Fees would be charged to users of this program's services.
2. Grants OHA flexibility in partnering with stakeholders and the ability to participate in partnerships or collaboratives that provide statewide HIT services. This is especially important where Oregon organizations are partnering to bring new statewide HIT services to Oregon (such as the EDIE Utility), and allows OHA to participate and provide support, including:
 - Ability to vote on governance boards for such services.
 - Ability to enter into agreements to support and provide funding for the appropriate Medicaid share of statewide HIT services.
3. Updates statute for Oregon's HIT Oversight Council (HITOC). Aligns HITOC under the Oregon Health Policy Board and solidifies its role in providing strategic and policy recommendations and oversight on the progress of Oregon HIT efforts.

CCO metrics “dashboards”

OHA continues to release regular quality metric progress reports for CCOs utilizing the automated metric reporting tool (“dashboard”) developed by CORE. During Q3 2015, OHA released monthly dashboards for periods covering March 2014 – February 2015, April 2014 – March 2015, and May 2014 – April 2015. All measures were converted to 2015 specifications during the reporting period.

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The dashboard currently includes all claims-based CCO incentive measures and five additional quality and access measures. The dashboards will continue to be expanded to include additional measures and filters as well as historical trend analysis capabilities.

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

Evaluation activities:

In this quarter, OHA's Transformation Center finalized a summary report about flexible services based on interviews with CCOs. Ten CCOs were represented in the interviews.

Interim findings:

Among CCOs interviewed, the Transformation Center found that flexible services usually address chronic conditions. Successes reported by CCOs included gym memberships and pool passes to support physical activity and wellness, rental assistance to stabilize mental health, early childhood programs to address trauma, incentives to increase adolescent well child visits, and health resilience specialists to identify member needs. CCOs expressed interest in learning about flexible services definitions and design, member communication, relationship of flexible services to rate setting, and examples of flexible services that worked at other CCOs.

Improvement activities:

In order to leverage findings from CCO interviews, OHA planned a flexible services learning collaborative to be held October 13, 2015. The goal of the meeting is to allow CCOs to gain a broader understanding of how to operationalize flexible services by sharing lessons learned with each other. The agenda will include a panel of CCO representatives discussing their successes and challenges implementing, institutionalizing, and communicating with members about flexible 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

Evaluation activities:

The formative evaluation of the Transformation Center continued in this quarter, with a focus on assessing the implementation of the Community Advisory Councils' (CACs') Community Health Improvement Plans (CHIPs) in order to help guide the Center's support of the CACs. The team conducted interviews of CCO CAC Coordinators or other CCO staff about their CHIP implementation activities and about what kind of support could be helpful to ensure implementation around CHIP priorities.

Findings from the Transformation Center's ongoing, internal process for rapidly evaluating the effectiveness of its learning collaboratives are below.

Interim findings/ Improvement activities:

In this quarter, the Transformation Center continued work on its seven external learning collaboratives. From July through September 2015, three of the learning collaboratives met at eight sessions, with 28 people attending each session on average.

Across all sessions, the roles of attendees were: 24% clinical, 24% administrative or operational lead, 11% quality improvement or quality assurance, and 41% in other roles.

Sessions included three teleconferences, two webinars, and three in-person sessions.

Session topics included colorectal cancer screening, community health care workers, and leadership for complex adaptive systems.

Across all sessions, 94% of respondents found the session valuable or very valuable to their work and 57% of all respondents said they would take action at their organization as a result of attending the learning collaborative session.

The evaluation forms asked attendees to identify the most helpful aspects of each learning collaborative. Among the most helpful aspects from learning collaboratives this quarter, participants identified: receiving information about the use and funding of community health workers, and learning about other CCOs' efforts across the state.

In addition to work on existing learning collaboratives, the Transformation Center prepared to launch learning collaboratives on alternative payment methodologies and flexible services.

VI. Public forums

Public comments received

Medicaid Advisory Committee

- July: Torrey Powers, ADT Health: commented on her support of the committee's direction to move forward with recommendation of 12-month continuous eligibility in Medicaid. She suggested that Oregon reach out to other states and then together approach CMS with a request to not reduce the FMAP for the ACA Medicaid expansion population.
- August: No public comment.
- September: No public comment.

Oregon Health Policy Board

No report this quarter.

VII. Transition Plan, related to implementation of the Affordable Care Act

No updates to the Transition Plan this quarter.

VIII. Appendices

Appendix A. Quarterly enrollment reports

1. SEDS reports

[Attached separately.](#)

2. State reported enrollment tables

| Enrollment | July 2015 | August 2015 | September 2015 |
|---|-----------|-------------|----------------|
| Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14 | 1,043,726 | 1,069,423 | 1,069,054 |
| Title XXI funded State Plan | 61,228 | 62,461 | 61,408 |
| Title XIX funded Expansion Populations 9, 10, 11, 17, 18 | NA | NA | NA |
| Title XXI funded Expansion Populations 16, 20 | NA | NA | NA |
| DSH Funded Expansion | NA | NA | NA |
| Other Expansion | NA | NA | NA |
| Pharmacy Only | NA | NA | NA |
| Family Planning Only | NA | NA | NA |

| | | | |
|---------------------------------|-----------|-----------|-----------|
| Enrollment current as of | 7/31/2015 | 8/31/2015 | 9/30/2015 |
|---------------------------------|-----------|-----------|-----------|

3. Actual and unduplicated enrollment

Ever-enrolled report

| POPULATION | | | Total Number of Clients | Member Months | % Change from Previous Quarter | % Change from Previous Year |
|-----------------------|----------|---------------------------|-------------------------|---------------|--------------------------------|-----------------------------|
| Expansion | Title 19 | PLM Children FPL > 170% | 301 | 776 | -185.05% | -510.30% |
| | | Pregnant Women FPL > 170% | 379 | 907 | -81.79% | -155.41% |
| | Title 21 | SCHIP FPL > 170 | 19,100 | 47,748 | -0.90% | -84.50% |
| Optional | Title 19 | PLM Women FPL 133-170% | 7,918 | 18,428 | -70.78% | -79.29% |
| | Title 21 | SCHIP FPL < 170% | 57,296 | 146,528 | -2.46% | 15.47% |
| Mandatory | Title 19 | Other OHP Plus | 243,386 | 665,829 | -13.81% | -100.44% |
| | | MAGI Adults/Children | 832,939 | 2,316,527 | 2.36% | 44.26% |
| | | MAGI Pregnant Women | 17,960 | 42,636 | 19.28% | 56.78% |
| QUARTER TOTALS | | | 1,179,279 | | | |

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

OHP eligibles and managed care enrollment

| OHP Eligibles* | | Coordinated Care | | | | Physical Health | Dental Care | Mental Health |
|----------------|-----------|------------------|--------|--------|--------|-----------------|-------------|---------------|
| | | CCOA** | CCOB** | CCOE** | CCOG** | FCHP | DCO | MHO |
| July | 1,030,594 | 891,714 | 1,047 | 983 | 37,042 | 1 | 51,370 | 3,902 |
| August | 1,054,453 | 905,631 | 1,204 | 1,028 | 36,364 | 0 | 52,943 | 3,878 |
| September | 1,051,620 | 909,784 | 1,180 | 1,067 | 37,696 | 0 | 54,138 | 3,999 |
| Qtr Average | 1,045,556 | 902,376 | 1,144 | 1,026 | 37,034 | 0 | 52,817 | 3,926 |
| | | 86.31% | 0.11% | 0.10% | 3.54% | 0.00% | 5.05% | 0.38% |

*Total OHP Eligibles include: TANF, GA, PLM-Adults, PLM-Children, MAGI Adults/ Children, MAGI Pregnant Women, OAA, ABAD, CHIP, FC and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.

