

IMPLEMENTING TOBACCO QUALITY MEASURES THROUGH MEDICAID INCENTIVE PAYMENTS IN OREGON

A Case Study



INTRODUCTION

In 2016, the Oregon Health Authority (OHA) implemented a benefit that gave all Medicaid enrollees access to comprehensive tobacco cessation treatment, and a Medicaid system incentivized to curb tobacco use utilizing strategies inside and outside of the clinical setting. Specifically, Oregon's Medicaid healthcare provider networks were financially incentivized to meet the following requirements:

- Meet minimum benefits requirements for cessation;
- Submit Electronic Health Record (EHR)-based cigarette smoking and tobacco prevalence data; and
- Meet benchmark or improvement targets established (and revised) by the Metrics and Scoring Committee.

To achieve this, Oregon leaders built upon a national and state-level movement toward emphasizing value-based care, and employed strategic cross-department collaboration, data communication and systems mapping. This case study outlines the steps Oregon leaders took to succeed in implementing financial incentives to improve tobacco cessation coverage and reduce smoking rates, and provides lessons learned for other state leaders hoping to reduce tobacco use in Medicaid populations in their state.



KEY PLAYERS

Coordinated Care Organizations (CCOs) An Oregon CCO is a healthcare provider network created by the state to serve people under the Oregon Health Plan (Medicaid). The CCOs consist of partnerships of payors, providers and community organizers that focus on providing local and regional distribution and coordination of healthcare. There is one CCO for each of the 16 service areas. This community-based, integrated organization connects state Medicaid enrollees to physical and behavioral healthcare and dental care in their local communities across the state.

The Oregon Health Authority (OHA) The OHA is a government agency that oversees most of the state's health-related programs. The OHA houses the Health Promotion and Chronic Disease Section, the Medicaid Administration and the Health Policy and Analytics Division, which includes the Health Evidence Review Commission and the Transformation Center, among other divisions. Notably, Medicaid and the Public Health Division are both under the OHA umbrella in Oregon.¹

The Health Promotion and Chronic Disease Prevention Section, within the OHA's Public Health Division, includes the **Tobacco Prevention and Education Program**. Among other duties, the Tobacco Prevention and Education Program leads tobacco cessation at the state and local level and ensures access to Oregon's tobacco quit line.

The Health Evidence Review Commission is a commission with the legal authority to direct what is on the Prioritized List of Health Services based on evidence. This list includes 660 lines, made up of health conditions and medical treatments for potential coverage by Medicaid. The Oregon Legislature (subject to approval from the Centers for Medicare and Medicaid Services) determines how many lines can be funded for each budget cycle, though the funding line is currently "frozen" under Oregon's 1115 waiver.²

The Metrics and Scoring Committee, an entity separate from, but staffed by OHA was created by legislation in concert with the CCOs. The body's specific charge is to select and review performance metrics with financial implications (incentives) for CCOs and set benchmarks to continue to ensure their performance improvement.

The Transformation Center, within Oregon's Health Policy and Analytics Division, is charged with innovation and quality improvement for Oregon's health system transformation efforts, with the specific aim of achieving value. They identify, support and share innovative ideas. Their tasks include technical assistance to CCOs in achieving the **CCO Cigarette Smoking Metric**.³

2016 CCO Cigarette Smoking Prevalence Metric:

- 1) Meet minimum benefits requirements (cessation benefit floor); and
- 2) Submit EHR-based cigarette smoking and tobacco prevalence data; and
- 3) Meet benchmark or improvement target established (and revised) by the Metrics and Scoring Committee

2019 CCO Cigarette Smoking Prevalence Metric:

- 1) Meet benchmark or improvement target established (and revised) by the Metrics and Scoring Committee



BACKGROUND: THE NATIONAL AND STATE CONTEXT

The national and state-level context of the Affordable Care Act's emphasis on paying for value, Medicaid expansion, Oregon's Coordinated Care Organizations (CCOs) and Oregon's history of a collaborative approach to tobacco control was essential to Oregon's success in developing a tobacco metric.

The Affordable Care Act and Medicaid Expansion

As part of the 2010 Affordable Care Act (ACA), states have the ability to expand their Medicaid program to cover all individuals up to 138 percent of the Federal Poverty Level, which is \$12,490 for an individual or \$25,750 for a family of four in 2020.⁴ Medicaid expansion is optional for states and is funded jointly by the federal government and states, with the federal government paying for approximately 90 percent of the expansion, a substantially higher share than for standard Medicaid.

