Oregon Health Plan

Section 1115 Annual Report

7/1/2020 – 6/30/2021

Demonstration Year (DY): 19

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I. Introduction

A. Letter from the State Medicaid Director

During this reporting period, the COVID-19 Public Health Emergency as well as Oregon's wildfires Public Health Emergency and ice storms continued to impact many aspects of Oregon's Medicaid system. The Oregon Health Authority continued to lead Coordinated Care Organizations (CCOs) and their provider networks in their response, while listening closely to members and providers to understand their changing needs.

While every person in Oregon has been affected, it became overwhelmingly clear that some individuals and communities – those that had already been economically or socially marginalized, or who had already suffered greater health difficulties – experienced worse health impacts from these events. Leadership at the Oregon Health Authority (OHA) have joined leaders throughout State government in committing to advancing equity goals in our public health emergencies responses as well as our in our regular processes and programs.

Also, during this reporting period, the OHA has conducted a comprehensive review of CCOs' provider networks focused on provider capacity, provider directory validation, and other issues affecting members' access to care to ensure transparency and to minimize the impact inadequate access can have on health equity. We are sharing that information with CCOs and requiring additional provider network information going forward in order to advance our access and equity goals.

Oregon's 2021 State Legislative session resulted in unprecedented activity related to our health system both in the number of bills and in the level of state funding commitments. There was a specific focus on equity and behavioral health issues, and a number of cross-agency and cross-sectoral committees and initiatives have already begun as a result.

In a separate document Oregon submitted to CMS the 1115 Oregon Health Plan Interim Evaluation Report. We will continue to work with our federal partners to understand the areas of progress and opportunities to improve our system of Coordinated Care Organizations, while sharing those lessons with our partners in serving Oregon's Medicaid population.

Dana Hittle, Interim State Medicaid Director

B. Demonstration description

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

In January 2017, CMS approved an extension to Oregon's 1115 Medicaid Demonstration waiver to continue and enhance Oregon's health system transformation initially approved in 2012. Moving forward, Oregon will continue to utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

Under the demonstration, Oregon strives to promote the objectives of Title XIX by:

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

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

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

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

- Conversion of the Tribal uncompensated care payments to a Medicaid benefit;
- Clarifying health-related services that meet the requirements as specified in the Code of Federal Regulations;
- Allowing passive enrollment of Medicare and Medicaid dually-eligible individuals into CCOs with the option for each individual to opt-out at any time;
- Specifying the demonstration will not impact American Indian and Alaska Natives rights to exemption from managed care, or the requirements to comply with the Medicaid Managed Care Regulations;

- Offering incentive payments to Patient-Centered Primary Care Homes and Comprehensive Primary Care Plus providers for enhanced fee-for-service delivery of care to Medicaid recipients; and
- Establishing minimum requirements for CCOs to collaborate and communicate in a timely and equitable manner with tribes and Indian Health Care providers.

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II. Title

Oregon Health Plan
Section 1115 Annual Report
Reporting period: 7/1/2020 – 6/30/2021
Demonstration Year (DY): 19

III. Overview of the current year

During this reporting period OHA and our CCO partners continued to pursue demonstration goals while responding to public health emergencies. Enrollment continued to rise steadily while OHA closely monitored CCO capacity.

OHA conducted a comprehensive review of CCO's provider capacity compliance in accordance with standards for access to care, provider directory validation, and network adequacy to ensure access standards are met for all members.

In response to the shifting priorities under the Covid-19 PHE, Oregon's Metrics and Scoring Committee altered the approach to baseline metrics to maximize access to supportive resources, and OHA shifted Quality Pool resources to incentivize Emergency Outcome Tracking for Covid-19.

A. Enrollment progress

1. Oregon Health Plan eligibility

Title XIX and Title XXI enrollment has continued to steadily increase over the past year as a direct result of Oregon's election to adopt provisions to simplify initial eligibility requirements as well as limit the circumstances under which benefits are terminated during the COVID-19 federal health emergency period as permitted in the H.R.6201 Families First Coronavirus Response Act. Self-attestations of income are accepted for new applicants without requiring verification. Additionally, individuals who were receiving coverage on or after March 18, 2020 are maintaining continued coverage unless they die, are suspended while being an inmate of a public institution, cease to be a resident of the state, or voluntarily request closure. Oregon has experienced an increase in applications over the past year as household income levels have decreased due to COVID-19 impacts as well as due to the extreme wildfire season in 2020.

Concurrent to pandemic-related rule and system changes, Oregon completed its 9-month-long transition to an integrated eligibility system in March 2021. This required robust staff engagement and training and included the implementation of an entirely new business and work model across the state. Despite staff learning curves and work disruptions, most new applications and renewals have continued to be processed within required timeframes. Eligibility teams are currently working through a backlog of unprocessed reported changes.

2. Coordinated care organization enrollment

Total CCO enrollment for July 2020 – June 2021 grew by 13.7%, across all plan levels (CCOA, CCOB, CCOE, CCOG). Specific Coordinated Care Organization membership growth ranged between 9.1% – 20.4%, with the exception of Trillium Community Health Plan in the Portland metro tri-county area which experienced exponential growth as it established itself in this new market. All CCOs saw April-June 2021 enrollment growth slowdown from the pace seen in the previous two to three quarters. Across the 16 Coordinated Care Organizations, there are 48 unique CCO-county combinations. To provide context for geographic variability in membership growth trends, please see the table below.

Member Growth Zone	Number of CCO-County areas
>20% growth	7
15-20% growth	13
10-15% growth	18
5-10% growth	6
0-5% growth	2
Negative growth	2

As noted in previous reports, on May 1, 2020, Oregon Health Authority waived the requirement to limit each Coordinated Care Organization's enrollment to the county limit(s) and grand total limit listed in its contract to mitigate enrollment challenges during the pandemic. This requirement was initially established for contract year 2020 and has since been extended through contract year 2021 (December 31, 2021). In the January-June 2021 time period, 4 CCO-County areas – representing 2 distinct CCOs – have required adjustments above their 2021 contract limits in order to sustain auto-enrollment algorithms.

Summary of Enrollment Capacity* across the 16 CCOs as of June 2021:

- 1 CCO has membership within 100-105% of contract limits
- 4 CCOs have membership within 90-99% of contract limits
- 4 CCOs have membership within 75-89% of contract limits
- 4 CCOs have membership within 50-74% of contract limits
- 3 CCOs have membership at <50% of contract limits

In addition to demand for Oregon Health Plan coverage, capacity levels are influenced by the membership capacity contract limits requested by each CCO. Approval of these requests are based on various factors, including community population, historical and expected future enrollment patterns, and network adequacy.

We have identified a group that were not getting captured on the SEDS reports, it is not a significant number but a systems request for correction was made in April. That system fix was approved 6/7 but will not be in production until after July so the numbers you have won't change until the next quarter. Despite those numbers, there are a number of things going on with CHIP and depending upon the period you look at in 2020. In the Pre-Covid period, the caseload had been growing before leveling off in January and February, 2020. After the start of COVID and the Public Health Emergency (PHE), Exits dropped off dramatically from 2,500 a month to 200 starting in April 2020. This was due to suspension of closures related to the PHE and is still ongoing, probably until next year. Then in the first few months after the PHE, around April and May, 2020 There was a large spike in transfers out of CHIP, almost entirely to Children's Medicaid. This was the period in which many people were laid off their jobs and saw large decreases in family income, so we saw a lot of people move to the lower

income eligibility category of Children's Medicaid. This caused the overall caseload for CHIP to decline for a few months.

After that burst of transfers, starting in July 2020 the CHIP caseload began growing sharply. This was due to the relatively normal amount of New Enters, but the very small number of Exits. If you look at the recent New Enters carefully you will notice two things, first there is a very distinctive seasonal pattern, where new enters grow around December and January every year. This is related to the open enrollment period on the federal marketplace, which brings a lot of new clients into the system through referrals from the federal marketplace website. Second, the trend in New Enters is downward overall since about April of last year. This is because, we have so many people already signed up, so the pool of potential clients has gotten a lot smaller. The newly eligible clients due to the COVID recession were mostly in April and May 2020, but since then we are seeing smaller numbers of new clients.

B. Benefits

The Pharmacy and Therapeutics (P&T) Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: short-acting and long-acting opioids; alglucosidase alfa; Neuromyelitis Optica Spectrum Disorder (NMOSD); Biologics for Rare Diseases; Antipsychotics in Young Children Safety Edit; Growth Hormone; Hereditary Angioedema; Oral Multiple Sclerosis agents; Verquvo (vericiguat); Entresto (sacubitril/valsartan); platelet Inhibitor**s;** Cystic Fibrosis; Oncology Agents; Platelet Inhibitors.

The committee also recommended changes to the preferred drug list (PDL): make alglucosidase alfa non-preferred; combine high-potency and low-medium potency statins into one class; make eculizumab non-preferred; make ravulizumab, satralizumab, and inebilizumab preferred; make rosuvastatin tablets preferred; make somapacitan-beco non-preferred; make ofatumumab and ponesimod non-preferred**;** rename the "ACEIs, ARBs and DRIs" PDL class to "Inhibitors of the Renin-Angiotensin-Aldosterone System (RAAS)" and include sacubitril/valsartan; make Nyvepria preferred and Neulasta non-preferred; make Entresto non-preferred; make prasugrel preferred.

Health Evidence Review Commission: Errata to the March 13, 2020 Prioritized List were posted 8/4/2020. The August 14, 2020 Prioritized List went into effect on 8/14/2020 and was reported in a Notification of Interim Changes. Errata to the August 14, 2020 List were published on 8/20/2020.

- Q2 10/1/2020 through 12/31/2020 quarter:

Health Evidence Review Commission: The October 1, 2020 Prioritized List went into effect on 10/1/2020 and was reported in a Notification of Interim Changes.

- Q3 1/1/2021 thru 3/31/2021 quarter:

Health Evidence Review Commission: The January 1, 2021 Prioritized List went into effect on 1/1/2021. The February 1, 2021 Prioritized List went into effect 2/1/2021. Both of these lists were reported in a Notification of Interim Changes. Errata to the February 1, 2021 list were published on 2/23/21.

- Q4 4/1/21 thru 6/30/21 quarter:

Health Evidence Review Commission: No changes in benefit coverage during this quarter.

C. Access to care (ANNUAL)

Federal and State regulations require each MCE to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. To support federal and State network adequacy requirements, the MCEs are contractually required to develop and submit DSN reports that consist of two components, an annual DSN Provider Narrative Report and quarterly DSN Provider Capacity Reports, that crosswalk to the network standards in the MCEs' contracts with the State, the 2021 OHP CCO Health Plan Services Contract and the 2021 DCO Health Plan Services Contract.