**CCOA = CCO provides physical, dental and mental health services
 CCOB = CCO provides physical and mental health services.
 CCOE= CCO provides mental health services only.
 CCOG = CCO provides dental and mental health services.

Appendix B. Neutrality reports

1. Budget monitoring spreadsheet

[Attached separately.](#)

2. CHIP allotment neutrality monitoring spreadsheet

[Attached separately.](#)

Appendix C. Two-percent trend reduction tracking

[Attached separately.](#)

Appendix D. DSHP tracking

[Attached separately.](#)

Appendix E. Oregon Measures Matrix

[Attached separately.](#) In this period, OHA began reporting on the 2015 coordinated care organization (CCO) and state performance measures, completed the measure selection and benchmark setting process for 2016 with the Metrics & Scoring Committee, and continued measure development and validation work. This quarterly report continues to include the final 2013 and 2014 results for the 17 CCO incentive measures and 33 quality and access test measures, and provides data for a new rolling 12-month window (June 2014 – May 2015) for a subset of measures for which data is available.

Also in this reporting period, OHA calculated and shared official improvement targets with each hospital involved in the Hospital Transformation Performance Program (HTPP), OHA’s hospital incentive measure program. OHA also worked with hospitals to validate data for the follow-up after hospitalization for mental illness measure, and launched a hospital metrics technical advisory group.

OHA also submitted a formal extension amendment request to extend the HTPP for an additional year under the current waiver to CMS in September. In addition, the committee advising on the hospital metrics program met twice and began preliminary discussions about proposed program structure changes to submit to CMS for future years of the program. Addendum 3 to this report includes preliminary data from the program for the first nine months of the second year of the program (October 2014 – June 2015).

CCO Incentive Metrics Updates

CCO reporting

During this reporting period, OHA continued to provide updated metrics to CCOs utilizing the automated metric reporting tool (“dashboard”), for periods covering March 2014 – February 2015, April 2014 – March 2015, and May 2014 – April 2015.

During this reporting period, OHA also re-calculated 2014 performance for several incentive measures where measure specifications had been updated for 2015. CY 2014 performance was recalculated using the 2015 specifications to ensure appropriate comparisons when calculating improvements. These measures include:

- Alcohol or Other Substance Misuse (SBIRT) – recalculated to include adolescents ages 12-17.
- Follow-up after Hospitalization for Mental Illness – recalculated to include same-day follow-up.
- Assessments for children in DHS Custody – recalculated to include mental, physical, and dental.

Oregon Health Authority

The recalculated CY 2014 data are provided in the measures matrix below. More information about these specification changes can be found online at: www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx.

Measure validation updates

OHA contracted with the Oregon Health Care Quality Corporation (Q Corp) to independently calculate and conduct a multi-directional validation process on the 33 quality and access test measures. This has been an ongoing process, with Q Corp calculating and validating the 2011 baseline, CY 2013, the “dry run” period (July 2012 – June 2013) and the first year of the test (July 2013 – June 2014). Q Corp has nearly completed validation of the CY 2014 time period and will begin validating the second year of the test in November.

In addition, Q Corp validated the baseline period (CY 2014) for two new CCO incentive measures: Dental Sealants on Permanent Molars for Children and Effective Contraceptive Use (see below for more on these measures).

The status of validation of the 22 measures that are computed using administrative claims data is shown below for each measurement period.

| Time Period | Baseline | Dry Run | CY 2013 | Year One Test | CY 2014 | Year Two Test |
|--------------------------------------|----------|---------|---------|---------------|---------|---------------|
| Measures Signed Off (as of 12/31/15) | 19 | 19 | 17 | 15 | TBD | TBD |
| Measures Signed Off (as of 3/31/15) | 20 | 20 | 20 | 19 | TBD | TBD |
| Measures Signed Off (as of 6/31/15) | 22 | 22 | 22 | 22 | 6 | TBD |
| Measures Signed Off (as of 9/30/15) | 22 | 22 | 22 | 22 | 21 | TBD |
| Total Measures | 22 | 22 | 22 | 22 | 22 | 22 |

Measure development updates

In this reporting period, OHA finalized measure specifications for the two new CCO incentive measure (Dental Sealants on Permanent Molars for Children and Effective Contraceptive Use), as well as published CY 2014 baseline data for CCOs. Specifications are online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx.

As these measures are not part of the 33 quality and access test measures, baseline data is reported below rather than in the measures matrix below.

| Measure | CY 2014 Baseline | High CCO Performance (CY 2014) | Low CCO Performance (CY 2014) | 2015 Benchmark |
|---|------------------|--------------------------------|-------------------------------|----------------|
| Dental sealants (ages 6-9) | 13.1% | 18.3% | 3.9% | N/A |
| Dental sealants (ages 10-14) | 9.4% | 14.1% | 2.8% | N/A |
| Dental sealants (ages 6-14)* | 11.2% | 15.3% | 3.3% | 20% |
| Effective contraceptive use (ages 15-17) | 28.7% | 41.5% | 22.0% | N/A |
| Effective contraceptive use (ages 18-50)* | 34.2% | 40.7% | 31.7% | 50% |
| Effective contraceptive use (ages 15-50) | 33.4% | 38.5% | 30.9% | N/A |

*Asterisked measures are incentivized, other breakouts are provided for monitoring only.

Hospital metrics updates

Hospital reporting

During this reporting period, OHA continued to provide data to hospitals for validation of the follow-up after hospitalization for mental illness measure; OHA runs this measure using Medicaid claims. Individual level data behind the metric are shared with hospitals on a quarterly basis. Hospitals then review to ensure there is transparency regarding the discharges included in the metric.

Progress report data for the other hospital measures are self-reported by the hospitals to OHA via the Oregon Association of Hospitals and Health Systems (OAHHS) each quarter. These preliminary data are presented in the [HTPP measures](#).

Hospital metric specifications

In this quarter a final decision was made regarding implications of the Centers for Disease Control and Prevention's (CDC) changes to the specifications for the National Healthcare Safety Network's (NHSN) Catheter-Associated Urinary Tract Infections measure. The NHSN made six substantive changes to the specifications for this measure beginning in January 2015. Because the HTPP runs the federal fiscal year, this meant that the Year 1 baseline (October 2014 – September 2014) would only be comparable to the first three months of Year 2 performance (October – December 2014); the final nine months of the performance year (January – October 2015) would use the new NHSN specifications, and not be comparable to the baseline.

The OHA consulted with hospital representatives on its newly formed hospital metrics technical advisory group (additional information below), public health experts within the OHA, and the CDC to decide how to deal with this change. The decision was therefore made to revise the baseline and performance periods to be in line with the new NHSN specifications (and to allow appropriate comparisons). This means:

- The baseline period for this measure will run January 1, 2015 – March 31, 2015 (3 months)
- The performance period will run April 1, 2015 – September 30, 2015 (6 months)
- The benchmark remains the same (50th percentile from HTPP baseline), but the absolute number will change based on data from the revised baseline time period.

Committee and workgroup updates

The **CCO Metrics & Scoring Committee** met twice during this period. In July, the Committee reviewed final 2014 performance and quality pool payout, and selected measures for CY 2016, including several changes to the measure set:

- Dropping *Electronic Health Record Adoption* – now that three EHR-based clinical quality measures are being incentivized (controlling hypertension, diabetes: hbA1c poor control, and depression screening), CCOs will continue to have incentive to ensure robust EHR adoption across their provider network.
- Adding *Childhood Immunization Status* as a new CCO incentive measure.
- Adding *Tobacco Prevalence* as a new CCO incentive measure. Note the tobacco prevalence measure is a bundled measure and will require CCOs to (1) offer a cessation benefit that meets certain requirements; (2) submit EHR-based tobacco prevalence data, essentially a fourth EHR-based clinical quality measure; and (3) reduce prevalence among the population. Measure specifications are being finalized with the Technical Advisory Workgroup and will be published in November 2015.