Oregon expanded its Medicaid program in 2014, and as a result is required to cover a minimum set of benefits for their expansion population: the Essential Health Benefits (EHBs). Preventive services are one of the 10 EHBs and are required to be covered without cost sharing. The ACA requires Medicaid expansion plans to cover any service or treatment given an "A" or "B" by the United States Preventive Services Task Force. Tobacco cessation treatment has an "A" grade. As a result, the state of Oregon provides all of their Medicaid enrollees, including the expansion population, a comprehensive cessation benefit that includes all seven medications approved by the Food and Drug Administration and all three types of counseling with minimal barriers.

Another critical element of the ACA was an emphasis on value-based care, including paying for quality over quantity and incentivizing use of electronic health records (EHRs). EHRs provide the opportunity for data on patient treatment and care to be collected in a standard, comparable format. The data from EHRs can be analyzed, and the results can be used to reinforce best practices and to improve the quality of patient care. One way to do that is through quality measures. Quality measures are tools that "quantify healthcare processes, outcomes, patient perceptions and organizational structure and/or systems that are associated with the ability to provide high-quality healthcare and/or that relate to one or more quality goals for healthcare."⁵

The passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act (2009) included Meaningful Use, a financial incentive program. Meaningful Use policies incentivized healthcare providers and hospitals to adopt and utilize EHRs to allow for the exchange of clinical data between providers and other entities (such as insurers and patients) to improve quality of care. Providers were required to report on quality measures in order to demonstrate "Meaningful Use" of EHRs. This resulted in a greater emphasis on quality measures and greater adoption of EHRs across the country.

Oregon's Coordinated Care Organizations

In 2011, Medicaid enrollees in Oregon received care in a fragmented, uncoordinated health system with growing, unsustainable costs and a projected Medicaid deficit. That year, Oregon launched a major health transformation focused on using innovative strategies in the health delivery system for Medicaid patients to slow the growth of Medicaid costs. The creation of CCOs in Oregon to improve health outcomes for the Medicaid population while achieving the triple aim of "improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations" was central to Oregon's health transformation.⁶



An Oregon CCO is a healthcare provider network created by the state to serve people under the Oregon Health Plan (Medicaid). The CCOs consist of partnerships of payors, providers and community organizers that focus on providing local and regional distribution and coordination of healthcare. There is one CCO for each of the 16 service areas. This community-based, integrated organization connects state Medicaid enrollees to physical, behavioral and dental care in their local communities across the state.

Most state Medicaid programs deliver health services through a combination of fee-for-service and managed care organization programs. In a fee-for-service program, the state directly pays for the cost of care. Medicaid managed care organizations are third-party payors that the state contracts with to administer the Medicaid program. With the movement at the national level toward improving and paying for the quality of care, accountable care organizations (ACOs) were created through an 1115 waiver. ACOs are provider collaborations that support the integration of healthcare providers and healthcare settings, working together to coordinate patient care and improve the quality of care. While Oregon CCOs are similar to ACOs in their focus on quality of care, they are also unique in several ways:

- CCOs are mandated by statute to create a community advisory council to ensure that they are addressing the needs of their local community;
- CCOs have flexibility to provide services outside of the traditional clinical health setting;
- CCOs have a heavier emphasis on prevention and nonmedical components to health (e.g., housing, transportation); and
- CCOs receive a global budget to cover all services with shared savings if quality measures are met.

Through integrated care at a local level with an emphasis on prevention, the Oregon CCO model allows for greater flexibility and focuses on improving the quality of care for the state's Medicaid enrollees.

This national context of Medicaid expansion, an emphasis on value-based care and greater penetration of EHRs was essential to the success of Oregon's healthcare transformation. However, equally important was Oregon's history of a systems-based collaborative approach to reducing tobacco use and dependence.

Oregon Tobacco Control: A Systems-Based Collaborative History

"I looked at a problem like smoking in terms of what a system can do to achieve population level health, not just what a healthcare provider can do...You need to think cross-sector to solve the problem."

