Measure 96

Explanatory Statement

Ballot Measure 96 would amend the Oregon Constitution to require that 1.5% of net proceeds from the State Lottery be used to provide services for the benefit of veterans.

Originally the Oregon Constitution dedicated net lottery proceeds to job creation and economic development. Subsequent initiatives have dedicated 15% of net proceeds from the State Lottery to a parks and natural resources fund, which is used to create and maintain parks and natural resources, and 18% to an education stability fund, which is used to supplement public education funding.

The remaining 67% of net lottery proceeds is currently allocated by the Legislature, including specific amounts for lottery backed bonds, county economic development, college athletics, gambling addiction treatment and other legislative priorities associated with job creation and economic development.

By creating a new 1.5% dedication, the measure would reduce the undedicated portion of net lottery proceeds to 65.5%. Dedicating this percentage to veterans' services may increase Oregon's eligibility for available federal matching funds.

Committee Member Name	Appointed By
Senator Alan Olsen	President of the Senate
Representative Paul Evans	Speaker of the House
Vicki Berger	Secretary of State
Jean Cowan	Secretary of State
Cory Streisinger	Secretary of State

State Fiscal Year 2016 (July 2015 - June 2016)

	Amount Distributed per Category									
	CCO/MCO Capitation Payments	Fee for Service Payments	Transformation Performance Pool (HTPP)	Incentive Pool (Distributed June 2016)	Total	Average Caseload	Average Caseload PMPM	Federal Match (FMAP)	State Funds	Federal Funds	Total Funds
OHP Plus	$ 2,388,000,000	$ 558,000,000	$ 150,000,000	$ 80,000,000	$ 3,176,000,000			64%	$ 1,134,000,000	$ 2,042,000,000	$ 3,176,000,000
ACA	$ 2,402,000,000	$ 353,000,000	$ -	$ 83,000,000	$ 2,838,000,000			100%	$ -	$ 2,838,000,000	$ 2,838,000,000
CHIP	$ 112,000,000	$ 51,000,000	$ -	$ 4,000,000	$ 167,000,000			92%	$ 13,000,000	$ 154,000,000	$ 167,000,000
Non-OHP	$ -	$ 25,000,000	$ -	$ -	$ 25,000,000			64%	$ 9,000,000	$ 16,000,000	$ 25,000,000
Total	$ 4,902,000,000	$ 987,000,000	$ 150,000,000	$ 167,000,000	$ 6,206,000,000	1,150,000	$ 450		$ 1,156,000,000	$ 5,050,000,000	$ 6,206,000,000

2017 Estimates for Display Purposes ONLY - Conceptual

State Fiscal Year 2017 (July 2016 - June 2017)

	CCO/MCO Capitation Payments	Fee for Service Payments	Hospital Transformation Performance Pool (HTPP)	2016 CCO Incentive Pool (Distributed June 2017)	Total	Average Caseload	Average Caseload PMPM
Total	$ 4,679,000,000	$ 1,134,000,000	$ 90,000,000	$ 179,000,000	$ 6,082,000,000	1,090,000	$ 465
					PMPM Rate Growth:		3.4%

2018 Estimates for Display Purposes ONLY - Conceptual

State Fiscal Year 2018 (July 2017 - June 2018)

	CCO/MCO Capitation Payments	Fee for Service Payments	Hospital Transformation Performance Pool (HTPP)	2017 Incentive Pool CCO (Distributed June 2018)	Total	Average Caseload	Average Caseload PMPM
Total	$ 4,838,086,000	$ 821,914,000	$ 90,000,000	$ 205,000,000	$ 5,955,000,000	1,032,163	$ 481
					PMPM Rate Growth:		3.4%

2019 Estimates for Display Purposes ONLY - Conceptual

State Fiscal Year 2019 (July 2018 - June 2019)