In September, the Committee learned more about the Hospital Transformation Performance Program, and finalized benchmarks for most measures for 2016. Meeting materials are available online at:

<http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>.

Oregon Health Authority

The **CCO Metrics Technical Advisory Workgroup (CCO TAG)** met monthly in this quarter and meetings focused primarily on measure development, including specifications for the tobacco prevalence measure, an EHR-based SBIRT measure, and development of a food insecurity screening measure. Meeting materials are available online at: www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx

The **Hospital Performance Metrics Advisory Committee** met two times during this reporting period.

- In July, the Committee continued discussion about Year 3 program structure, potential measures, and benchmarking options.
- In August, the Committee formalized a process for selecting ‘on deck’ measures, made several Year 3 measure decisions, and continued discussion potential measures for future program years. As part of this process, OHA began fielding a stakeholder survey in September. Stakeholders were asked to comment on the current domains and measures (whether they should be continued in future years as-is, continued with modification, or dropped), and asked to submit additional domains and measures for the Committee’s consideration. Results of the report will be shared with the Committee in the next quarter.

Meeting materials are available online here: <http://www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx>.

The **Hospital Metrics Technical Advisory Workgroup (Hospital TAG)** was established during this reporting period. The Hospital TAG will provide advice to the OHA and the Committee regarding measures included in the HTPP. This work includes ensuring measures are operationalized in a way that supports hospital operations, processes, and best practice. The Hospital TAG is not a decision-making body, but is a venue for discussion and solution-finding. Membership is open to staff from all hospitals participating in the program. Community partners and OHA contractors may also participate as needed.

The Hospital TAG met three times during this reporting period:

- In July, the Hospital TAG had its first meeting. The meeting focused on clarifying the group’s role, and providing updates on plans for future years of the program.
- The August meeting solicited feedback from the Hospital TAG on possible solutions to the NHSN CAUTI measure specification changes, and potential measures for future years of the program.
- In September, the Hospital TAG discussed potential changes to the CAUTI and Central Line Associated Bloodstream Infections measures, specifically the possibility of switching to the Standardized Infection Ratio; there was also further discussion of the metric related to emergency department notification of primary care providers.

A website including meeting dates and materials for the Hospital TAG is available here:

<http://www.oregon.gov/oha/analytics/Pages/Hospital-Metrics-Technical-Advisory-Group.aspx>

Core Performance Measure Matrix

Several of the core performance measures that overlap with the 33 quality and access test measures have been updated; data is available in the measures matrix below. OHA will provide an update on the additional core performance measures in next quarter’s report.

Hospital Transformation Performance Program (HTPP) Measures Matrix

This matrix is available in the Measures and Benchmarks Table online at:

<http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx>.

Hospital Transformation Performance Program (HTPP) Measures

[Attached separately.](#)

Appendix F: Uncompensated Care Program

Nothing to report this quarter. OHA is currently implementing system updates to support collection of UCCP claim data.

Oregon^{one}eligibility

10 Things to Know about the MAGI Medicaid System Transfer Project

1. Oregon has elected to transfer and implement the Kentucky eligibility and enrollment system (called KYNECT) – meaning we are bringing a system that already works, to Oregon for use by OHA.
2. The project is minimizing changes to the KYNECT system and limiting them to the ones needed for Medicaid policies in Oregon that don't exist in Kentucky (like emergency Medicaid for non-citizens) or are necessary to support a Supported State Based Marketplace – (like Account Transfer with the Federal Marketplace (FFM) or Medicaid Coverage Check (MEC)).
3. OHA is using a system integrator on the project – Deloitte Consulting – who built the original system in Kentucky.
4. The system will be hosted in the Oregon DAS Enterprise Technology Services State Data Center – under control of state resources to support it.
5. There are some technical changes that need to be made to the Kentucky system to make it work in Oregon, including integration with an existing Document Management Solution and a new security COTS software product (Kentucky had a custom developed application) for their specific needs.
6. The ONE system will have interfaces with Oregon's MMIS (5 total), with the FFM (10 total) and with a few Oregon specific data sources (like Employment Department). Interface development is on-track based on the project schedule.
7. There is a phased implementation schedule planned for the ONE system:
 - Worker Portal & integration with FFM (i.e. Bi-Directional Account Transfer) – December 15, 2015
 - Applicant Portal for client self-service – February 6, 2016 (after open enrollment finishes)
8. OHA is convening a group of external advisors – including Legislators, Coordinated Care Organization representatives, as well as Community Partner representatives – to advise on implementation planning for the ONE system. First meeting will be held in July 2015.
9. When the system goes live, each current Medicaid enrollee will need to have an eligibility determination completed in the ONE system by a worker before they can use the Applicant Portal for inquiries or reporting changes in circumstance, via self-service.
10. Nothing about the new ONE system makes the problem of Medicaid clients wanting to choose a CCO based on participating providers better (or worse). The ONE system will provide a webpage with links to CCO provider directories, maintained by CCOs so that Oregonians can search to see if their provider is in a particular organization. The ONE system does provide applicants (accessing the system through the online Applicant Portal) the ability to choose a preferred CCO based on residential zip code should the applicant be found eligible. The ONE system will NOT interface with OHA Office of Health IT (OHIT) Provider Directory at initial implementation.
 - OHIT is currently working on a statewide provider directory project that will leverage data from existing, authoritative, and accurate provider data sources, such as common credentialing. The provider directory is not anticipated to be consumer-facing but instead will be a resource for provider directory systems (potentially including MAGI) to validate their own directories and improve the accuracy of their data they provide.

Questions about the MAGI Project? Email: OHAOregon.Eligibility@dhsosha.state.or.us



HB 2934—Oregon Basic Health Program (BHP) Stakeholder Advisory Group: Recommendations

November 2015

Prepared by
The Oregon Health Authority

Prepared on behalf of
BHP Stakeholder Advisory Group

Prepared for
The Oregon State Legislature
Per House Bill 2934

This report is available online at: <http://www.oregon.gov/oha/OHPR/Pages/Basic-Health-Program-Stakeholder-Group.aspx>



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November 12th, 2015

House Committee on Health Care
Oregon Legislative Assembly

Dear Chair Greenlick and Members of the Committee,

In 2015, the Oregon Legislature passed House Bill 2934 tasking the Oregon Health Authority (OHA) with convening a stakeholder advisory group (SAG) to examine key policy issues related to the federal Basic Health Program (BHP) in the context of Oregon's health care system. The BHP is a health coverage option for individuals with incomes between 138 and 200 percent of the federal poverty level (FPL) and individuals from 0-200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to immigration status.

From July through November 2015, the group met on six separate occasions to develop recommendations on the policy, operational and financial preferences for the design of a BHP. In developing recommendations, the group considered findings from an independent study conducted in 2014 that investigated the financial feasibility of operating a BHP in Oregon per HB 4109 (2014). The recommendations and companion report are based on available information shared with the group during the stakeholder process and input provided by participants.¹ The recommendations in this report are exclusively the product of the workgroup, do not convey any policy recommendations from the Oregon Health Authority, and seek to further the goals of reducing the cost of health care and ensuring all residents of this state equal access to health care.

Principles for Designing and Selecting a BHP in Oregon

States have considerable flexibility in how to establish a BHP. The recommendations are thus designed to provide direction and guidance to the Oregon Legislature on key elements of a BHP, and overlap with the requirements outlined in the federal Blueprint,² the mechanism to officially request federal program approval. The stakeholder group proposes a development framework and program structure based on a set of design principles. The principles were used as decision-making criteria in selecting the preferred design and approach for a BHP in Oregon.