In 2020, OHA conducted a comprehensive review of the MCEs' DSN reports to evaluate provider capacity compliance in accordance with standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN.

As a component of the DSN Provider Narrative Reports, MCEs were additionally required to report provider time and distance data including minutes, miles, and percentage of overall member access for each geographic classification in each MCE's service area to determine compliance based on the following three OHA-defined time and distance standards:

- In urban areas, not exceeding 30 miles, 30 minutes.
- In rural areas, not exceeding 60 miles, 60 minutes.
- A minimum of 90 percent of members in each service area accessing care within the respective routine travel time or distance listed above.

To improve data quality, OHA conducted a one-time Targeted DSN Provider Capacity Report Review and provided feedback to each MCE to allow data corrections to be made prior to the October 1, 2020 DSN Provider Capacity Report submission. For the one-time and annual analyses, OHA's EQRO processed, cleaned, and evaluated the MCEs' DSN Provider Capacity Report data to evaluate the general capacity of each MCE's compliance with the required provider file layout (PFL) as outlined in the 2020 Quarterly CCO DSN Provider Capacity Report Instructions and 2020 Quarterly DCO DSN Provider Capacity Report Instructions.

Most CCOs incorporated the required response specifications outlined in the 2020 Annual CCO DSN Provider Narrative Instructions in their narrative responses. CCO responses and analysis improved from previous years and included more comprehensive descriptions demonstrating how each CCO ensured, monitored, and evaluated adequate provider capacity and member access to health care services. Answers included geographic location of network providers and members, considering distance, travel time, member needs, coordination of care, and performance metrics.

CY 2020 represented the first year DSN Provider Narrative Reports were required of the DCOs. The DCOs performed well in the Additional Analysis of the DCO's Provider Network to Meet Member Needs category but earned their lowest scores in the Description of Members category. The lower scores likely represented a need for TA in proper reporting rather than operational deficiencies.

Network Adequacy Results

CCO Results

Overall, the CCOs received an average score of approximately 88.1 percent of the maximum points possible (26.0 points) in the DSN Provider Narrative Report categories. Three of the CCOs met the requirements of all DSN Provider Narrative Report categories. While most CCOs met the *Coordination of Care* and *Performance on Metrics* categories, two CCOs struggled to meet the possible points across all narrative categories.

As part of the DSN Provider Narrative Report, each CCO was required to demonstrate time and distance compliance by reporting the time and distance standards of minutes, miles, and percentage of overall member access for each geographic classification in its service area distance. The CCOs received an average score of approximately 94.3 percent of the maximum points possible (14.0 points) in the DSN Provider Narrative Report—Time and Distance Standards category.

The DSN Provider Capacity Report provided an inventory of providers and facilities within the CCOs' provider networks. The CCO DSN Provider Capacity Report submissions illustrated improved quality, consistency, and accuracy with data elements, data field format/value, and data file layout validity and alignment with reporting specifications.

DCO Results

As 2020 was the first year DSN reporting was required of the DCOs, some of the lower scores likely represent a need for TA in proper reporting rather than operational failings.

Overall, the DCOs received an average score of approximately 77 percent of the maximum points possible (14.0 points) across aggregated DSN Provider Narrative Report categories. Two DCOs achieved a perfect score in at least one category, while all DCOs received at least a positive score in each categorical element. While all DCOs earned their lowest scores in the Description of Members category, all performed strongest in the Additional Analysis of the DCO's Provider Network to Meet Member Needs category. The DCOs achieved an average score of approximately 80 percent of the maximum points possible (5.0 points) across aggregated DSN Provider Narrative Report—Time and Distance Standards.

The DCO DSN Provider Capacity Report submissions illustrated many areas for improvement with regard to the quality, consistency, and accuracy of data field format/value and data file layout validity, and overall alignment with the reporting specifications.

Complete results for the Annual DSN Narrative Report Evaluation and the DSN Provider Capacity Report Evaluation can be found in the 2020 EQR Technical Report on the OHA Quality Assurance page.

Provider Directory Validation

To additionally support federal and State network adequacy requirements, OHA validated each of its coordinated care organizations' (CCOs') and dental care organizations' (DCOs') online provider directories to ensure Oregon Health Plan (OHP beneficiaries ("members") have appropriate access to provider information. The goal of the provider directory validation was to determine whether the information in the managed care

entities' (MCEs') online provider directories matched the data in provider capacity reports submitted to OHA as part of a quarterly delivery system network (DSN) evaluation. Key elements published in the online provider directories were compared with the data in the provider capacity reports to confirm each MCEs' website meets the federal requirements in 42 CFR §438.10(h), OAR 410-141-3585, and relevant State contractual requirements.

Coordinated Care Organizations

This section summarizes the PDV findings specific to the 15 CCOs listed in Table 1-1. As shown in Table 2-1 through Table 2-7, the CCOs' online directories varied by their ease of use. Of the 15 CCOs included in this PDV, six CCOs allowed their members to search for all provider types using a single online provider directory (e.g., AH members only need to search the AH online directory to find physical, mental, and oral health providers). In contract, nine CCOs contained delegate directories that were separately linked on the CCOs' websites, which may result in additional difficulty for members looking for a provider.

CCOs With Single Provider Directories

Table 2-1 presents the search fields available to find providers in the online directories for CCOs with one online provider directory per CCO. Each of the six CCOs' online directories listed allowed users to search by the provider's last name and the provider type or specialty. Most of the CCOs allowed users to search by first name, acceptance of new patients, and languages spoken. None of the CCOs allowed users to search providers with available interpreters or providers that offer telehealth appointments.

Table 2-1—Search Fields Available to Find Providers in Online Directory by CCO

Provider Information	AH	AllCare	CHA	EOCCO	TCHP	UHA
First Name	No	Yes	No	Yes	Yes	Yes
Last Name	Yes	Yes	Yes	Yes	Yes	Yes
Street Address	No	No	No	Yes	No	No
City	Yes	No	No	Yes	No	Yes
State	Yes	No	No	Yes	No	No
ZIP Code	Yes	Yes	No	Yes	No	No
Provider Type/Specialty	Yes	Yes	Yes	Yes	Yes	Yes
Group Affiliation	No	No	No	No	No	No
Accepting New Patients	Yes	Yes	Yes	Yes	No	Yes
Languages Spoken	Yes	Yes	Yes	Yes	No	Yes

Provider Information	AH	AllCare	CHA	EOCCO	TCHP	UHA
Completed Cultural Competency Training	No	No	Yes	No	No	No
Accommodates Physical Disabilities	No	Yes	Yes	No	No	No
Availability of Auxiliary Aids	No	Yes	Yes	No	No	No
Availability of Qualified or Certified Interpreters	No	No	No	No	No	No
Provider Offers Telehealth Appointments	No	No	No	No	No	No
Note 1: This table includes CCOs with a single directory for mental, physical, and oral health providers. Note 2: Blue shading indicates a "Yes" response, the associated search field is available in the CCO's online directory.						

CCOs With Delegate Provider Directories

Table 2-2 presents the search fields available to find providers in the online directories associated with CPCCO. CPCCO had one provider directory for physical and mental health providers and four delegate oral health provider directories, listed in Appendix A. The most common search fields available included the provider's first name, last name, city, state, ZIP code, provider type or specialty, the provider's acceptance of new patients, and languages spoken. None of the online directories associated with CPCCO allowed members to search by providers that offer telehealth appointments.

Table 2-2—Search Fields Available to Find Providers in Online Directories for CPCCO

Provider Information	CPCCO-Physical and Mental Health Provider Directory	CPCCO-Oral Health Provider Directories			
		ADS	CareOregon Dental	ODS	Willamette
First Name	Yes	Yes	Yes	Yes	No
Last Name	Yes	Yes	Yes	Yes	No
Street Address	No	No	No	Yes	No

Provider Information	CPCCO-Physical and Mental Health Provider Directory	CPCCO-Oral Health Provider Directories			
		ADS	CareOregon Dental	ODS	Willamette
City	Yes	No	Yes	Yes	Yes
State	Yes	No	Yes	Yes	Yes
ZIP Code	Yes	Yes	Yes	Yes	Yes
Provider Type/Specialty	Yes	No	Yes	Yes	Yes
Group Affiliation	No	No	Yes	No	No
Accepting New Patients	Yes	Yes	Yes	Yes	No
Languages Spoken	Yes	Yes	Yes	Yes	No
Completed Cultural Competency Training	No	Yes	No	No	No
Accommodates Physical Disabilities	No	Yes	No	No	No
Availability of Auxiliary Aids	No	Yes	No	No	No
Availability of Qualified or Certified Interpreters	No	Yes	No	No	No
Provider Offers Telehealth Appointments	No	No	No	No	No

Note 1: This table includes one CPCCO directory for physical and mental health providers and four delegate oral health provider directories.

Note 2: Blue shading indicates a "Yes" response, the associated search field is available in the CCO's online directory.

Table 2-3 presents the search fields available to find providers in the online directories associated with Health Share. Health Share allows users to search for mental health providers on the Health Share website; however,

Health Share has five delegate physical health provider directories and five delegate oral health provider directories. All provider directories associated with Health Share are listed in Appendix A. The most common search fields available include the provider's first name, last name, ZIP code, and provider type or specialty. Of the 11 directories associated with Health Share, only ADS allowed providers to be searched by the availability of qualified or certified interpreters.

Table 2-3—Search Fields Available to Find Providers in Online Directories for Health Share

Provider Information	Health Share - Mental Health Provider Directory	Health Share- Physical Health Provider Directories					Health Share- Oral Health Provider Directories				
		CareOregon	KP	Legacy Health	OHSU Health	Providence	ADS	CareOregon Dental	KP Dental	ODS	Willamette
First Name	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
Last Name	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Street Address	Yes	No	No	No	No	No	No	No	Yes	Yes	No
City	Yes	Yes	Yes	No	No	No	No	Yes	Yes	Yes	Yes
State	Yes	Yes	Yes	No	No	No	No	Yes	Yes	Yes	Yes
ZIP Code	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Provider Type/Specialty	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Group Affiliation	No	Yes	No	No	No	Yes	No	Yes	No	No	No
Accepting New Patients	No	Yes	No	No	No	Yes	Yes	Yes	No	Yes	No
Languages Spoken	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	No

Provider Information	Health Share - Mental Health Provider Directory	Health Share- Physical Health Provider Directories					Health Share- Oral Health Provider Directories				
		CareOregon	KP	Legacy Health	OHSU Health	Providence	ADS	CareOregon Dental	KP Dental	ODS	Willamette
Completed Cultural Competency Training	Yes	No	No	No	No	No	Yes	No	No	No	No
Accommodates Physical Disabilities	Yes	No	No	No	No	No	Yes	No	Yes	No	No
Availability of Auxiliary Aids	Yes	No	No	No	No	No	Yes	No	Yes	No	No
Availability of Qualified or Certified Interpreters	No	No	No	No	No	No	Yes	No	No	No	No
Provider Offers Telehealth Appointments	No	No	No	No	No	Yes	No	No	Yes	No	No

Note 1: This table includes one Health Share directory for mental health providers, five delegate physical health provider directories, and five delegate oral health provider directories.