—Catherine Livingston,
Associate Medical Director,
the Health Evidence Review
Commission, OHA

The Oregon Health Authority (OHA) and the state of Oregon have a long history of tackling tobacco, beginning over 20 years ago in 1997 when the Tobacco Prevention and Education Program in Oregon was established with revenue from a 1996 state tobacco tax increase. Oregon's state-wide smokefree indoor workplace law went into effect in 2012, and the year following that Oregon established a policy prohibiting the use of tobacco on any state property.⁷

Within the OHA, the Tobacco Prevention and Education Program's ability to coordinate across divisions was essential

"We knew that if we didn't address tobacco use in a meaningful way, we were not going to bend the cost curve or get to the health outcomes we were targeting."

—Kirsten Aird, Chronic Disease
Program Manager, OHA

to their ability to sustain visibility of tobacco control needs at OHA. For example, in the OHA, state medical directors in every department meet regularly to identify action items for progress and key areas OHA



needs to address collectively. It was important that the Tobacco Prevention and Education Program staff understood that these meetings were occurring so that they could request that tobacco be on the agenda for discussion, and thus remain a priority across OHA.

This history and culture of a systematic and collaborative approach to tobacco control in Oregon helped lay the foundation for prioritizing reducing tobacco use when the opportunity arose with Oregon's Medicaid transformation. The most vital partnership, however, was that between the Tobacco Prevention and Education Program and Medicaid.

A CRITICAL PARTNERSHIP BETWEEN MEDICAID AND PUBLIC HEALTH

"We were able to break down silos in here. Often public health people and medical people think in their own ways and don't think about how to cross-pollinate, and that is where we were really successful."

—Catherine Livingston,
Associate Medical Director,
the Health Evidence Review
Commission, OHA

In Oregon, the offices that support Medicaid and the Public Health Division are both a part of the Oregon Health Authority (OHA), a structure that facilitates collaboration across all of the divisions. This collaboration has been critical to success in Oregon. The two entities began working together over 20 years ago, when the 1996 tobacco tax increase established the Tobacco Prevention and Education Program, which allowed the program to fund and place a full-time employee in the Medicaid office. Over the next decades, the Tobacco Prevention and Education Program and Medicaid collaborated on initiatives, including tobacco quitlines, through the lens of a comprehensive approach to reducing tobacco dependence, and a commitment to multisector interventions.

"Even if the Medicaid office doesn't sit with the public health office structurally, it doesn't mean they can't meet regularly. Having tobacco brought up on a regular basis was key."

—Kirsten Aird, Chronic Disease
Program Manager, OHA

As part of the partnership, staff responsible for implementing Medicaid and the Tobacco Prevention and Education Program were expected to work together and meet on a regular basis formally and informally. Staff of the Health Evidence Review Commission collaborated with staff implementing Medicaid and with the Public Health Division to identify comprehensive evidence-based strategies to improve health in Oregon. After careful review, the Health Evidence Review Commission ranked tobacco dependence treatment as a **top priority** on the prioritized list of health services.

Through their review of evidence and collaboration with the Public Health Division, the Health Evidence Review Commission staff knew that focusing on tobacco cessation alone would not be sufficient. Staff members from the Health Evidence Review Commission and the Public Health Division met to brainstorm ways to use an evidence-based approach to integrate population health ideas through the lens of healthcare and Medicaid. As a result of this discussion, the Health Evidence Review Commission developed a multisector interventions statement, which listed effective interventions beyond medical coverage, including financial incentives, smokefree legislation and tobacco excise taxes. Some of these nonmedical services can be provided using Medicaid funds under Oregon's Medicaid 1115 waiver.

With this history of collaboration, Medicaid funding of multisector interventions, and tobacco dependence as a high priority for Medicaid coverage, it was natural for the Tobacco Prevention and Education Program and the Health Evidence Review Commission staff to collaborate again when Oregon began thinking about a



health system transformation initiative. They asked the question—“what is an evidence-based way to ensure Medicaid is pushing CCOs to maximize population health?”⁸

THE PROCESS

The Case for a Tobacco Incentive Metric

To the Health Promotion and Chronic Disease Prevention Section and the Health Evidence Review Commission staff, the data on tobacco were compelling. In 2012, 36 percent of Medicaid members were current smokers compared to 13 percent of Oregonians under other insurance providers. Smoking-related illness is expensive for Oregon—in 2012, smoking cost Oregon \$374 million in medical costs.⁹ The cost of smoking is especially high for Medicaid. A more recent 2019 study estimated that a one percent decrease in the smoking rate among the general population in Oregon would save the state \$44.7 million in Medicaid expenditures.¹⁰ With such high costs and prevalence of tobacco in Medicaid populations, Oregon leaders saw a payment model emphasizing value as necessary. In the Oregon context, adding a tobacco incentive metric to the list of metrics that CCOs would be required to meet in order to receive incentive payments was a logical solution.