¹ All meeting materials, presentations and supporting documents are available at:

<http://www.oregon.gov/oha/OHPR/Pages/Basic-Health-Program-Stakeholder-Group.aspx>

² See CMS federal BHP Blueprint: <http://www.medicaid.gov/basic-health-program/downloads/minnesota-bhp-blueprint-december.pdf>

The principles also outline the group’s rationale for its final recommendations and include:

- Increase access to coverage for uninsured, including those ineligible for Medicaid, and Oregon’s COFA population³
- Increase affordability of coverage for low-income Oregonians
- Reduce churn by minimizing and mitigating the frequency of and impact from coverage transitions, including the benefit cliff among federal insurance affordability programs (IAPs)
- Sponsor an accountable care model using a measurement framework to incentivize quality and population health improvements
- Promote a sustainable and predictable rate of growth (e.g. 3.4 percent in Medicaid, PEBB, and OEBC)
- Maintain a healthy and vital Marketplace and spread the coordinated care model (CCM)
- Exercise stewardship of State resources by maximizing federal resources available through the ACA

Recommended BHP Framework: Policy, Operational, and Financial Preferences

Based on the principles outlined above, the stakeholder group decided upon the following framework and program design for a BHP.

| Hybrid Marketplace | |
|-------------------------------------|--|
| Delivery System | CCOs and commercial QHPs plans compete for BHP enrollees using principles of Oregon’s coordinated care model (CCM) |
| Benefit Coverage | Full Medicaid benefit level without adult dental |
| Provider Reimbursement | Average of Medicaid and Commercial (~81% of Oregon’s commercial reimbursement rate) |
| Premiums & Cost-sharing | <138% FPL, \$0; 138-200% FPL graduated premium structure; no cost-sharing |
| Eligibility & Enrollment | Marketplace standards; 12-month continuous eligibility; FFM eligibility system (federal hub)* |
| Consumer Choice | Standard Health Plan (SHP) offerings via Marketplace |
| Administrative Functions | Marketplace and carriers (client services, grievances, premium billing) |
| Sustainable Growth Rate | Annualized sustainable fixed rate of growth; methodology and rate to be determined by Legislature |

*Please see paragraph on page II regarding use of federal hub as the FFM cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations.

³ Compact of Free Association (COFA): refers to individuals from the Republic of Palau, the Republic of the Marshall Islands and the Federated States of Micronesia. For more info, please see COFA Alliance National Network (CANN): www.cann.us

The group also recommends that the Legislature consider updating the 2014 BHP financial feasibility model and to develop financial projections for future years beyond 2017 based on the design preferences outlined above. It is important to note that as of October 2015, the Federally-Facilitated Marketplace (FFM) cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations for states such as Oregon, which rely on a federally-supported State-based Marketplace (SBM).

Through careful consideration of the federal program in the context of Oregon, the group concluded that the BHP could serve as a potential policy tool to further expand coverage to the remaining uninsured and increase affordability for low-income Oregonians (138-200 percent of FPL) already insured through the Marketplace. The group identified a broader question for consideration by policy makers about whether the BHP could serve to help stabilize Oregon's individual market by potentially resetting rates in the Marketplace. The group also discussed the potential disruption a BHP could create to the Marketplace by removing BHP enrollees from current Marketplace risk pools. Lastly, the group observed that fees would continue to be assessed on plans for the population, maintaining the population's support of Marketplace administration.

Recommendations from the 2015 BHP Stakeholder group offer a comprehensive approach and rationale for pursuing a BHP for consideration by Oregon policy makers. The stakeholder group identified an approach to designing a BHP that may expand coverage to some of the remaining uninsured, offer more affordable coverage to Marketplace enrollees below 200 percent of FPL, leverage federal funding to help control long-term costs in Oregon's Marketplace, and further spread the coordinated care model (CCM) in the Marketplace.

The workgroup recommends that the Legislature carefully consider the important benefits of a BHP program and weigh those benefits against the implementation costs and technological barriers identified in the report. Although adult dental was not included in the preferred benefit package, the group strongly recommends that the Legislature determine if there's sufficient federal revenue to pay for this benefit. In closing, the BHP could be an opportunity to build on existing innovative state coverage and reform initiatives in Oregon. We hope the report offers a comprehensive assessment of the BHP for consideration by Oregon policy makers and stakeholders.

Roster: HB 2934 BHP Stakeholder Group (July-November 2015)

Staff, Senator Chip Shields

Senate Health Committee

Representative Alissa Keny-Guyer

House Health Committee

Janet Bauer

Policy Analyst

Oregon Center for Public Policy

Victoria Demchak

Policy Analyst

Oregon Primary Care Association

Jim Francesconi

Vice President, Public Policy

Moda Health

D'Anne Gilmore

Performance Improvement Advisory

Department of Consumer and Business

Services

Oregon Health Insurance Marketplace

Robin J Moody

Associate Vice President of Public Policy

Oregon Association of Hospitals and

Health Systems

Hannah Rosenau

Senior Policy & Access Coordinator

Oregon Foundation for Reproductive

Health

Joseph Santos-Lyons

Executive Director

Asian Pacific American Network of

Oregon

Martin Taylor

Director, Public Policy and Regulatory

Affairs

CareOregon

Danielle Sobel

Associate Director of Health Policy

Oregon Medical Association

Staff:

Oliver Droppers V

OHA, Division of Health Policy and

Analytics

Background

In 2015, the Oregon Legislature passed House Bill 2934 tasking the Oregon Health Authority (OHA) with convening a stakeholder group to examine key policy issues related to the implementation of the federal Basic Health Program (BHP) in the context of Oregon's health care system. This work was to build on previous work of [House Bill 4109](#) (2014) that resulted in an independent [study](#) of the costs and impacts of a BHP in Oregon. The legislature required the group to submit their recommendations to the interim legislative committees by December 1, 2015.

A number of stakeholders were required to participate in this work (see roster):

- Advocates for low-income individuals and families;
- Advocates for consumers of health care;
- Representatives of health care provider groups;
- Representatives of the insurance industry; and
- Members from the House of Representatives and the Senate appointed by the chairs of the legislative committees related to health care.

What is a BHP?

Beginning January 1, 2015, states have the option under the Affordable Care Act (ACA) to establish a Basic Health Program (BHP) to provide federally subsidized coverage to low-income individuals. The BHP serves as one of several insurance affordability programs (IAPs) offered through the ACA. In states that implement a BHP, BHP-eligible individuals cannot receive federal subsidies to purchase qualified health plans (QHPs) in the Marketplace. Rather, BHP consumers are enrolled in "standard health plans" (SHPs)⁴ that cover the 10 essential health benefits (EHBs). The BHP effectively sits between Medicaid and Marketplace coverage.

A BHP program provides coverage to residents under age 65 who are:

- U.S. citizens with incomes between 138-200 percent of the FPL;
- Lawfully present immigrants⁵ and COFA⁶ individuals up to and including 138% FPL who are not eligible for Medicaid due to immigration status (i.e. have lived in the U.S. less than five years);⁷

⁴ Standard health plans may be sponsored by state-contracting HMOs, insurers, Medicaid or CHIP managed care organizations, provider networks, or other qualified entities.

⁵ Lawful permanent residents (LPRs): people lawfully admitted to live permanently in the United States by either qualifying for immigrant visas abroad or adjusting to permanent resident status in the United States. Many but not all LPRs are sponsored (i.e., brought to the United States) by close family members or employers.

⁶ Compact of Free Association (COFA): refers to individuals from the Republic of Palau, the Republic of the Marshall Islands and the Federated States of Micronesia.

- Ineligible for coverage under Medicaid, CHIP, or Military/CHAMPUS-TRICARE; and
- Lack access to employer-sponsored insurance (ESI) that meets ACA standards for comprehensiveness and affordability.