	CCO/MCO Capitation Payments	Fee for Service Payments	Hospital Transformation Performance Pool (HTPP)	2018 Incentive Pool (Distributed June 2019)	Total	Average Caseload	Average Caseload PMPM
Total	$ 5,002,580,924	$ 819,419,076	$ -	$ 200,000,000	$ 6,022,000,000	1,009,460	$ 497
					PMPM Rate Growth:		3.4%

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

January 12, 2017

Lori Coyner, MA
Medicaid Director
Oregon Health Authority
421 SW Oak Street, Suite 875
Portland, OR 97204

Dear Ms. Coyner:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to extend Oregon's section 1115(a) Medicaid demonstration, entitled "Oregon Health Plan (OHP)" (Project Number 21-W-00013/10 and 11-W-00160/10). Approval of this extension is under the authority of section 1115(a) of the Social Security Act, and is effective from January 12, 2017, through June 30, 2022.

This extension allows the Oregon Health Plan demonstration to continue utilizing community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement. The extension will build on Oregon's progress and improve the coordinated care model, maintaining Coordinated Care Organizations' ("CCOs") focus on integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and restraining costs.

This extension maintains Oregon's commitment to a sustainable rate of cost growth and adopts a payment methodology and contracting protocol for CCOs that advances the use of value-based payments and that promotes CCO flexibility and innovation. Specifically, the extension authorizes Oregon to provide new performance incentive payments to primary care providers under the "Patient-Centered Primary Care" medical homes and "Comprehensive Primary Care Plus" initiatives. The extension clarifies that health-related services (previously known as flexible services) delivered by CCOs that meet the regulatory definition of "Activities that Improve Health Care Quality" as specified at 45 CFR 158.150 or "Expenditures related to Health Information Technology and Meaningful Use Requirements" as specified at 45 CFR 158.151 will be included in the numerator of the Medical Loss Ratio as required under 42 CFR 438.8 and 42 CFR 438.74. The extension also transitions hospital pay for performance payments into the CCO program. The Hospital Transformation Performance Program will have a transitional one year extension through June 30, 2018, during which Oregon expects that any hospital pay for performance payments will be built into the 2018 CCO contracts.

The extension expands the coordinated care model to Medicaid and Medicare dual-eligible

members. Medicare and Medicaid dually eligible individuals who choose to enroll in the Oregon Health Plan may be passively enrolled by the state into a CCO. They retain the option to opt out and return to the fee for service system at any time.

The extension maintains and strengthens important services and protections for American Indians and Alaska Natives in Oregon. The extension maintains the services paid for under the Tribal uncompensated care (supplemental) payments while converting the program into a Medicaid benefit.

CMS approval of this extension is conditioned upon continued compliance with the STCs defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to your written acknowledgment of the award and acceptance of the STCs within 30 days of the date of this letter. A copy of the revised STCs and expenditures are enclosed along with a copy of the waiver list.

Your project officer for this demonstration is Linda Macdonald. Ms. Macdonald is available to answer any questions concerning your section 1115 demonstration. Her contact information is as follows:

Centers for Medicare & Medicaid Services Center
for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-3872
Email: Linda.Macdonald@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Macdonald and to Mr. David Meacham, Associate Regional Administrator in our Regional Office. Mr. Meacham's contact information is as follows:

David Meacham
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
Operations
701 Fifth Avenue, MS RX-200
Seattle, WA 98121

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director of the State Demonstrations Group in the Centers for Medicaid & CHIP Services at (410) 786-5647.

Demonstrations Group in the Centers for Medicaid & CHIP Services at (410) 786-5647.

Sincerely,

Vikki Wachino
Director

Enclosures

cc: Mr. David Meacham, Associate Regional Administrator, Region X

Health Policy and Analytics Division
Medicaid Policy
Kate Brown, Governor

Oregon Health Authority

421 SW Oak St., Suite 875
Portland, OR 97204
Voice 971-673-3377
FAX 971-673-3320

January 12, 2017

Ms. Victoria Wachino
Centers for Medicare and Medicaid Services
Children and Adults Health Programs Group
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Wachino,

I am pleased to accept the Centers for Medicare & Medicaid Services' (CMS) approval of the amendments to and extension of the Oregon Health Plan, the State's Medicaid and Children's Health Insurance Program (CHIP) demonstration project authorized under Section 1115(a) of the Social Security Act (project numbers 21-W-00013/10 and 11-W-00160/10, dated January 12, 2017.)