“Having Medicaid really thinking outside the box, with CMS then giving federal leeway by saying it is okay for Medicaid to spend money in innovative ways, opened the door for [the Health Evidence Review Commission] to look at the data and create a menu of evidence-based options as mechanisms by which [CCOs] can spend money to achieve outcomes.”
—Catherine Livingston, Associate Medical Director, the Health Evidence Review Commission, OHA

The Decision to Include a Metric on Smoking Prevalence

The Metrics and Scoring Committee was charged with selecting and reviewing the performance incentive metrics for CCOs and setting benchmarks to continue to ensure their performance improvement.

“The idea that CCOs are responsible for prevalence, not just process and outcome metrics, but pushing toward population health—is transformative”
—Catherine Livingston

Although a tobacco metric was considered in 2012, they did not agree to implement it until 2016, after much debate centered largely on the smoking prevalence benchmark and improvement component of the metric.

A tobacco prevalence incentive metric meant holding CCOs financially accountable for effecting a change largely impacted by variables outside of the healthcare setting. This concept was originally highly controversial and created a significant amount of debate within the

Metrics and Scoring Committee. Ultimately, the Health Promotion and Chronic Disease Prevention Section played a role in the final decision to include the Smoking Cessation Incentive Metric, by presenting data to

Excerpt from the first Metrics and Scoring Committee meeting ¹¹

Core Metrics for Oregon Health Transformation	
Metric	Why Selected
#3 Rate of tobacco use among CCO enrollees (percent of members who use tobacco products)	<ul style="list-style-type: none">• Tobacco use is disproportionately high among the Medicaid population and a driver of high costs and poor health• Outcome measure relevant to key topics of prevention and cost control• Meets stakeholder measure selection criteria of relevance, transformative potential, consumer engagement, attainability, accuracy, feasibility and reasonable accountability



the committee when requested and serving as an information resource. Other contributors to the Metrics and Scoring Committee's decision included a multitude of letters from local public health departments emphasizing the importance of outcome and tobacco-focused incentive metrics and input from a technical workgroup that included many CCOs. As a result, the Metrics and Scoring Committee generated a list of hundreds of potential incentive metrics. With a focus on measurement, one of their key criteria for finalizing incentive metrics was the ability to effectively measure each metric. Cigarette smoking did not pass this criterion until 2015 (for implementation in 2016).

Between 2012 and 2015, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC) released final rules for Meaningful Use, a set of quality measures that created incentives and penalties for hospitals and medical providers to use electronic health records (EHRs) in a meaningful way.¹² ONC's rollout of Meaningful Use between 2012 and 2015 was crucial to the Metrics and Scoring Committee's decision to include a tobacco prevalence metric. The new measures fostered widespread implementation of EHRs in Oregon, which ultimately served as the data source for tobacco prevalence. By 2015, EHRs had been adopted widely enough in Oregon to serve as a reliable source of data on smoking prevalence, thus satisfying this criterion of the Metrics and Scoring Committee. As a result of significant input from the public health community and progress with Meaningful Use, the CCO Cigarette Smoking Prevalence Metric implemented in 2016 was the first metric financially incentivizing health systems to reduce smoking rates.*

"The Metrics and Scoring Committee...prioritized measures on tobacco because physicians and other quality leaders in the group knew how important reduction of smoking would be for the prevention of many other health conditions such as cancers, COPD, CHD and others."

—Valerie T Stewart, Ph.D.,
Metrics and Evaluation
Manager, Oregon Health
Authority Health Policy and
Analytics

COMPREHENSIVE CESSATION BENEFIT:

Seven Medications:

- NRT Gum (OTC)
- NRT Patch (OTC)
- NRT Lozenge (OTC)
- NRT Inhaler
- NRT Nasal Spray
- Bupropion
- Varenicline

Three Forms of Counseling:

- Individual
- Group
- Phone

A Staged Approach to Tobacco Quality Measures

In 2016, a benchmark improvement in smoking prevalence was one of three components of the bundled CCO Cigarette Smoking Prevalence Metric. Initially, simply reporting EHR-based smoking and tobacco prevalence data was included, because the way tobacco was reported in EHRs varied significantly across the states (e.g., some providers collected tobacco prevalence while others collected data on smoking only) and took time to consolidate into a single consistent measure. However, once reporting became widespread and consistent, this reporting metric was no longer incentivized.