States can operate a BHP either as an extension of its Medicaid program or as an extension of the Marketplace. States that establish the program need to address a number of design elements for federal approval, ranging from benefits and cost sharing structure to the myriad of implementation options. Specifically, states implementing a BHP will:

- Receive federal funds equal to 95% of the premium tax credits and cost-sharing reductions a state's BHP enrolled population would have otherwise received to purchase a QHP coverage in the Marketplace;
- Provide federally mandated 10 essential health benefits (EHBs) through a managed care or similar system at a medical-loss ratio of no lower than 85%;
- Ensure consumer cost sharing is no greater than what enrollees would have paid in QHP coverage through the Marketplace;
- Offer standard health plans to BHP enrollees from at least two different offerors, with some exceptions; and
- Establish a competitive procurement process for selecting standard health plans.

HB 4109: BHP Study Results (2014)

In the 2014, the Oregon Legislature passed HB [4109](#) requiring the Oregon Health Authority (OHA) to commission an independent study of the feasibility of operating a BHP in Oregon. Through a competitive bid process, the OHA contracted with national experts, Wakely Consulting Group and Urban Institute, to conduct the study and prepare a [comprehensive report](#). Key conclusions of the study were:

- An estimated 87,600 people would qualify for BHP in 2016; 61,400-66,300 individuals would enroll. This would result in a slight decline (5,400-9,900) in the overall number of uninsured in Oregon.
- Two different BHP scenarios were modeled. Neither scenario yielded a financial "break even" point for Oregon. Projections indicate deficits ranging from \$1.6-\$119.1 million in 2016.
- A BHP program would have a marginal impact on the individual market risk pool, carrier interest in the exchange Marketplace, and Marketplace stability.

The analysis in the 2014 report was dependent on a number of assumptions and limitations, some of which are highly variable. Several limitations identified were the analysis was limited to a single year, 2016, without projected costs for future years, did not

⁷ Five-year ban: under TANF, SNAP, Medicaid, and CHIP, post-enactment qualified immigrants, with important exemptions, are generally banned from receiving federal means-tested benefits during their first five years in the United States.

incorporate annual changes to the 2nd lowest cost silver plan over a multiple-year period (used as the basis for determining federal BHP revenues), or assess whether providers would be willing to accept reimbursement rates similar to Medicaid levels. The report also did not address Oregon's transition to the FFM. For complete results including study limitation, please see the full report.⁸

HB 2934: Stakeholder Advisory Group Process (2015)

From July through November 2015, the group met on six separate occasions to develop recommendations on the policy, operational and financial preferences for the design and operation of a BHP, in order to further the goals of reducing the cost of health care and ensuring all residents of this state equal access to health care. Staff with the Oregon Health Authority (OHA) and Department of Business and Consumer Services (DCBS) provided participants with an overview of the BHP, results from the 2014 BHP study, and shared data on Oregon's Marketplace including enrollment, premiums and federal subsidies available through the ACA. HB 2934 required the following:

- OHA to convene a stakeholder group to develop recommendations for the Legislative Assembly concerning the BHP.
 - Stakeholder advisory group to develop recommendations to address “*the policy, operational, and financial*” preferences of the group in the “design and operation” of a BHP.
 - Stakeholder advisory group's recommendations further the goals of the Legislative Assembly of “*reducing the cost of health care and ensuring all residents*” of Oregon have equal access to health care.
- OHA report recommendations to interim legislative committees no later than Dec. 1, 2015.

The advisory group carefully considered federal policy that governs the BHP including a requirement that states must offer at least two standard health plans (SHPs) that are selected through a competitive contracting process.⁹ The group also considered issues around consumer affordability, provider reimbursement, several operational considerations, and different benefit designs (see next section). Towards the end of the process, participants reviewed several straw models that encapsulated preliminary design preferences expressed by the group. Based on the design principles and identified advantages and disadvantages, the group reached a consensus on the recommendations described in this report (see pg. 12).

⁸ Available: http://www.oregon.gov/oha/OHPR/docs/OregonBasicHealthPlanReport_11.10.2014.pdf

⁹ Federal reqs ([42 CFR 600.420\(a\)\(1\)](#)) require states to have at least two carriers offer standard health plans in a BHP.

Outlined in Table 1 is the timeline and list of topics considered by the group.

| Table 1. Stakeholder Group Timeline – July-November 2015 | |
|---|--|
| July 2nd | Initial convening of stakeholder group; outlined key findings from 2014 BHP study. |
| July 29th | Reviewed federal guidance related to the BHP; considered consumer affordability, premium and cost-sharing options for BHP, and levels of benefit coverage. |
| Aug. 13th | Reviewed delivery systems, contracting and provider networks, and provider reimbursement. |
| Sept 16th | Assessed operational and financing considerations; identified initial design preferences. |
| Oct 8th | Evaluated straw models and identified initial set of recommendations including guiding principles. |
| Nov 5th | Reviewed draft report and adopted recommendations. |

Principles for Designing and Selecting a BHP in Oregon

The group opted to develop a set of principles used as decision-making criteria in selecting the preferred design and approach for a BHP in Oregon. These include:

- Increase access to coverage for uninsured, including those ineligible for Medicaid, and Oregon’s COFA population¹⁰
- Increase affordability of coverage for low-income Oregonians
- Reduce churn by minimizing and mitigating the frequency of and impact from coverage transitions, including the benefit cliff among federal insurance affordability programs (IAPs)
- Sponsor an accountable care model using a measurement framework to incentivize quality and population health improvements
- Promote a sustainable and predictable rate of growth (e.g. 3.4 percent in Medicaid, PEBB, and OEBB)
- Maintain a healthy and vital Marketplace and spread the coordinated care model (CCM)
- Exercise stewardship of State resources by maximizing federal resources available through the ACA

¹⁰ Compact of Free Association (COFA): refers to individuals from the Republic of Palau, the Republic of the Marshall Islands and the Federated States of Micronesia. For more info, please see COFA Alliance National Network (CANN): www.cann.us

Program Design and Operational Considerations

The stakeholder advisory group reviewed a number of policy considerations regarding preferences for designing a BHP including delivery system options. The key policy considerations, although not exhaustive, are summarized below.

Delivery System Options for Offering a BHP

The group considered four potential options to offer standard health plans (SHPs) in Oregon based on the state's existing delivery system:

1. Marketplace: competitive contracting process for commercial health plans to offer BHP options.
2. Coordinated care organizations (CCOs): seek federal permission to waive the two plan offerings and competitive contracting requirement; contract directly w/ CCOs to offer BHP.
3. Stand-alone option: state contract directly with carriers to offer BHP (e.g. PEBB/OEBB).
4. Alternative hybrid model: competitive contracting among CCOs and QHP carriers through Marketplace (pending federal/state approval).

Consumer affordability: consider the fiscal impact to consumers in terms of out-of-pocket options including potential savings by selecting preferred premiums and cost-sharing levels for BHP enrollees in Oregon. A critical issue is how to improve affordability of coverage for individuals between 138-200% FPL as compared to the required federal contribution to premium and maximum out-of-pocket costs (OOP) in the Marketplace.

Benefit coverage: several different benefit packages were considered, Medicaid/OHP and the 10 essential health benefits (EHBs) package offered in the Marketplace.¹¹ A key difference between the two packages is adult dental, which is not an EHB in the Marketplace. In addition, Medicaid covers a range of services either not typically covered by commercial health insurers or covered with limitations such as non-emergency medical transportation (NEMT), hearing aids, and mental/behavioral health services without limitations.