Note 2: Blue shading indicates a "Yes" response, the associated search field is available in the CCO's online directory.

Table 2-4 presents the search fields available to find providers in the online directories associated with IHN. IHN had one provider directory for physical and mental health providers and four delegate oral health provider directories, listed in Appendix A. The most common search fields available included the provider's first name, last name, city, state, ZIP code, provider type or specialty, the provider's acceptance of new patients, and languages spoken. None of the online directories associated with IHN allowed members to search by providers that offer telehealth appointments.

Table 2-4—Search Fields Available to Find Providers in Online Directories for IHN

Provider Information	IHN-Physical and Mental Health Provider Directory	IHN-Oral Health Provider Directories			
		ADS	CareOregon Dental	ODS	Willamette
First Name	Yes	Yes	Yes	Yes	No
Last Name	Yes	Yes	Yes	Yes	No
Street Address	Yes	No	No	Yes	No
City	Yes	No	Yes	Yes	Yes
State	Yes	No	Yes	Yes	Yes
ZIP Code	Yes	Yes	Yes	Yes	Yes
Provider Type/Specialty	Yes	No	Yes	Yes	Yes
Group Affiliation	No	No	Yes	No	No
Accepting New Patients	Yes	Yes	Yes	Yes	No
Languages Spoken	Yes	Yes	Yes	Yes	No
Completed Cultural Competency Training	No	Yes	No	No	No
Accommodates Physical Disabilities	No	Yes	No	No	No
Availability of Auxiliary Aids	No	Yes	No	No	No
Availability of Qualified or Certified Interpreters	No	Yes	No	No	No
Provider Offers Telehealth Appointments	No	No	No	No	No

Provider Information	IHN-Physical and Mental Health Provider Directory	IHN-Oral Health Provider Directories			
		ADS	CareOregon Dental	ODS	Willamette
Note 1: This table includes one IHN directory for physical and mental health providers and four delegate oral health provider directories. Note 2: Blue shading indicates a "Yes" response, the associated search field is available in the CCO's online directory.					

Table 2-5 presents the search fields available to find providers in the online directories associated with JCC. JCC had one provider directory for physical and mental health providers and four delegate oral health provider directories, listed in Appendix A. The most common search fields available included the provider's first name, last name, city, ZIP code, and provider type or specialty. None of the online directories associated with JCC allowed members to search by providers that offer telehealth appointments.

Table 2-5—Search Fields Available to Find Providers in Online Directories for JCC

Provider Information	JCC-Physical and Mental Health Provider Directory	JCC-Oral Health Provider Directories			
		ADS	CareOregon Dental	ADS	Willamette
First Name	Yes	Yes	No	Yes	No
Last Name	Yes	Yes	Yes	Yes	No
Street Address	No	No	No	Yes	No
City	Yes	No	Yes	Yes	Yes
State	Yes	No	No	Yes	Yes
ZIP Code	Yes	Yes	Yes	Yes	Yes
Provider Type/Specialty	Yes	No	Yes	Yes	Yes
Group Affiliation	No	No	No	No	No
Accepting New Patients	Yes	Yes	No	Yes	No
Languages Spoken	Yes	Yes	No	Yes	No

Provider Information	JCC-Physical and Mental Health Provider Directory	JCC-Oral Health Provider Directories			
		ADS	CareOregon Dental	ADS	Willamette
Completed Cultural Competency Training	No	Yes	No	No	No
Accommodates Physical Disabilities	No	Yes	No	No	No
Availability of Auxiliary Aids	No	Yes	No	No	No
Availability of Qualified or Certified Interpreters	No	Yes	No	No	No
Provider Offers Telehealth Appointments	No	No	No	No	No

Note 1: This table includes one JCC directory for physical and mental health providers and four delegate oral health provider directories.

Note 2: Blue shading indicates a "Yes" response, the associated search field is available in the CCO's online directory.

Table 2-6 presents the search fields available to find providers in the online directories associated with PSCS CCOs. All four PSCS CCOs share one provider directory for physical and mental health providers. The PSCS CCOs have three delegate oral health provider directories: ADS, CDC, and ODS. The links to the PSCS-associated directories are included in Appendix A. The most common search fields available included the provider's last name, city, ZIP code, and provider type or specialty. Of the six directories associated with PSCS CCOs, only KP Dental allowed providers to be searched by the availability of telehealth appointments.

Table 2-6—Search Fields Available to Find Providers in Online Directories for PSCS-CO, PSCS-CG, PSCS-Lane, and PSCS-MP

Provider Information	PSCS-Physical and Mental Health Provider Directory	PSCS-Oral Health Provider Directories		
		ADS	CDC	ODS
First Name	Yes	Yes	No	Yes

Provider Information	PSCS-Physical and Mental Health Provider Directory	PSCS-Oral Health Provider Directories		
		ADS	CDC	ODS
Last Name	Yes	Yes	Yes	Yes
Street Address	Yes	No	No	Yes
City	Yes	No	Yes	Yes
State	Yes	No	No	Yes
ZIP Code	Yes	Yes	Yes	Yes
Provider Type/Specialty	Yes	No	Yes	Yes
Group Affiliation	Yes	No	No	No
Accepting New Patients	Yes	Yes	No	Yes
Languages Spoken	Yes	Yes	No	Yes
Completed Cultural Competency Training	Yes	Yes	No	No
Accommodates Physical Disabilities	No	Yes	No	No
Availability of Auxiliary Aids	No	Yes	No	No
Availability of Qualified or Certified Interpreters	No	Yes	No	No
Provider Offers Telehealth Appointments	No	No	No	No

Provider Information	PSCS-Physical and Mental Health Provider Directory	PSCS-Oral Health Provider Directories		
		ADS	CDC	ODS
Note 1: This table includes one PSCS directory for physical and mental health providers and a total of six delegate oral health provider directories. Note 2: Blue shading indicates a "Yes" response, the associated search field is available in the CCO's online directory.				

Table 2-7 presents the search fields available to find providers in the YCCO and CDC online provider directories. YCCO had one provider directory for physical and mental health providers and one delegate oral health provider directory (i.e., CDC), listed in Appendix A. The most common search fields available for both directories included the provider's last name, city, ZIP code, and provider type or specialty. YCCO and CDC directories did not allow users to search by the following fields: street address, completion of cultural competency, accommodation of physical disabilities, availability of auxiliary aids, availability of interpreters, or availability of telehealth appointments.

Table 2-7— Search Fields Available to Find Providers in Online Directories for YCCO - One Physical and Mental Health Provider Directory and One Oral Health Provider Directory

Provider Information	YCCO-Physical and Mental Health Provider Directory	YCCO-Oral Health Provider Directory: CDC
First Name	Yes	No
Last Name	Yes	Yes
Street Address	No	No
City	Yes	Yes
State	Yes	No
ZIP Code	Yes	Yes
Provider Type/Specialty	Yes	Yes
Group Affiliation	Yes	No
Accepting New Patients	Yes	No
Languages Spoken	Yes	No

Provider Information	YCCO-Physical and Mental Health Provider Directory	YCCO-Oral Health Provider Directory: CDC
Completed Cultural Competency Training	No	No
Accommodates Physical Disabilities	No	No
Availability of Auxiliary Aids	No	No
Availability of Qualified or Certified Interpreters	No	No
Provider Offers Telehealth Appointments	No	No
Note 1: This table includes one YCCO directory for physical and mental health providers and one delegate oral health provider directory (CDC). Note 2: Blue shading indicates a "Yes" response, the associated search field is available in the CCO's online directory.		

Percentage of Providers Found in the Online Directory

HSAG conducted 5,398 validations of the CCOs and found 49.2 percent of the sampled providers in the corresponding online provider directory.

Table 2-8 displays the number and percentage of providers found and not found in the online directories for each CCO. Approximately 44.7 percent of the providers were not found online. For an additional 6.1 percent of the providers, the provider could be found by name in the online directory but could not be found at the location in the sample data for the provider. Except for the four CCOs under PSCS, most CCOs had high percentages of providers not found in the directory.

Table 2-8—Percentage of Providers Found in the Online Directory by CCO

CCO	Number of Sampled Providers	Providers Found in Directory	Providers Not Found in Directory	Provider Locations Not Found in Directory
AH	235	44.3% (104)	53.6% (126)	2.1% (5)
AllCare	335	45.7% (153)	47.5% (159)	6.9% (23)
CHA	245	34.3% (84)	62.9% (154)	2.9% (7)
CPCCO	395	31.6% (125)	56.7% (224)	11.6% (46)

CCO	Number of Sampled Providers	Providers Found in Directory	Providers Not Found in Directory	Provider Locations Not Found in Directory
EOCCO	390	45.1% (176)	51.3% (200)	3.6% (14)
Health Share	400	24.5% (98)	65.0% (260)	10.5% (42)
IHN	390	50.5% (197)	44.4% (173)	5.1% (20)
JCC	395	31.4% (124)	56.2% (222)	12.4% (49)
PSCS-CG	395	72.2% (285)	20.5% (81)	7.3% (29)
PSCS-CO	395	79.0% (312)	15.7% (62)	5.3% (21)
PSCS-Lane	395	74.2% (293)	22.0% (87)	3.8% (15)
PSCS-MP	395	77.7% (307)	18.2% (72)	4.1% (16)
TCHP	380	30.8% (117)	64.2% (244)	5.0% (19)
UHA	270	48.1% (130)	47.8% (129)	4.1% (11)
YCCO	383	39.2% (150)	57.4% (220)	3.4% (13)
All CCOs	**5,398**	**49.2% (2,655)**	**44.7% (2,413)**	**6.1% (330)**
Note: Percentages in the table may not total 100% due to rounding.				