In addition, this 2016 metric required CCOs to cover a comprehensive tobacco cessation benefit.¹³ When approved by the Metrics and Scoring Committee in 2015 for implementation, this requirement was more comprehensive than what the Health Evidence Review Commission had included in the prioritized list of what Medicaid-covered entities

*In the end, although CCOs reported prevalence data on all tobacco products when available, the incentives were only paid for cigarette smoking cessation because all CCOs were not able to report tobacco data equally.



are required to offer. However, in 2016, the Health Evidence Review Commission adopted the comprehensive tobacco cessation benefit, thus requiring CCOs to offer it as a part of their contract with the

“Most CCO money is tied to medical billing codes and covered services, but the health-related services are non-covered services which provide CCOs the flexibility to invest in population health strategies to improve care delivery and overall member and community health.”

—Shira Pope, Health Systems Policy Specialist

OHA. Recognizing that this tobacco cessation benefit no longer needed to be incentivized because it was already required, the Metrics and Scoring Committee removed the cessation component of the CCO Cigarette Smoking Prevalence Metric in 2019.

Finally, although the tobacco prevalence benchmark or improvement component of

the metric remained, the target tobacco use rate varied for CCOs, recognizing the differences in the populations they served. This benchmark tobacco prevalence rate also changed over time to recognize previous successes and to encourage CCOs to continue to make progress year after year.¹⁴

IMPLEMENTATION

OHA succeeded in a major effort to create Medicaid funding incentives to encourage CCOs to take major steps to reduce tobacco dependence and prevalence in the populations they serve, however, implementation of the metric is an ongoing challenge. The Metrics and Scoring Committee define 18 metrics overall; but, CCOs only need to meet benchmarks or improvement targets in 13 of the 18 to qualify for incentive payments, which means CCOs do not necessarily have to choose the *CCO Cigarette Smoking Prevalence Metric*.¹⁵ Further, CCOs have great flexibility in defining how they plan to meet each metric, resulting in great variability in implementation. This flexibility, afforded to CCOs in statute, is a particular challenge for the tobacco cessation component of the metric. The Tobacco Prevention and Education Program staff note that some CCOs meet the cessation component of the smoking metric through contracts with the state tobacco quitline, while others meet the incentive with in-house services, creating significant variability in the quality of the tobacco cessation services offered.¹⁶

The Tobacco Prevention and Education Program tackled the initial challenge of encouraging CCOs to prioritize the tobacco metric with targeted, coordinated communication, and collaborated across OHA to provide technical assistance. In particular, OHA collaborated with the Transformation Center, which is responsible for technical assistance to CCOs to help them meet their incentive metrics. Every year, the Transformation Center administers a survey to CCOs, which provides OHA with insights as to what specific benefits they are providing, and if they are meeting the tobacco prevalence benchmarks or improvement component of the incentive metric. After careful analysis of the survey results, the Tobacco Prevention and Education Program identifies where technical assistance in applying evidence-based strategies may be needed.

2016 CCO Cigarette Smoking Prevalence Metric:

- 1) Meet minimum benefits requirements (cessation benefit floor); and
- 2) Submit EHR-based cigarette smoking and tobacco prevalence data; and
- 3) Meet benchmark or improvement target established (and revised) by the Metrics and Scoring Committee

2019 CCO Cigarette Smoking Prevalence Metric:

- 1) Meet benchmark or improvement target established (and revised) by the Metrics and Scoring Committee



The Tobacco Prevention and Education Program helps Oregon CCOs maintain tobacco reduction as a priority by communicating the disproportionate impact of tobacco use on the Medicaid population, the impact of tobacco on other chronic diseases, and thus, how reducing tobacco use would also help the CCOs meet other incentive metrics. The Tobacco Prevention and Education Program further uses local and national data, including recommendations from the United States Preventive Services Task Force and the Community Guide[†] to communicate information to CCOs on how to support local tobacco control efforts. To ensure that OHA tobacco messages to CCOs were as streamlined as possible, the Tobacco Prevention and Education Program participated in monthly coordination calls with different chronic disease-focused sections in the Health Promotion and Chronic Disease Prevention Section and coordinated with the Transformation Center.