Eligibility and enrollment: two different approaches were assessed: (1) Medicaid continuous, open enrollment, and (2) Marketplace's open enrollment period (OEP) and

¹¹ See: [PacificSource Health Plans Preferred CoDeduct Value 300 plan](#).

special enrollment period (SEP). The group also considered whether enrollees should have 12-month, continuous eligibility.¹²

Delivery system: evaluated a BHP offered through “standard health plans” (SHPs) as a part of Medicaid, offered by coordinated care organizations (CCOs), or through the Marketplace. Federal regulations¹³ require states to offer a choice of SHPs through a competitive contracting process. According to CMS, an exception to the requirement to implement a competitive contracting process was only available for program year 2015.¹⁴ If offered through CCOs, Oregon would likely need the Centers for Medicare and Medicaid Services (CMS) approval to waive two federal requirements: (1) ensuring consumers have a choice of at least two carriers, and (2) competitive contracting in selecting SHP carriers.

Provider reimbursement: several different reimbursement levels were considered: Medicaid, commercial (100%), Medicare (77% of commercial), and an in between rate (~81% of commercial, higher than Medicaid and Medicare, but lower than commercial reimbursement). Provider reimbursement effect issues of participation and network adequacy, carrier interest, and overall financial viability of the program. A key concern raised by the group was provider willingness to accept reimbursement rates significantly lower (i.e. commercial) for individuals already enrolled in Marketplace coverage between 138-200% of FPL.

In addition to the policy considerations, several operational and financing considerations were also reviewed as part of the stakeholder process, summarized below.

Enrollment and eligibility system: as a federally-supported State-based Marketplace (SBM), setting aside critical questions around IT feasibility, Oregon currently has two options to manage eligibility determination and enrollment: (1) OHA’s new Medicaid eligibility system, or (2) the Federal Facilitated Marketplace (FFM). The critical IT feasibility issue the group considered is whether CMS will be able to accommodate BHP eligibility determination for states that are a federally-supported SBM in 2017 or 2018. As of October 2015, CMS has indicated they are not able to support BHP through the FFM as it cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations.

¹² CMS federal [regs](#): States have the option of only redetermining eligibility every 12 months, regardless of any changes in income or other circumstances, as long as the enrollee is under age 65, is not otherwise enrolled in minimum essential coverage (MEC), and remains a residents of the state.

¹³ See 42 [CFR](#) 600.420(a)(2)

¹⁴ See 42 [CFR](#) 600.410(c)(1) and 600.410(c)(3).

Financing: federal funds cannot be used for development, start-up, or ongoing administration costs. Consequently, Oregon needs to determine what, if any, source(s) of funding would be available for BHP start-up (including eligibility system modifications, plan procurement, actuarial work, etc.) and ongoing administration (consumer outreach & assistance, premium billing if relevant, appeals, general program costs).

Stakeholder Constraints

The group was directed to rely upon the study results from 2014. During the process, several members of group asked if OHA staff could update the study results based on the preferences expressed by the group. The legislature did not allocate any funding for HB 2934; thus, OHA was unable to update the 2014 study. As a result, the group did not have more recent actuarial data and current estimates of federal BHP funding (e.g. 2016/17) in making their recommendations.

Oregon's Marketplace

Using 2015 Marketplace enrollment data, the group examined the potential impact of a BHP on the Marketplace. The group assessed the number of individuals enrolled inside the Marketplace in 2014 and 2015, as well as the remaining uninsured below 200% of FPL (See Figures 1 and 2; Tables 1-3, and 5), including how many adults with Marketplace coverage opted to enroll in stand-alone dental (see Table 4).

Based on the information below, the group concluded that the BHP could potentially offer an opportunity to enroll a *sizable* portion of the remaining uninsured below 200% of FPL. Participants also acknowledged, that based on 2015 enrollment, approximately 42% of individuals currently enrolled in QHP coverage fall below 200% of FPL. Depending on how the BHP is setup (Medicaid vs. Marketplace), participants raised the question about the impact to Oregon's Marketplace (see Tables 3 and 5). However, DCBS maintained that the Marketplace was flexible and had the capacity to adapt, if policymakers decided to establish a BHP separate from the QHP-eligible population. Participants also considered consumer affordability based on the 2016 Marketplace premiums and advance premium tax credits (APTC) (See Table 6).

Figure 1. Eligibility for Qualified health Plans (QHPs)^{15,16}

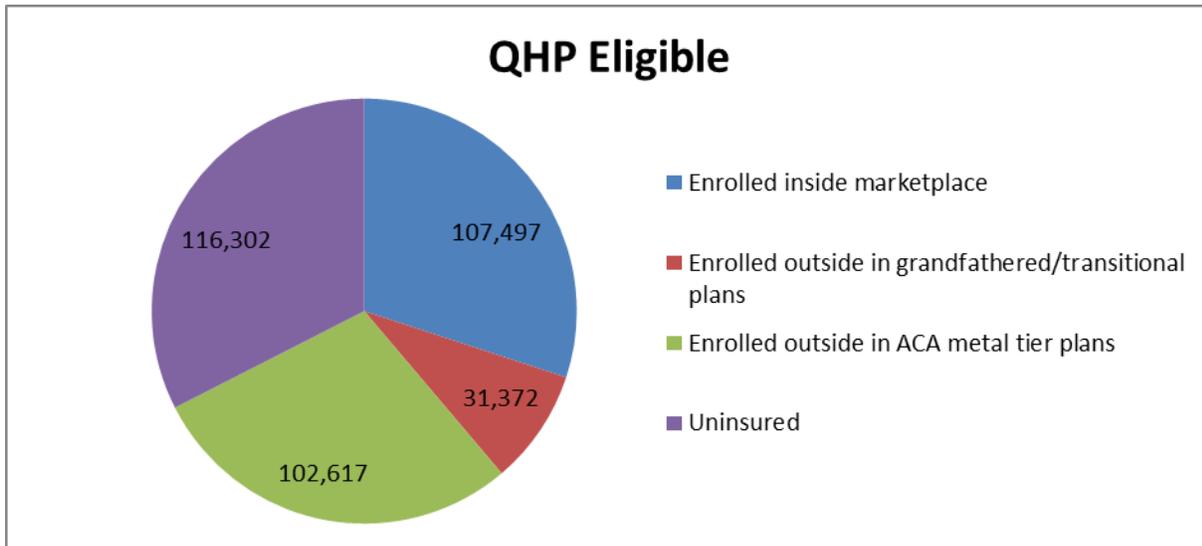
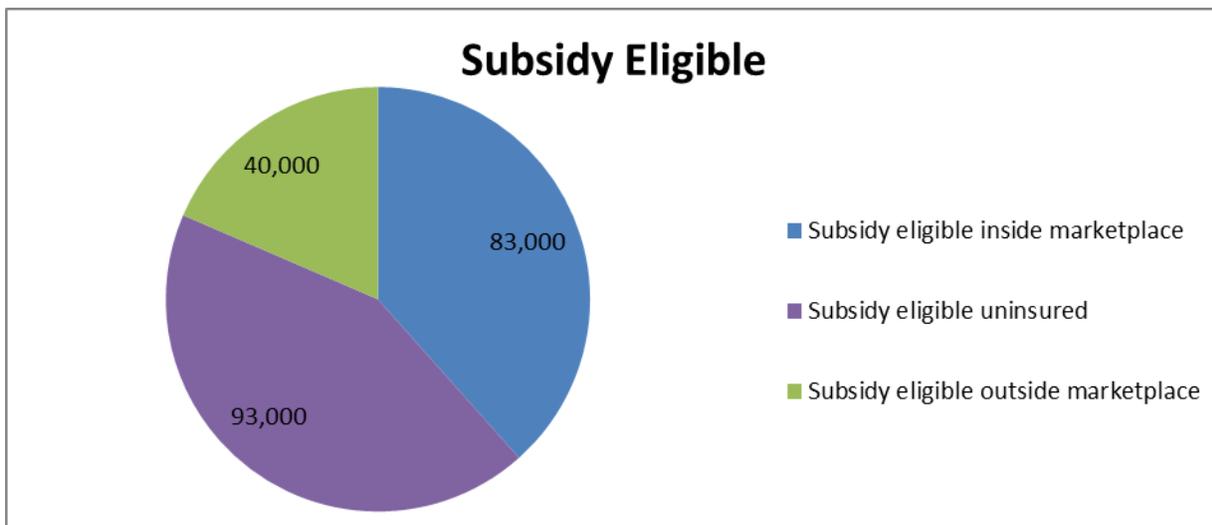


Figure 2. Premium Subsidy Eligible Oregonians^{17, 18}



¹⁵ Best estimates based on demographic and plan selection data on persons who selected a plan at HealthCare.gov, enrollment data reported by carriers to the Oregon Insurance Division, and a U.S. Department of Health and Humans Services (HHS) commissioned analysis of Oregon’s eligible population.