Table 2-9 presents the number and percentage of provider information available in the CCOs' online directories by provider category. Compared to physical health specialties, both MH and SUD providers were consistently not found in the online directory across most CCOs. Additionally, none of the MH and SUD providers were found in the online directory for four CCOs (CPCCO, EOCCO, JCC, and YCCO).

Table 2-9—Percentage of CCO Providers Found in the Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in Directory	Providers Not Found in Directory	Provider Locations Not Found in Directory
PCP	1,128	67.2% (758)	24.5% (276)	8.3% (94)
Specialty	1,126	56.0% (630)	35.1% (395)	9.0% (101)

Provider Category	Number of Sampled Providers	Providers Found in Directory	Providers Not Found in Directory	Provider Locations Not Found in Directory
MH	1,127	37.4% (422)	58.7% (661)	3.9% (44)
SUD	1,035	36.6% (379)	61.8% (640)	1.5% (16)
Oral Health	982	47.5% (466)	44.9% (441)	7.6% (75)
Note: Percentages in the table may not total 100% due to rounding.				

Table 2-10 and Table 2-11 present the percentage of exact matches between the submitted provider data and the online directory by CCO. HSAG compared 12 elements from the submitted provider data against the information retrieved from the online provider directory for the 2,655 providers initially found in the online provider directories. HSAG searched for an exact match between the submitted provider data and the data found in the online provider directory, except for provider specialty, which was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory.

In general, the provider information had a high match percentage between the submitted provider data and the online directories, except for whether the provider was accepting new patients. Twelve MCEs had less than 50 percent of providers with exact matches on whether the provider is accepting new patients. Additionally, CHA (60.7 percent) had a relatively low percentage match on the telephone number, and YCCO had a low percentage match on street address (64.7 percent) and suite number (67.3 percent).

The match percentage for non-English language speaking providers was calculated as a composite score using the number of languages in the DSN data and those found in the online directory divided by the total number of languages in the DSN data for a provider. For example, if a provider had three languages in the DSN data, but only one was found in the online directory, then the composite score was calculated as 0.33. At the CCO level, the denominator for Match Percentage and Mismatched Percentage for Non-English Language Speaking Provider constitutes the number of providers with at least one non-English language in the DSN data. Both AH and Health Share had less than 50 percent of providers with exact matches on non-English language.

Table 2-10—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory by CCO

Provider Information	All CCOs	AH	AllCare	CHA	CPCCO	EOCCO	Health Share	IHN	JCC
First Name	**99.2%**	98.1%	99.3%	95.2%	100.0%	98.3%	98.0%	100.0%	100.0%
Last Name	**99.5%**	96.2%	99.3%	98.8%	99.2%	98.9%	99.0%	100.0%	100.0%

Provider Information	All CCOs	AH	AllCare	CHA	CPCCO	EOCCO	Health Share	IHN	JCC
Street Address	**94.4%**	80.8%	99.3%	100.0%	99.2%	100.0%	95.9%	82.2%	99.2%
Suite Number	**93.3%**	70.2%	98.7%	92.9%	93.6%	98.3%	86.7%	83.2%	96.0%
City	**99.7%**	97.1%	100.0%	98.8%	100.0%	100.0%	100.0%	99.0%	100.0%
State	**100.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ZIP Code	**99.1%**	95.2%	98.0%	98.8%	100.0%	98.9%	99.0%	98.5%	100.0%
Telephone Number	**90.6%**	79.8%	98.0%	60.7%	92.0%	94.3%	81.6%	95.9%	91.1%
Accepting New Patients	**35.3%**	75.0%	69.9%	45.2%	39.2%	27.3%	32.7%	46.2%	21.0%
Provider Specialty**	**98.8%**	99.0%	99.3%	97.6%	99.2%	96.6%	92.9%	99.5%	98.4%
Group Affiliation	**79.6%**	79.8%	81.0%	51.2%	92.0%	58.0%	69.4%	90.9%	79.0%
Non-English Language Speaking Provider*	**83.9%**	28.6%	50.0%	50.0%	100.0%	66.7%	13.6%	100.0%	100.0%

*The denominator for Match Percentage and Mismatched Percentage for Non-English Language Speaking Provider constitutes the number of providers with at least one non-English language in the DSN data.

**For reporting purposes, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory.

Table 2-11—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory by CCO (continued from Table 2-10)

Provider Information	All CCOs	PSCS-CO	PSCS-CG	PSCS-Lane	PSCS-MP	TCHP	UHA	YCCO
First Name	**99.2%**	99.4%	99.3%	99.7%	100.0%	100.0%	97.7%	100.0%
Last Name	**99.5%**	100.0%	100.0%	100.0%	99.7%	100.0%	99.2%	100.0%
Street Address	**94.4%**	98.7%	97.9%	98.3%	99.3%	100.0%	87.7%	64.7%
Suite Number	**93.3%**	99.4%	99.3%	99.0%	99.3%	94.0%	90.8%	67.3%
City	**99.7%**	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%
State	**100.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ZIP Code	**99.1%**	99.7%	100.0%	100.0%	99.7%	100.0%	94.6%	100.0%
Telephone Number	**90.6%**	95.8%	95.4%	92.8%	94.8%	59.8%	81.5%	99.3%
Accepting New Patients	**35.3%**	30.8%	42.8%	21.2%	24.8%	54.7%	30.0%	6.7%
Provider Specialty**	**98.8%**	100.0%	100.0%	99.0%	100.0%	99.1%	96.9%	98.7%
Group Affiliation	**79.6%**	95.5%	93.7%	89.1%	92.8%	66.7%	35.4%	44.7%
Non-English Language Speaking Provider*	**83.9%**	100.0%	100.0%	87.9%	100.0%	83.3%	72.7%	100.0%

*The denominator for Match Percentage and Mismatched Percentage for Non-English Language Speaking Provider constitutes the number of providers with at least one non-English language in the DSN data.

**For reporting purposes, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory.

Table 2-12 reflects the number of providers found online who had a non-English language in the DSN data and the percentage of providers with an exact match in the online directory. The count of providers varied across the different CCOs as displayed in the Total column, with the percentage of providers found online who had a non-English language in the DSN data ranging from 1.7 percent (EOCCO) to 14.4 percent (CPCCO). See Appendix B. for the detailed results for each CCO.

Table 2-12—Percentage of CCO Provider Records which had a Language Match in Online Directory

MCE	Total	Percentage Exact Match for Language 1	Percentage Exact Match for Language 2	Percentage Exact Match for Language 3	Providers with Additional Languages in the Online Directory
AH	104	28.6% (14)	0.0% (3)	0.0% (0)	9
AllCare	153	50.0% (8)	0.0% (1)	0.0% (1)	7
CHA	84	50.0% (8)	0.0% (1)	0.0% (0)	7
CPCCO	125	100.0% (18)	100.0% (2)	0.0% (0)	5
EOCCO	176	66.7% (3)	0.0% (0)	0.0% (0)	7
Health Share	98	10.0% (10)	50.0% (2)	0.0% (1)	16
IHN	197	100.0% (11)	100.0% (3)	100.0% (1)	9
JCC	124	100.0% (16)	100.0% (4)	0.0% (0)	8
PSCS-CG	285	100.0% (28)	100.0% (2)	100.0% (1)	14
PSCS-CO	312	100.0% (19)	100.0% (4)	100.0% (1)	5
PSCS-Lane	293	90.9% (22)	0.0% (2)	0.0% (2)	6
PSCS-MP	307	100.0% (29)	100.0% (2)	0.0% (0)	9
TCHP	117	83.3% (6)	0.0% (1)	0.0% (0)	15
UHA	130	72.7% (11)	100.0% (3)	100.0% (1)	3
YCCO	150	100.0% (15)	100.0% (1)	100.0% (1)	0

Table 2-13 and Table 2-14 present the percentage of provider service information available in the online directories by CCO. HSAG determined which information and service elements were present in the online provider directories for the 2,655 providers. All the providers found online had information available on provider specialty across all CCOs, and most providers had information on primary language (89.2 percent). The least commonly available service information categories were provider URL (22.0 percent), providers offering telehealth and in-person appointments (39.0 percent), and availability of auxiliary aids (10.7 percent). None of the providers in AH, AllCare, CHA, CPCCO, and EOCCO had information on whether they offer both telehealth and in-person appointments in the online directory. As shown in Table 2-14, all four CCOs under PSCS had high percentages of provider service information available across the different service elements except for provider URL and availability of auxiliary aids.

Table 2-13—Percentage of Provider Service Information Available in Online Directory by CCO

Provider Information	All CCOs	AH	AllCare	CHA	CPCCO	EOCCO	Health Share	IHN	JCC
Provider URL	**22.0%**	100.0%	57.5%	65.5%	12.8%	9.7%	11.2%	8.1%	14.5%
Provider Primary Language	**89.2%**	100.0%	100.0%	79.8%	100.0%	68.8%	99.0%	19.3%	96.0%
Provider Accommodates Physical Disabilities	**75.7%**	100.0%	77.1%	3.6%	24.8%	15.9%	21.4%	96.4%	32.3%
Provider Completed Cultural Competency Training	**44.3%**	13.5%	0.7%	3.6%	29.6%	14.2%	4.1%	1.5%	8.9%
Availability of Auxiliary Aids	**10.7%**	0.0%	0.0%	0.0%	17.6%	14.8%	11.2%	15.7%	13.7%

Provider Information	All CCOs	AH	AllCare	CHA	CPCCO	EOCCO	Health Share	IHN	JCC
Availability of Qualified or Certified Interpreters	**46.8%**	13.5%	8.5%	0.0%	11.2%	15.9%	23.5%	15.7%	12.9%
Provider Offers Both Telehealth and In-Person Appointments	**39.0%**	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%	3.0%	12.1%
Capture of Detailed Provider Specialty	**100.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 2-14—Percentage of Provider Service Information Available in Online Directory by CCO (continued from Table 2-13)

Provider Information	All CCOs	PSCS-CO	PSCS-CG	PSCS-Lane	PSCS-MP	TCHP	UHA	YCCO
Provider URL	**22.0%**	5.8%	11.6%	9.2%	5.5%	6.0%	100.0%	18.7%
Provider Primary Language	**89.2%**	98.7%	98.9%	97.3%	99.3%	87.2%	100.0%	88.0%
Provider Accommodates Physical Disabilities	**75.7%**	98.7%	98.9%	99.3%	99.3%	11.1%	99.2%	98.0%

Provider Information	All CCOs	PSCS-CO	PSCS-CG	PSCS-Lane	PSCS-MP	TCHP	UHA	YCCO
Provider Completed Cultural Competency Training	**44.3%**	76.0%	74.0%	78.2%	77.9%	14.5%	98.5%	11.3%
Availability of Auxiliary Aids	**10.7%**	9.9%	13.7%	15.7%	7.5%	0.0%	0.0%	26.0%
Availability of Qualified or Certified Interpreters	**46.8%**	87.8%	87.4%	88.1%	88.6%	8.5%	1.5%	26.0%
Provider Offers Both Telehealth and In-Person Appointments	**39.0%**	81.4%	80.4%	84.0%	78.8%	0.9%	0.8%	23.3%
Capture of Detailed Provider Specialty	**100.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Dental Care Organizations

This section summarizes the PDV findings specific to the five DCOs listed in Table 1-1. Table 2-15 presents the search fields available for members to find providers in the online directories by DCO. The most common search fields available included the provider's last name, city, and ZIP code. None of the DCOs' online directories allowed members to search by providers that offer telehealth appointments. Each DCO was associated with a single online directory which are listed in Appendix A.