This approval, provided through the CMS approval letter, Special Terms and Conditions and waiver and expenditure authority documents for the period of January 12, 2017 through June 30, 2022, allows the State to continue to enhance Health System Transformation with the expansion of the Coordinated Care Model and performance-driven system aimed at improving health outcomes while continuing to bend the cost curve.

Oregon is committed to building on the gains it has made in partnership with this Administration, and to renewing this demonstration to take Health System Transformation to the next level through targeted modifications to the current waiver. Applying lessons learned from implementing Coordinated Care Organizations (CCOs) in the preceding demonstration period, Oregon will expand and refine the state's transformed health care delivery system while continuing to maintain a sustainable rate of growth of health care costs. Areas of focus in this renewed demonstration include maintaining CCOs and the coordinated care model; integration of physical, behavioral, and oral health care; increased investments in health related and flexible services; advanced use of value-based payments; improvements in access and quality of care for American Indians and Alaska Natives; and expansion of the Coordinated Care Model to dual-eligible members.

I want to thank you for your time and commitment as well as that of your staff in working with the State on this demonstration renewal over the past several months. The staff's perseverance, thoughtful feedback, and assistance was exceptional. Our work together will benefit the lives of the more than 1 million people served by the Oregon Health Plan.

Thank you again for your commitment to this effort.

Sincerely,

Lori Coyner, MA
Medicaid Director

CC:

Kate Brown, Oregon Governor
Andy Slavitt, Acting Administrator, CMS
Eliot Fishman, Director, State Demonstrations, CMS
Susan Johnson, Director, HHS Region X
Lynne Saxton, Director, Oregon Health Authority
Jeremy Vandehey, Health Care Policy Advisor, Office of the Governor

benefit package under the approved state plan and 2) included on the state's prioritized list, as approved by the Secretary, to the extent that the state has authority under its section 1115 demonstration to apply the prioritized list to coverage..

21. **Breast and Cervical Cancer Treatment Program (BCCTP).** Individuals determined to be eligible as specified in the state plan for BCCTP services (population 21 in Attachment D) will be enrolled in the Oregon Health Plan.

V. DELIVERY SYSTEM TRANSFORMATION

Health System Transformation

22. Health care services authorized under this demonstration may be provided through (1) fee for service (FFS) for beneficiaries who are not required to enroll into a CCO or (2) managed care organizations called Coordinated Care Organizations (CCOs). Individuals who are not required to enroll into a CCO or who may disenroll from a CCO in accordance with 42 C.F.R. § 438.52 or who do not have another CCO option in their geographic area, will receive their services through a FFS delivery system.

    a. Individuals receiving covered health care services through the FFS delivery system may be required to receive dental and mental health services through a managed care delivery system, specifically:

        i. Dental Care Organizations, prepaid ambulatory health plan as defined in 42 C.F.R. § 438.2, for the provision of dental services including preventive care, restoration of fillings, and repair of dentures; and

        ii. Mental Health Organizations, prepaid inpatient health plan as defined in 42 C.F.R. § 438.2, for the provision of outpatient and acute inpatient mental health services.

    b. Patient Centered Primary Care Homes (PCPCH): the PCPCHs provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. The PCPCHs are optional and will be available to OHP beneficiaries whether they are enrolled with a CCO or served through the FFS delivery system.

23. The majority of health care services are provided through a managed care delivery system, CCOs. The CCOs provide medical, behavioral health services and dental services. The state contracts with CCO's.

    a. Enrollment of OHP Populations into CCOs

        i. New applicants will be offered their choice of CCOs only if more than one CCO exists in that region.