¹⁶ Please Note: This graph has been corrected since first presented in September 2015. In September, the total enrolled outside in ACA metal tier plans was listed as 107,363 and the total enrolled outside in grandfathered/transitional plans was listed as 26,626. The total enrollment outside the marketplace is still the same (133,989), but the split is actually 102,617 in ACA metal tier plans and 31,372 in grandfathered/transitional plans.

¹⁷ See above.

¹⁸ The estimated 93,000 subsidy eligible uninsured does not include uninsured who are ineligible to purchase QHPs.

Table 2. Marketplace Enrollment 2nd Quarter 2015

| Enrollment By Plan Types 2015 ¹⁹ | | | | | | | | |
|---|---------------|--------|--------|-------|----------|------------------------|------------------------|-------------------------------------|
| Plan types | Cata-strophic | Bronze | Silver | Gold | Platinum | 2015 Marketplace Total | 2014 Marketplace Total | 2014 to 2015 Marketplace Change +/- |
| Total | 752 | 27,839 | 68,713 | 9,294 | 899 | 107,497 | 76,514 | 30,983 |

Table 3. Marketplace Enrollment <200% FPL

| Marketplace Enrollment <200 % FPL (2 nd quarter, 2015) ²⁰ | | |
|--|------------------------|-------------------------------|
| 0-200% FPL | 2015 Marketplace Total | % Enrollment in QHP <200% FPL |
| 46,116 | 107,497 | 42.9% |

Table 4. Dental Plan Enrollment

| Adult Dental Plan Enrollment ²¹ | |
|--|-------------------------------|
| 2015 Marketplace Total | % Enrollment in QHP <200% FPL |
| 21,592 | Unknown |

Table 5. Uninsured QHP Eligible below 200% FPL²²

| Approximate QHP Eligible Uninsured Below 200% FPL | |
|---|-------------------|
| FPL | Number of persons |
| 138-150% FPL | 2,938 |
| 150-200% FPL | 22,108 |
| Total | 25,046 |

¹⁹ Data Source: Oregon Insurance Division (OID) Quarterly Enrollment Report

²⁰ Information reported by Department of Human and Health Services (DHHS)

²¹ Adults with dental-only plans: unknown what number/percentage of adults <200% FPL enrolled in QHPs purchased dental.

²² Estimate made by HHS commissioned consultant during open enrollment in February 2015, when 99,000 persons of all incomes had selected a Marketplace plan.

Table 6. 2016 Marketplace Premiums and APTC

| Individual Required to Pay | | | | Total Premium with APTC | | | |
|----------------------------|-----------------------------|---|---|------------------------------------|--------------------------------|----------------|--|
| 1 Household 2016 | Household Income (2015 FPL) | Percentage of income Individual will pay toward premium for 2 nd lowest silver ²³ | Premium Cap (annual maximum contribution to premium paid by the individual) | Second Lowest Silver Plan Premium* | Number of Months Premiums Paid | Annual Premium | Total Covered by CMS with APTC ²⁴ |
| 133% FPL | \$15,654 | 2% | \$318 | \$261 | 12 | \$3,132 | \$2,814 |
| 150% FPL | \$17,655 | 4% | \$719 | \$261 | 12 | \$3,132 | \$2,413 |
| 200% FPL | \$23,540 | 6% | \$1,509 | \$261 | 12 | \$3,132 | \$1,623 |
| 250% FPL | \$29,425 | 8% | \$2,407 | \$261 | 12 | \$3,132 | \$775 |

²³ Based on 2nd lowest approved standard plan silver rate for age 40, single, non-tobacco users in Portland metro.

²⁴ Does not include savings for those who also qualify for cost share reduction, which may reduce their coinsurance, copays, deductibles and maximum out-of-pocket. A single person household at 300% of FPL could qualify for APTC in some areas of the state, such as Eastern Oregon, Deschutes Co., and some coastal counties where premiums exceed the affordability premium cap set for APTC.

Potential Advantages and Disadvantages: Recommended Framework

The group's recommendations are based on a set of principles (see pg. 4), data from Oregon's Marketplace, identified advantages and disadvantages with offering the program, and federal regulations. At the group's first in-person meeting (July 29th), Representative Greenlick posed a fundamental question for the group: "*What's the issue that the BHP is attempting to address in Oregon?*" In response, at each meeting the group identified a set of potential advantages and disadvantages. It is important to note that several of the identified advantages and disadvantages are contingent on the design of the BHP. Summarized below are the advantages and disadvantages of a BHP in Oregon.

Potential advantages:

- Increase affordability with more low-income individuals able to afford coverage by reducing premiums and cost sharing for low-income individuals;
- Expand coverage and access to care for some of the remaining uninsured 0-200% FPL;
- Reduce churn below 200% by smoothing transitions as incomes fluctuate at 138% FPL, potentially reduce rate of pregnancy related churn between Medicaid and the Marketplace;
- Reduce potential net reduction in income for individuals moving from Medicaid to Marketplace coverage (i.e. the benefits cliff);
- Offer additional benefit coverage and encourage appropriate use of primary and preventive care (e.g. by removing copayments);
- Opportunity to expand the Oregon's coordinated care model to the Marketplace; and
- Incorporate a sustainable rate of growth, creating potential long-term savings by controlling annual costs.

Potential Disadvantages:

- Federal funding may not cover cost of plans leading to financial exposure for the State, and
- State funding for start-up and ongoing administrative costs.

Recommended BHP Framework

The stakeholder group decided upon the following design framework and program structure.

| Hybrid-Marketplace | |
|-------------------------------------|--|
| Delivery System | CCOs and commercial QHPs plans compete for BHP enrollees using principles of Oregon’s coordinated care model (CCM) |
| Benefit Coverage | Full Medicaid benefit level without adult dental |
| Provider Reimbursement | Average of Medicaid and Commercial (~81% of Oregon’s commercial reimbursement rate) |
| Premiums & Cost-sharing | <138% FPL, \$0; 138-200% FPL graduated premium structure; no cost-sharing |
| Eligibility & Enrollment | Marketplace standards; 12-month, continuous eligibility; FFM eligibility system (federal hub)* |
| Consumer Choice | Standard Health Plan (SHP) offerings via Marketplace |
| Administrative Functions | Marketplace and carriers (client services, grievances, premium billing) |
| Sustainable Growth Rate | Annualized sustainable fixed rate of growth; methodology and rate to be determined by Legislature |

*The FFM cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations.

Summarized below is the group’s rational for selecting their preferences in designing a BHP.