Table 2-15—Search Fields Available to Find Providers in Online Directory by DCO

Provider Information	ADS	CDC	FDCi	MDCO	ODS
First Name	Yes	No	No	No	Yes
Last Name	Yes	Yes	No	Yes	Yes
Street Address	No	No	No	No	Yes
City	No	Yes	Yes	Yes	Yes
State	No	No	No	No	Yes
ZIP Code	Yes	Yes	No	Yes	Yes
Provider Type/Specialty	No	Yes	No	Yes	Yes
Group Affiliation	No	No	No	No	No
Accepting New Patients	Yes	No	No	No	Yes
Languages Spoken	Yes	No	No	No	Yes
Completed Cultural Competency Training	Yes	No	No	No	No
Accommodates Physical Disabilities	Yes	No	Yes	No	No
Availability of Auxiliary Aids	Yes	No	No	No	No
Availability of Qualified or Certified Interpreters	Yes	No	No	No	No
Provider Offers Telehealth Appointments	No	No	No	No	No
Note: Blue shading indicates a "Yes" response, the associated search field is available in the DCO's online directory.					

Table 2-16 presents the number and percentage of providers found and not found in the online directories by DCO. HSAG conducted 752 validations for the DCOs and found 53.1 percent of sampled providers in the corresponding online provider directory. Approximately 44.4 percent of the providers were not found online. For an additional 2.5 percent of the providers, the provider could be found by name in the online directory, but not found in the sampled location for the provider. The majority of the MDCO providers (81.0 percent) were not found online.

Table 2-16—Percentage of Providers Found in the Online Directory by DCO

DCO	Number of Sampled Providers	Providers Found in Directory	Providers Not Found in Directory	Provider Locations Not Found in Directory
ADS	214	67.8% (145)	32.2% (69)	0.0% (0)
CDC	146	64.4% (94)	34.9% (51)	0.7% (1)
FDCi	57	59.6% (34)	36.8% (21)	3.5% (2)
MDCO	63	19.0% (12)	81.0% (51)	0.0% (0)
ODS	272	41.9% (114)	52.2% (142)	5.9% (16)
All DCOs	**752**	**53.1% (399)**	**44.4% (334)**	**2.5% (19)**

Note: Percentages in the table may not total 100% due to rounding.

Table 2-17 presents the number and percentage of provider information available in the DCOs' online directories by provider category. The percentage of providers not found online was high for both primary care dentists and specialty dental providers. The percentage of primary care dentists found online ranged from 21.3 percent for MDCO to 85.0 percent for ADS. The percentage of specialty dental providers found online ranged from 12.5 percent for MDCO to 62.0 percent for ODS. See Appendix C. for detailed DCO-specific results.

Table 2-17—Percentage of DCO Providers Found in the Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in Directory	Providers Not Found in Directory	Provider Locations Not Found in Directory
Primary Care Dentists	436	54.1% (236)	43.6% (190)	2.3% (10)
Specialty Dental Providers	316	51.6% (163)	45.6% (144)	2.8% (9)

Note: Percentages in the table may not total 100% due to rounding.

Table 2-18 presents the percentage of exact matches between the submitted provider data and the online directory by DCO. HSAG compared 12 demographic elements from the submitted provider data against the information retrieved from the online provider directory for the 399 providers initially found in the online provider directories. HSAG searched for an exact match between the data submitted and the data found in the

online provider directory, except for the provider specialty, which was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory.

In general, the provider information had a high match percentage between the submitted provider data and the online directories. However, ADS (37.9 percent) reported a low match percentage for providers accepting new patients, while both CDC (26.6 percent) and ODS (34.2 percent) reported low match percentages for group affiliation.

The match percentage for non-English language speaking providers was calculated as a composite score using the number of languages in the DSN data and found in the online directory divided by the total number of languages in the DSN data for a provider. For example, if a provider had three languages in the DSN data, but only one was found in the online directory, then the composite score was calculated as 0.33. At the DCO-level, the denominator for matched percentage and mismatched percentage for non-English language speaking provider constitutes the number of providers with at least one non-English language in the DSN data. None of the providers who were found online for FDCi included non-English language in the DSN data.

Table 2-18—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory by DCO

Provider Information	All DCOs	ADS	CDC	FDCi	MDCO	ODS
First Name	**99.5%**	99.3%	100.0%	97.1%	100.0%	100.0%
Last Name	**99.7%**	100.0%	100.0%	97.1%	100.0%	100.0%
Street Address	**96.0%**	100.0%	95.7%	67.6%	100.0%	99.1%
Suite Number	**99.5%**	100.0%	98.9%	97.1%	100.0%	100.0%
City	**99.5%**	100.0%	98.9%	100.0%	100.0%	99.1%
State	**100.0%**	100.0%	100.0%	100.0%	100.0%	100.0%
ZIP Code	**99.0%**	100.0%	98.9%	91.2%	100.0%	100.0%
Telephone Number	**97.2%**	98.6%	98.9%	88.2%	100.0%	96.5%
Accepting New Patients	**67.9%**	37.9%	73.4%	73.5%	100.0%	96.5%
Provider Specialty**	**99.2%**	99.3%	98.9%	100.0%	100.0%	99.1%

Provider Information	All DCOs	ADS	CDC	FDCi	MDCO	ODS
Group Affiliation	**54.6%**	80.7%	26.6%	73.5%	100.0%	34.2%
Non-English Language Speaking Provider*	**98.9%**	100.0%	97.8%	NR	100.0%	100.0%

*The denominator for Match Percentage and Mismatched Percentage for Non-English Language Speaking Provider constitutes the number of providers with at least one non-English language in the DSN data.
**For reporting purposes, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory.
Note: NR indicates the data provided by the MCE did not include any non-English language providers in the DSN data

Table 2-19 reflects the number of providers found online who had non-English language in the DSN data and the percentage of providers with an exact match in the online directory. The count of providers varied across the different DCOs as displayed in the Total column with the percentage of providers found online who had a non-English language in the DSN data ranging from 0.0 percent (MDCO) to 47.9 percent (CDC). See Appendix C. for additional details by DCO.

Table 2-19—Percentage of Provider Records Which Had a Language Match in Online Directory - DCO

MCE	Total	Percentage Exact Match for Language 1	Percentage Exact Match for Language 2	Percentage Exact Match for Language 3	Providers with Additional Languages in the Online Directory
ADS	145	100.0% (14)	0.0% (0)	0.0% (0)	47
CDC	94	97.8% (45)	100.0% (7)	100.0% (5)	2
FDCi	34	0.0% (0)	0.0% (0)	0.0% (0)	19
MDCO	12	100.0% (5)	0.0% (0)	0.0% (0)	1
ODS	114	100.0% (26)	100.0% (6)	100.0% (3)	3

Table 2-20 presents the percentage of provider service information available in the online directories by DCO. HSAG determined which information and service elements were present in the online provider directories for

the 399 providers initially found in the directories. All the providers found online had information on provider specialty across all DCOs. Most providers had information on primary language (92.5 percent) and accommodating physical disabilities (87.0 percent). Providers offering telehealth and in-person appointments (19.8 percent) and completed cultural competency training (9.3 percent) were the least commonly available service information, except for CDC, where none of the providers in the other DCOs had service information on offering both telehealth and in-person appointments.

Table 2-20—Percentage of Provider Service Information Available in Online Directory by DCO

Provider Information	All DCOs	ADS	CDC	FDCi	MDCO	ODS
Provider URL	**54.6%**	68.3%	56.4%	73.5%	66.7%	28.9%
Provider Primary Language	**92.5%**	95.9%	83.0%	100.0%	50.0%	98.2%
Provider Accommodates Physical Disabilities	**87.0%**	94.5%	100.0%	100.0%	100.0%	61.4%
Provider Completed Cultural Competency Training	**9.3%**	0.0%	20.2%	32.4%	8.3%	5.3%
Availability of Auxiliary Aids	**37.1%**	9.0%	100.0%	70.6%	100.0%	4.4%
Availability of Qualified or Certified Interpreters	**39.8%**	9.7%	100.0%	100.0%	100.0%	4.4%
Provider Offers Both Telehealth and In-Person Appointments	**19.8%**	0.0%	83.0%	2.9%	0.0%	0.0%
Capture of Detailed Provider Specialty	**100.0%**	100.0%	100.0%	100.0%	100.0%	100.0%

Provider Directory Validation Conclusions

The results of the provider directory validation showed substantial variation in the percentage of providers found online across the different CCOs and DCOs and by provider category. Moreover, less than 50 percent of the sampled providers could be found online for 10 CCOs and two DCOs. Among CCOs, the low percentages of providers found online were primarily driven by SUD providers and MH providers. Overall, only 36.6 percent of the sampled SUD providers and 37.4 percent of the sampled mental health providers were found online. Several CCOs also had low percentages for sampled oral health providers found online. Additionally, the PDV revealed the use of multiple delegate directories that were separately linked on the CCOs' websites, which results in additional complexity for members attempting to find a provider. Among the DCOs, the percentage of providers not found online was spread across both primary care dentists and specialty dental providers.

The matched percentage of provider information between the submitted provider data and online directory was generally high across most indicators except for accepting new patients and group affiliation. Although the matched percentage was usually high for non-English language among the sampled providers who had submitted provider data on non-English language, only 8.2 percent of the CCO providers and 22.6 percent of the DCO providers in the submitted provider data had at least one non-English language. Further, the number of providers with additional languages in the online directories indicated that the non-English language information in the DSN data could be improved.