In their technical assistance, the Transformation Center and the Tobacco Prevention and Education Program build upon two vehicles: 1) the “Sustainable Relationships for Community Health” competitive grant program, and 2) health-related services funds. The grant program administered by the Health Promotion and Chronic Disease Prevention Section requires public health entities and CCOs to work together, align shared goals, strengthen relationships and bring in additional partners to pilot, implement and sustain activities toward a joint goal.

The health-related service funds are payments for services outside of the clinical setting that impact health outcomes and healthcare spending. They give CCOs flexibility to use Medicaid dollars for nonclinical services, which can include activities to support evidence-based community-wide tobacco control efforts such as mass communications, tobacco-free communications and tobacco-free properties. Health-related service funds were developed because the OHA believed the incentive metrics alone were insufficient to meet their goals of improving population health while reducing healthcare spending. Early health-related services included individual options such as pill minders and gym memberships, as well as group services such as community youth programs.¹⁷ In their nascent phase, outcomes from health-related services between 2012–2017 were evaluated only qualitatively. By the end of 2019, OHA intends to update their contracts with CCOs to develop health-related services more fully.

“It’s important to think through structural elements to support the solutions and connect to take advantage of resources that already exist.”

—Catherine Livingston,
Associate Medical Director,
the Health Evidence Review
Commission, OHA

The Tobacco Prevention and Education Program and the Transformation Center assist CCOs in not only identifying community partners, but also identifying ways CCOs may use their flexible dollars to meet their smoking prevalence targets. Although implementation of the *CCO Cigarette Smoking Incentive Metric* is a continued challenge, the OHA addresses this challenge through communication and technical assistance, contributing to more CCOs meeting the tobacco metric in 2017 compared to 2016 (see below). However, the challenge of inconsistent cessation services remains, as the flexibility given to CCOs in statute is not easily changed.

“We hoped [health-related services] would be used for things that will overcome some of the challenges to health as a result of social barriers such as transportation, lack of shoes or other health risk.”

—Valerie T Stewart, Ph.D.,
Metrics and Evaluation
Manager, OHA

[†]See [usa.gov](https://www.thecommunityguide.org/) for more information on the Community Guide at <https://www.thecommunityguide.org/>



OUTCOMES

In the first year (2016), 15 of 16 CCOs met the cessation benefit requirement, all 16 CCOs met the requirement to report tobacco prevalence in their EHRs, and two CCOs reached their cigarette smoking prevalence benchmark or prevalence target. As a result, 15 of the 16 CCOs received their incentive payment in the first year. The next year, CCOs reported significant progress with all 16 CCOs meeting the cessation benefit requirement and the EHR data reporting requirement, and seven of the 16 CCOs met the benchmark or specified cigarette smoking prevalence target in 2017.¹⁸ As a result, all CCOs received their incentive payments in 2017.[‡]

LESSONS LEARNED

While building upon data from the CDC and Meaningful Use, Oregon's success in developing incentive metrics relied on three essential components:

- A culture of collaboration across sectors;
- A shared understanding on the health impact and cost of tobacco; and
- A commitment to a systems approach and fostering partnerships with community members.

Although Oregon has a long history of tobacco control success, these elements can be applied to other states. For example, while the structure of OHA where Medicaid and the Public Health Division sit together facilitated collaboration, a shared recognition of the burden of tobacco and the return on investment of reducing tobacco use can occur in other states. Further, systems mapping, a key to success for public health staff in Oregon, is necessary and applicable in any organizational structure. Understanding the relative agencies and authoritative structures that should be present at key stakeholder meetings was essential to driving the change in Oregon and has application to other states.

Similarly, while the mechanism of success in other states may vary, an important component of Oregon's success was OHA's approach using structural elements that build upon the system the state has in place (or is in the process of building). In Oregon, this meant that public health needed to prioritize tobacco through collaboration with the Health Evidence Review Commission, Metrics and Scoring Committee and the Transformation Center, given the structure created through Oregon legislation and the 1115 Medicaid Waiver.

Finally, a major challenge in Oregon was the concept of holding CCOs accountable for an outcome such as tobacco prevalence, which is highly impacted by variables outside of the community. Oregon solved this by breaking down silos across the OHA and building community partnerships into the Medicaid system, from the governance of the CCOs to funding for actions such as support for a tobacco tax in collaboration with a broader community-led intervention.