Delivery system: there are advantages and disadvantages with operating a BHP through the Marketplace or as a State Medicaid program. Several members of the group shared concerns with the potential impact on the Marketplace outside of the results provided in the 2014 BHP study report. Participants evaluated whether to offer BHP coverage through a traditional insurance product or incorporate a CCO like-design, specifically, adopting the principles for Oregon’s coordinated care model (CCM).²⁵ As demonstrated by CCOs, Oregon’s CCM is making progress by bending the cost curve and has demonstrated measurable improvement in quality and integration of services.²⁶ Another design consideration identified by participants was to incorporate a fixed and sustainable rate of growth. Specifically, establishing a sustainability rate of growth including a methodology that mirrors Oregon’s approach in CCOs, and is now also a requirement in PEBB and OEBC.

²⁵ For more info, see Oregon’s Coordinated Care Model Alignment [Work Group](#).

²⁶ See Oregon’s Health System Transformation 2014 [Final Report](#).

This approach aligns with the recommendations and strategies put forward by the Oregon Health Policy Board in 2013 to align implementation of the ACA in Oregon.²⁷

Benefit coverage: the group identified that offering OHP as a single benefit package for all BHP enrollees would be more protective for this low-income population. It would also support administrative simplification of the program, potentially resulting in lower administrative costs, and create less confusion among providers serving both Medicaid and BHP enrollees. In terms of cost drivers with the BHP, offering dental benefits is the largest and most costly benefit when comparing benefit differences between Medicaid and the Marketplace. Census was not to include adult dental in benefit package unless the legislature decides there's sufficient federal revenue to pay for this benefit.

Provider reimbursement: the group recognized that there would likely be significant reservations among certain providers if a BHP were offered with rates considerably lower than currently offered by commercial plans (i.e. QHPs). It was acknowledged that offering a BHP based on Medicaid rates could limit provider and/or carrier participation, potentially creating an access issue for BHP enrollees, and thus limited in terms of statewide feasibility.

- The group ultimately recommended a reimbursement rate that would serve as a mid-point between Medicaid and commercial, but higher than Medicare. The rationale is providers may be supportive of expanding coverage but unwilling to accept Medicare level reimbursement or even lower, Medicaid (e.g. ~81% of commercial, ~18% higher the Oregon Medicaid rate). A concern expressed was that providers would receive a considerable decrease in reimbursement for those individuals already enrolled in the Marketplace, approximately a 19% reduction in reimbursement compared to Oregon's commercial reimbursement rate.

Consumer cost-sharing: the group agreed to increase affordability for individuals by removing deductibles and co-pays for direct services, costs which potentially create barriers to care. The group agreed to no-cost or premiums below 138% of FPL and a graduated premium tier structure for those between 139-200% FPL (similar to New York's BHP model). The focus should be on premiums rather than co-pays due to administrative complexities and encouraging access to care.

Eligibility and enrollment: the group preferred enrollment via the Marketplace's open enrollment period (OEP) and special enrollment period. The group also opted for 12-month, continuous eligibility once enrolled. The group did not decide on the issue of

²⁷ See Oregon Health Policy Board (Dec. 2013). [Report](#) Recommendations for Aligning Affordable Care Act implementation with Oregon's health system reform.

disenrollment upon non-payment of premiums as this would require additional study to understand the potential impact.

To create savings to Oregon's budget, the group also considered transitioning Medicaid pregnancy coverage between 139-185% into a BHP that could potentially generate annual state savings of up to \$12 million.²⁸ Pregnancy-related CAWEM could be an additional population to consider. Any such changes would require consultation with CMS and legislative approval.²⁹

Based on the recommendations, the group suggests the following next steps:

- 2016—Develop federal CMS Blueprint
- 2017—Introduce enabling legislation;
- 2018—Implement, contingent on federal approval and IT feasibility

Federal Blueprint

States considering the BHP must make a number of policy and operational decisions prior to requesting federal approval. To date, two states currently offer the BHP, both of which support a state-based Marketplace (SBM) and provide state funding for the BHP. As of 2015, Oregon relies on the Federal Facilitated Marketplace (FFM) to determine eligibility for federal subsidies through the Marketplace. As previously stated, CMS informed Oregon they are currently unable to develop and modify the federal eligibility system (FFM) needed to implement the BHP in Oregon in 2016 or 2017.

How the Blueprint Works: The Blueprint is the official form states must use and is intended to collect the program design choices of the state while providing a full description of the operations and management of the program and its compliance with the federal rules. The Blueprint must also be accompanied by a funding plan that provides for any non-federal funding that will be used to pay for benefits or services not covered by federal funds available through the BHP. The Blueprint:

- Provides vehicle for CMS to grant BHP certification to states choosing to operate a BHP.
- Demonstrates compliance with program standards and show operational readiness.
- Incorporates funding plan for first 12-months of operations.
- Grants operational authority but does not obligate state to operate BHP.

²⁸ See Oct. 8th 2015 HB 2934 Stakeholder Advisory Group presentation [materials](#).

²⁹ Citizen Alien Waived Emergent Medical ([CAWEM](#)): is Medicaid program in Oregon that covers provide health benefits for individuals not eligible for Medicaid services due to citizen/alien status.

Conclusion

The BHP is an insurance affordability program (IAP) established by the ACA, that offers coverage in lieu of Marketplace coverage for individuals with incomes between 138-200% of the federal poverty level (FPL) and for individuals lawfully present up to 200% FPL but do not qualify for Medicaid due to their immigration status. Per HB 2934, the stakeholder advisory group recommends a number of financial, policy and operational preferences.

If the Oregon Legislature opts to pursue a BHP in Oregon based on the proposed design principles and framework, the BHP provides an opportunity to expand coverage to some of the remaining uninsured, offer more affordable premiums and cost-sharing for low-income residents, potential increase in federal funding to cover additional populations in combination with a federal 1332 waiver, and leverage control over health care costs in Oregon's Marketplace. The BHP also provides the State of Oregon an opportunity to spread the coordinated care model (CCM) beyond Medicaid, PEBB, and OEBB.

The workgroup recommends that the Legislature carefully consider the important benefits of a BHP program and weigh those benefits against the implementation costs and technological barriers as outlined in this report. In closing, the BHP could be an opportunity to build on existing innovative state coverage and reform initiatives in Oregon. We hope the report offers a comprehensive assessment of the BHP for consideration by Oregon policy makers and stakeholders.

Attachments

1. HB 2934 (2015)

Enrolled
House Bill 2934

Sponsored by COMMITTEE ON HEALTH CARE

CHAPTER

AN ACT

Relating to access to health care; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) The Oregon Health Authority shall convene a stakeholder group consisting of:

- (a) Advocates for low-income individuals and families;**
- (b) Advocates for consumers of health care;**
- (c) Representatives of health care provider groups;**
- (d) Representatives of the insurance industry; and**
- (e) Members from the House of Representatives and the Senate appointed by the chairs of the legislative committees related to health care.**

(2) The first meeting of the group shall occur no later than 30 days after the effective date of this 2015 Act.

(3) The group shall provide recommendations to the Legislative Assembly regarding the policy, operational and financial preferences of the group in the design and operation of a basic health program, in accordance with 42 U.S.C. 18051 and 42 C.F.R. part 600, in order to further the goals of the Legislative Assembly of reducing the cost of health care and ensuring all residents of this state equal access to health care.

(4) The group shall, in its deliberations, consider the findings from the independent study commissioned under section 1, chapter 96, Oregon Laws 2014.

(5) The authority shall report the recommendations of the group to the interim legislative committees related to health care no later than December 1, 2015.

SECTION 2. Section 1 of this 2015 Act is repealed December 31, 2015.

SECTION 3. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.

Passed by House April 20, 2015

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate May 26, 2015

.....
Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2015

Approved:

.....M,....., 2015

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2015

.....
Jeanne P. Atkins, Secretary of State

Health Systems Division