Availability of provider service information in the online directories varied by indicator, across all CCOs and DCOs. Most CCOs and DCOs had high percentages of providers with information on detailed specialty and provider primary language and had low percentages of providers with service information on providers offering both telehealth and in-person appointments. Additionally, several CCOs had a low percentage of providers with information on the availability of auxiliary aids and provider URL, while several DCOs had low percentages of providers with information on cultural competency training. Effective January 1, 2021, after the review period included in this report, OHA began requiring MCEs to indicate telehealth and in-person appointment availability for all online provider directories. As a result of the Coronavirus Disease 2019 (COVID-19) pandemic, effective September 10, 2020, OHA enacted a temporary MCE telehealth rule that required MCEs to ensure all telemedicine services met all language access requirements, including interpreters and translations services.

Statewide Workforce Development

In February 2021, OHA's Equity and Inclusion Division (OEI) and the Transformation Center began convening a statewide THW learning collaborative to engage CCOs, health system providers, CCOs' THW liaisons, THW workforce, private payers, community-based organizations, culturally specific organizations and key stakeholders in peer-to-peer learning and networking opportunities to work on strategies to better integrate and utilize THWs, with the goal of addressing social determinants of health.

During the reporting period, OHA focused on enhancing integration and utilization of Traditional Health Workers to ensure delivery of high quality, and culturally and linguistically appropriate care to improve health outcomes. OEI focused on implementing the recommendations from the THW Commission including requiring CCOs to:

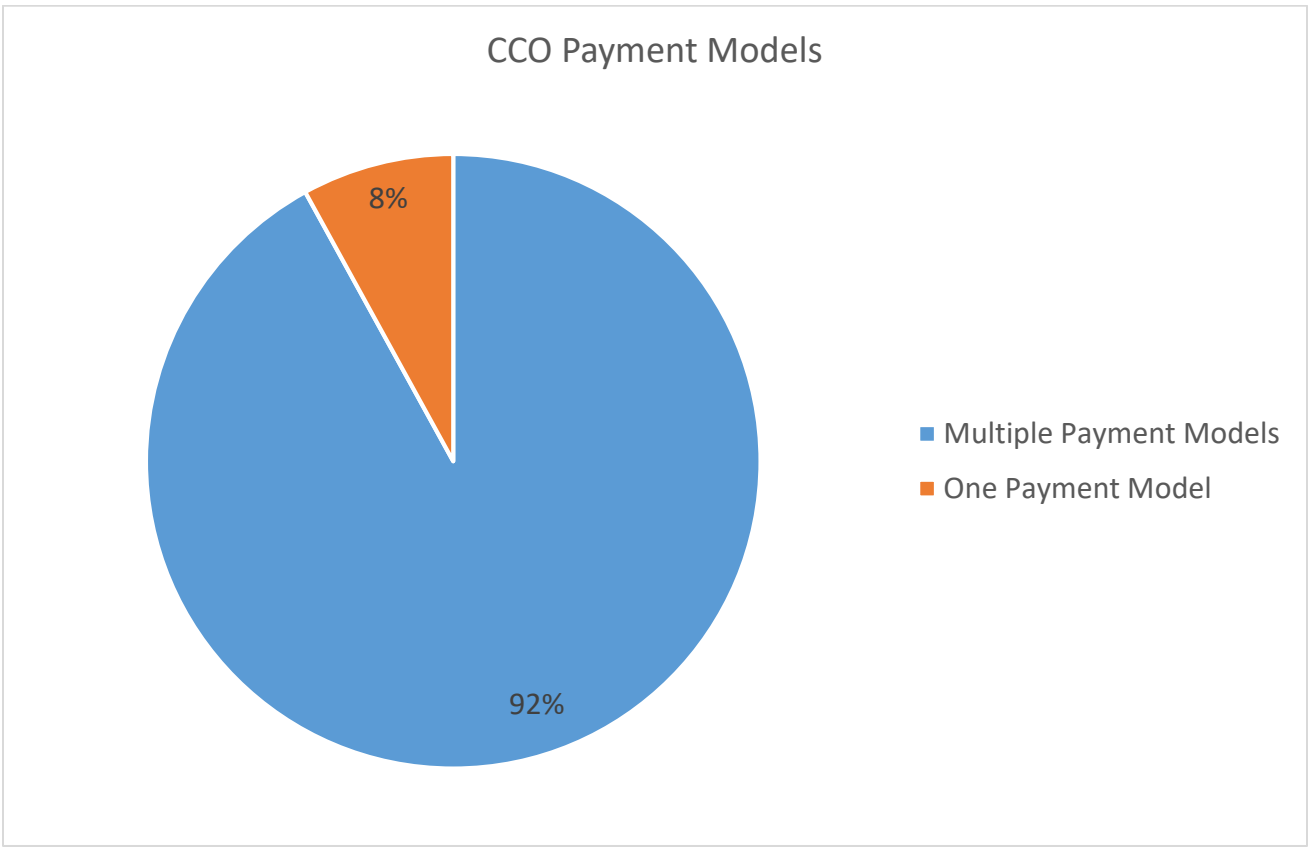
- Create a plan for integration and utilization of THWs.

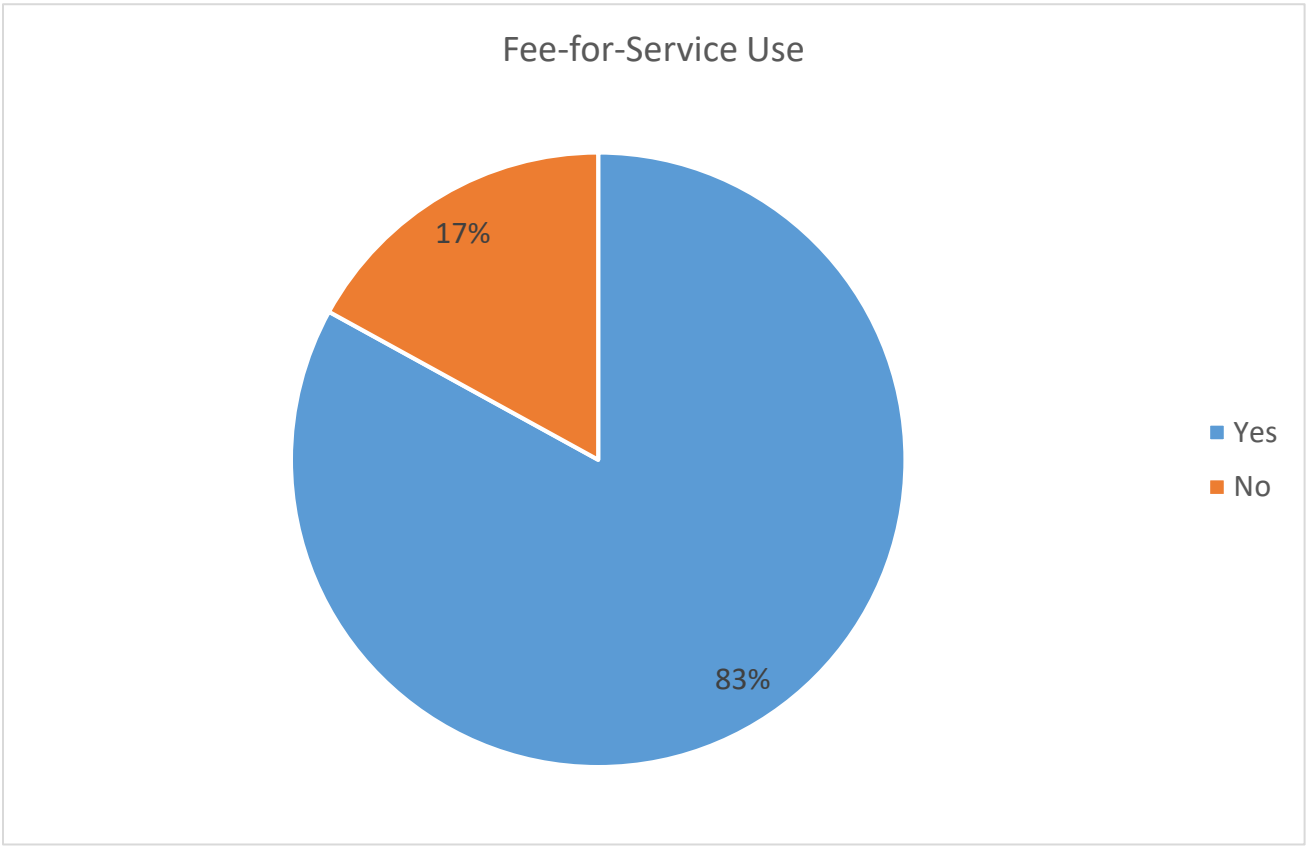
- Incorporate alternative payment methods to establish sustainable payment rates for THW services.
- Integrate best practices for THW services in consultation with THW commission.
- Designate a CCO liaison as a central contact for THWs.
- Identify and include THW affiliated with organizations listed under ORS 414.627 in the development of the Community Health Needs Assessment and Community Health Improvement Plan.