CONCLUSION

The Oregon case study provides an example of how, with cross-sector and cross-agency collaboration and a shared understanding of the importance of tobacco control, Oregon took advantage of a national priority moving toward improving quality of care and utilized quality measures to ensure tobacco control was included in their broader Medicaid transformation efforts. The Oregon example provides meaningful insights into how other states make the case for and implement a tobacco prevalence and cessation incentive metric

[‡]At the time of writing, 2018 data was unavailable.



that has the potential to reduce tobacco use in the Medicaid population, where tobacco use rates are particularly high, and save lives.

ACKNOWLEDGEMENTS

The American Lung Association wishes to acknowledge Kirsten Aird, MPH, Catherine Livingston, MD, MPH, Shira Pope, MS, and Valerie T Stewart, Ph.D. The Lung Association also acknowledges Payal Shah Martin, MPH, for her contributions. This publication was supported by Cooperative Agreement Number 6NU38OT000292-01 funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the American Lung Association.

1. Oregon Health Authority. About OHA. Retrieved May 20, 2019 from <https://www.oregon.gov/oha/Pages/Portal-About-OHA.aspx>
2. Oregon Health Authority. Health Evidence Review Commission. Retrieved May 20, 2019 from <https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/index.aspx>
3. Oregon Health Authority. Transformation Center. Retrieved May 20, 2019 from <https://www.oregon.gov/oha/hpa/dsi-tc/Pages/index.aspx>
4. American Lung Association. Tobacco Cessation Coverage: Medicaid Expansion. Retrieved June 6, 2019 from <https://www.lung.org/assets/documents/tobacco/tobacco-cessation-and-medicaid-expansion.pdf>
5. Centers for Medicare & Medicaid Services. Quality Measures. Retrieved June 6, 2019 from <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualitymeasures/index.html>
6. Monney, J., Chang, D. Medicaid and Public Health Collaboration in Oregon. National Academies of Medicine. April 24, 2017. Retrieved on May 20, 2019 from <https://nam.edu/case-study-medicaid-and-public-health-collaboration-in-oregon/>
7. Centers for Disease Control and Prevention. Smoking and Tobacco Use. Oregon Monitor. Retrieved May 20, 2019 from https://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/states/oregon/index.htm
8. Livingston, Catherine. (2019 April). Phone Interview.
9. Hedberg, Katrina. Oregon Health Authority. Possible Incentive Metrics: Public Health Recommendation. Retrieved May 20, 2019 from <https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/Population-Health-Metrics-Presentation.pdf>
10. Glantz, Stanton, A. Estimation of 1-Year Changes in Medicaid Expenditures Associated with Reducing Cigarette Smoking Prevalence by 1%. JAMA Network Open. 2019;2(4):e192307. doi:10.1001/jamanetworkopen.2019.2307.
11. Oregon Health Authority. Oregon Metrics and Scoring Committee Agenda August 22, 2012. Retrieved May 20, 2019 from <https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/August-22-2012-Materials.pdf>
12. Centers for Disease Control. Meaningful Use Introduction. Retrieved May 20, 2019 from <https://www.cdc.gov/ehrmeaningfuluse/introduction.html>
13. Oregon Health Authority. Tobacco Cessation Coverage Standards. Retrieved June 6, 2019 from https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCPREVENTION/Documents/tob_cessation_coverage_standards.pdf
14. Oregon Health Authority. Oregon Health System Transformation: CCO Metrics 2016 Final Report. Retrieved June 6, 2019 from <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2016-CCO-Performance-Report.pdf>
15. American Lung Association. Quality Measures and Tobacco Cessation: The Oregon Experience. Retrieved May 20, 2019 from <https://www.lung.org/assets/documents/tobacco/quality-measures-experience.pdf>
16. Pope, Shira. (2019 April). Phone Interview.
17. Oregon Health Authority. Summative Medicaid Waiver Evaluation – Final Report. Retrieved May 20, 2019 from <https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf>
18. Oregon Health Authority. Oregon Health System Transformation: CCO Metrics 2017 Final Report. Retrieved June 6, 2019 from <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2017-CCO-Performance-Report.pdf>





American Lung Association | 55 W. Wacker Drive, Suite 1150 | Chicago, IL 60601
1-800-LUNGUSA (1-800-586-4872) | Lung.org