1. New members not choosing a plan will be auto-assigned to a CCO through an auto-enrollment process, if capacity exists, which will include enrolling family members in the same plan.

ii. Tribal members must make an affirmative voluntary choice for CCO enrollment (i.e., cannot be auto-enrolled).

iii. Dually eligible individuals must make a voluntary choice for CCO enrollment via passive enrollment.

iv. Beginning January 1, 2018, dually eligible individuals will be voluntarily enrolled in a CCO via passive enrollment pursuant to 438.54(c) with the option to opt out and return to FFS at any time. Passive enrollment of dual eligible individual will only begin when each CCO has been determined by the state and CMS to meet certain readiness and network requirements.

1. Dually eligible individuals will receive a ninety (90) day notice regarding passive enrollment in a CCO, where sufficient capacity exist.

2. Dually eligibles who live in an area with two CCOs will be enrolled using the same process as other OHP members, which is based on previous enrollment, enrollment of other family members, and CCO area capacity limit.

3. Dual eligibles who are enrolled in a dual eligible special needs plan (D-SNP) will be assigned to the affiliated CCO. Additionally, dual eligibles who are enrolled in a Medicare Advantage plan will be assigned to the affiliated CCO.

v. Certain individuals with significant medical conditions or special health needs will have individualized transition plans, as described below.

vi. OHA member transition strategies for FFS members with special considerations include:

1. Members and populations with conditions, treatments, and special considerations, including medically fragile children, Breast and Cervical Cancer Treatment Program members, members receiving CareAssist assistance due to HIV/AIDS, members receiving services for End Stage Renal Disease, may require individualized case transition, including elements such as the following, in the development of a prior-authorized treatment plan, culminating in a manual CCO enrollment:

- Care management requirements based on the beneficiary's medical condition;
- Considerations of continuity of treatment, services, and providers, including behavior health referrals and living situations;

- Transitional care planning (e.g., hospital admissions/discharges, palliative and hospice care, long term care and services);
- Availability of medically appropriate medications under the CCO formulary; and
- Individual case conferences as appropriate to assure a "warm hand-off" from the FFS providers to the CCO care team.

2. CCOs will be expected to cover FFS authorized services for a transitional period until the CCO establishes a relationship with the member and is able to develop an evidence-based, medically appropriate care plan.

3. For dually eligible, CCOs will be required to provide a minimum 90 day continuity of care period.

Description of Delivery System Transformation

24. **Definition and Role of Coordinated Care Organizations.** CCOs are community-based comprehensive managed care organizations which operate under a risk contract with the state. For purposes of CMS regulations, CCOs are managed care organizations and will meet the requirements of 42 CFR Part 438 unless a requirement has been specifically identified in the waiver authorities for this demonstration. CCOs will provide a governance structure to align the specialized services under one managed care organization. CCOs will partner with OHA to further the state's implementation of PCPCH and utilization of Traditional Health Workers (THWs). CCOs will be accountable for provision of integrated and coordinated health care for each organization's members.

a. CCO Criteria. The CCOs are required to meet the following criteria:

i. Governance and Organizational Relationships.

1. Governance. Each CCO has a governance structure in which persons that share in the financial risk of the organization constitute a majority. The governance structure must reflect the major components of the health care delivery system and must include: at least two health care providers in active practice (a physician or nurse practitioner whose area of practice is primary care and a mental health or chemical dependency treatment provider); at least one member of the Community Advisory Council (see 2 below); and at least two members from the community at large to ensure that the organizations decision making is consistent with the community members' values.

2. Community Advisory Council (CAC). The CCOs are required to convene a CAC that include representatives from the community and of county government, but with consumers making up the majority of the CAC. The CAC must be ongoing bodies and meet no less frequently than once every three months to ensure that the health care needs of the community are being met. At least one member from the CAC must serve on the governing board.