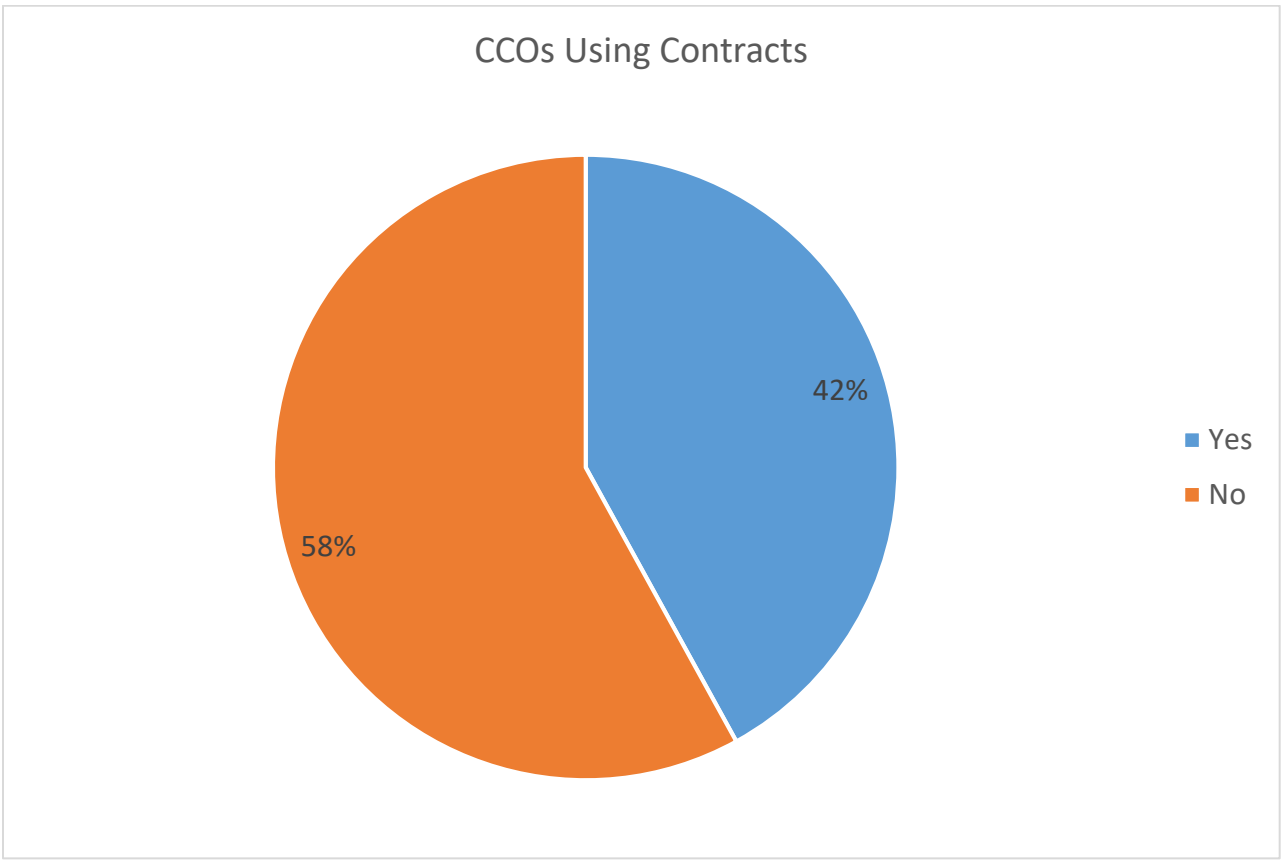
CCO contract language was revised to achieve the following:

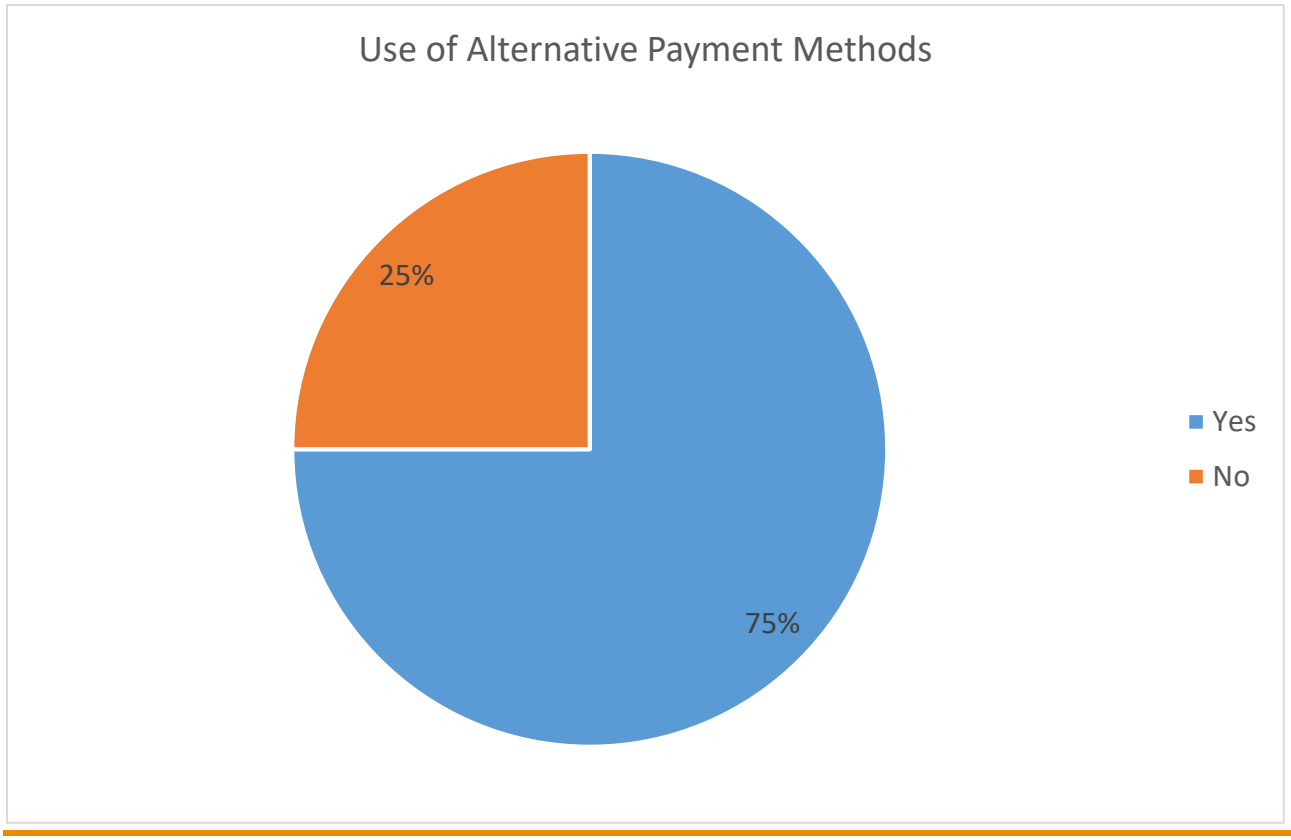
- Increase the THW workforce by creating a livable and equitable payment system.
- Show a positive return on investment by increasing access to preventative, high-quality care beyond the clinical setting thus improving health outcomes.
- Increase access to culturally and linguistically diverse providers beyond the clinical setting.

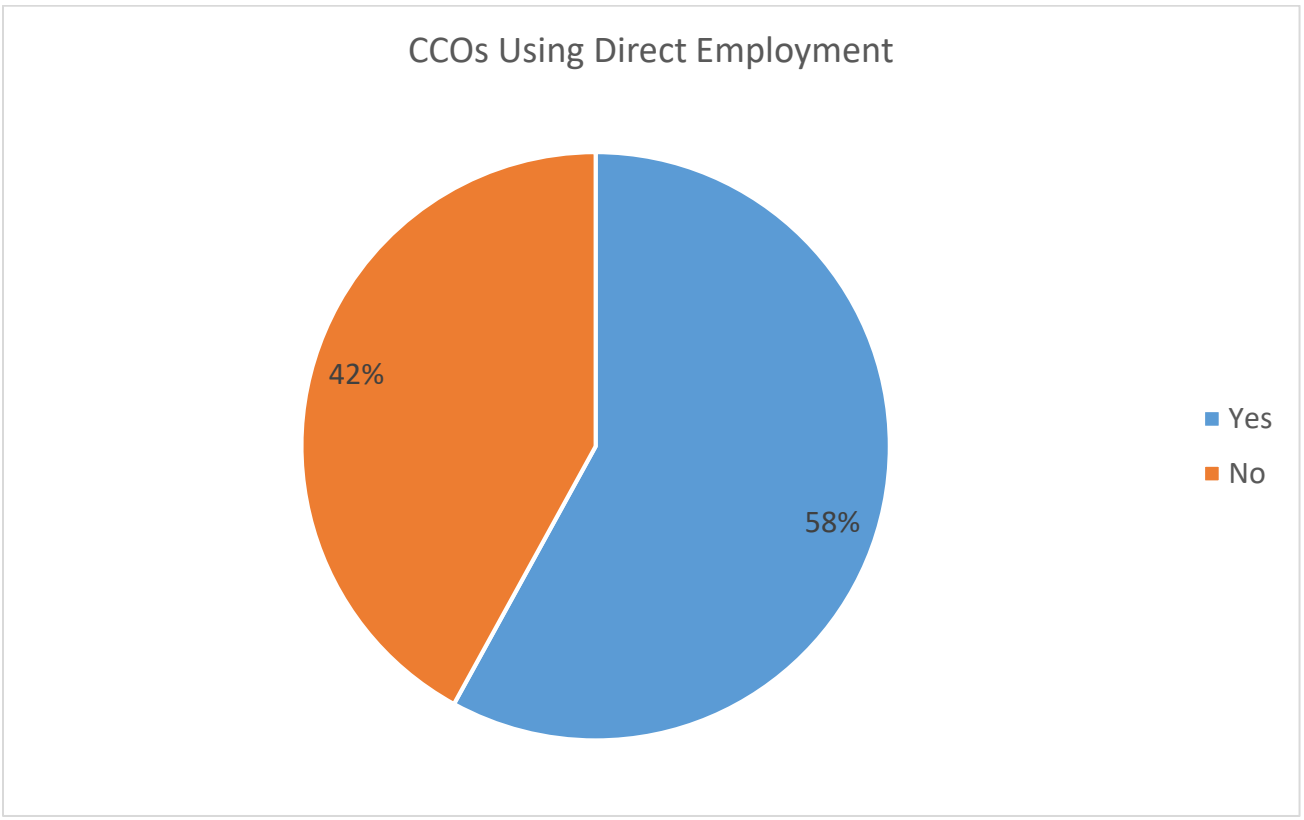
Through CCO deliverable reporting completed in early 2021, CCOs reported to OHA the use of the following payment models. See Figures below.


CCO Payment Models
8%
92%
Multiple Payment Models
One Payment Model


Fee-for-Service Use
17%
83%
Yes
No


CCOs Using Contracts
42%
58%
Yes
No


Use of Alternative Payment Methods
25%
75%
Yes
No


CCOs Using Direct Employment
42%
58%
Yes
No

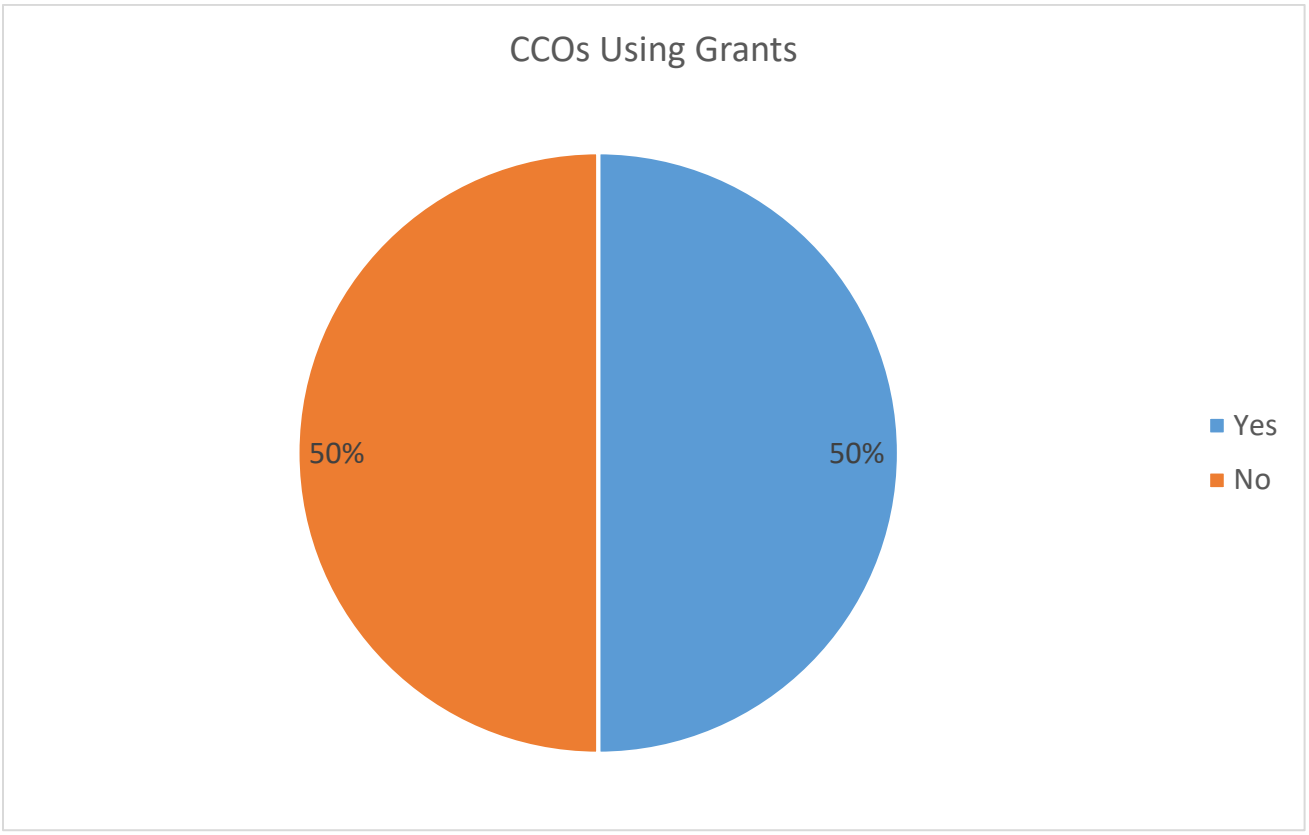

CCOs Using Grants
50%
50%
Yes
No

Table 1 below captures the progress made towards increasing the number of certified Traditional Health Workers across various regions in Oregon.

Table 1: Certified traditional health workers (THWs) (annual reporting)

Active State Certified THWs on State Registry as of 9/28/2021	Greater Portland	Columbia Gorge	Willamette Valley	Oregon Coast	Central Oregon	Southern Oregon	Eastern Oregon
Community Health Workers (CHW)	153	96	75	70	63	68	74
Personal Health Navigators (PSN)	15	7	7	6	6	6	6
Peer Wellness Specialists (PWS)	185	38	54	43	36	37	37
Peer Support Specialists (PSS)	503	201	285	214	189	191	190
Birth Doulas	42	9	28	13	8	9	8
Total	**898**	**351**	**449**	**346**	**302**	**310**	**315**

Table 2: THW programs that are active or in development (annual reporting)

From 7/1/20 - 6/30/21, 804 new and recertified THWs have been added. At the time of the annual report submission, OHA is unable to provide a breakdown of this information as suggested in Table 2, but can provide the information at a later date.

Region	Active programs				In Development
	CHW	Peer Support	Peer Wellness	Other	
Greater Portland					

Columbia Gorge					
Willamette Valley					
Oregon Coast					
Central Oregon					
Southern Oregon					
Eastern Oregon					
Total					

COVID-19 Impact

During COVID-19, OEI's Traditional Health Worker Program has never stopped serving the public and the communities by continuing the certification of the workforce and maintain a steady supply of this workforce who have been critical in the fight against this deadly disease with testing, contact tracing and vaccination. In 2020, OEI received a total of 753 applications out of which 716 THWs were certified and placed on the registry.

OEI/THW Program quickly made changes to the certification process to reduce the burden on individuals and yet retaining the program integrity.

- Temporary allowance for training programs to provide trainings online
- Postponement of fingerprint requirement in person
- Reopening of Doula and update the program and certification requirement
- Approval of 5 new training for THW

OEI/THW Program also worked with the Public Health Division and provided important webinar/training on COVID-19.

As the co-lead with Tribal Affairs, the THW Program developed the Tribal Traditional Health Worker Legislative Concept for 2021 Legislative Session, adding a category of worker type to the current THWs workforce.

D. Quality of care (ANNUAL)

Quality Strategy

Federal regulations under 42 CFR §438.340 require each state Medicaid agency contracting with MCOs to develop and implement a written quality strategy to assess and improve the quality of managed care services. OHA's current quality strategy was included as part of Oregon's 1115 Medicaid Demonstration Waiver and approved by CMS in June 2018. The quality strategy provides a framework to accomplish OHA's mission to improve the lifelong health of Oregonians, increase the quality, reliability, and availability of care for all

Oregonians, and lower or contain cost of care so it is affordable to everyone. This framework for quality includes the following eight focus areas:

- Reduce preventable re-hospitalizations
- Address population health issues (i.e., diabetes, hypertension, and asthma) within a specific geographic area
- Deploy care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers
- Integration of health: physical health, oral health, and/or behavioral health
- Ensure appropriate care is delivered in appropriate settings
- Improve perinatal and maternity care
- Improve primary care for all populations through increased adoption of the patient-centered primary care home (PCPCH) model of care
- SDOH

CCOs are required to submit their own Transformation and Quality Strategy (TQS) incorporating all components of the Quality Assessment and Performance Improvement (QAPI) program to ensure a robust quality program that supports the strategic goals of OHA. The TQS goals are to support the safe and high-quality care for all members under CCOs by ensuring the quality and transformation plan adequately covers federal requirements, pushes health transformation forward, and continues the path towards the triple aim (better care, better health, lower cost). These strategies, ongoing accountability and compliance reviews, and PIP activities are assessed and monitored by OHA for continuous improvement and incorporated in quality strategy updates.

Quality and Access Assessment

OHA works closely with its MCEs, partners, and stakeholders on improving quality of care for OHP members. This is primarily done through the engagement of internal and external committees to support quality and access monitoring, the requirement for MCEs to annually maintain a TQS to ensure robust and streamlined quality programs, and statewide and MCE-specific PIPs and focus studies.

The OHA contract requires each CCO to conduct three PIPs and one focus study designed to improve care in at least four of the eight QI focus areas noted above. The CCOs all participated in Oregon's statewide PIP on opioid safety and continue to implement their interventions for 46 CCO PIPs and focus study projects ranging from one PIP addressing OHA's focus area on reducing preventable re-hospitalizations, to 15 PIPs addressing the focus area on ensuring appropriate care is delivered in appropriate settings. Validation results for the statewide PIP demonstrated that the CCOs used methodologically sound and effective strategies for improving the safety of opioid prescribing and that there was a statistically significant statewide improvement (decrease) in the rate of high-dose opioid prescriptions from baseline to the final remeasurement. The CCO PIPs and focus study projects include reducing ED utilization, ensuring oral health during pregnancy, screening for specific conditions (e.g., colorectal cancer, Hepatitis C, and SDOH), tobacco cessation, and contraceptive care.

For the March 2020 TQS submissions, OHA received a total of 156 TQS projects. The average score for CCOs was 28.84 (42 being the highest possible score). Individual CCO scores for 2020 TQS submissions are noted below.

CCO Name	Total score

Advanced Health	27.5
AllCare	33.2
Cascade Health Alliance	22.5
Columbia Pacific CCO	22.4
Eastern Oregon CCO	28.5
Health Share of Oregon	32
InterCommunity Health Network	31
Jackson Care Connect	32
PacificSource Community Solutions—Central Oregon	31.5
PacificSource Community Solutions—Columbia Gorge	31.5
PacificSource Community Solutions—Lane	32
PacificSource Community Solutions—Marion Polk	32
Trillium Community Health Plan	23
Umpqua Health Alliance	25.5
Yamhill CCO	22

Overall, the CCOs showed strong potential for improving member care and outcomes; addressing critical and exciting areas of transformation; improved use of SMART goals; and demonstrated increased partnerships across the delivery system. The CCOs submitted projects across the following component areas. As noted below, the CCOs have continued room for improvement across several areas.

Component	Average score*
Access: Cultural Considerations	1.75
Access: Quality and Adequacy	1.75
Access: Timely	1.80
Behavioral Health Integration	2.33
CLAS Standards	2.23
Grievances and Appeals	2.27
Health Equity: Cultural Responsiveness	2.03
Health Equity: Data	2.37
Oral Health Integration	1.90
PCPCH	2.23
Serious and Persistent Mental Illness	2.71
SDOH-E	1.69
Special Health Care Needs	1.85
Utilization Review	2.10

OHA has provided individual CCOs with written evaluations of the 2020 project submissions and recommendations for improvement for their 2021 TQS submissions. OHA will continue to work closely with CCOs to improve their 2021 submissions and improve overall scores.

All of the CCOs coordinate care at some level and most of them have dedicated care managers that work with members identified as needing intensive care coordination. Care coordination is generally tracked in care management systems that are sometimes linked to claims data, but many MCEs continue to lack formal care and treatment plans. The delegation of care coordination also continues to present a challenge for managing care coordination at the CCO level. Full integration continues to be a challenge for the CCOs but could greatly impact care coordination efforts if achieved.

E. Complaints, grievances, and hearings

CCO and FFS Complaints

The information provided in the charts below is a compilation of data from the current 15 coordinated care organizations (CCO) and fee-for-service (FFS) data. The annual reporting period covers July 1, 2020 through June 30, 2021.

Trends

	Jul – Sep 2020	Oct – Dec 2020	Jan – Mar 2021	Apr – Jun 2021
Total complaints received	3,181	3,529	3,437	3,895
Total average enrollment	1,093,854	1,138,377	1,344,628	1,389,453
Rate per 1,000 members	2.91	3.10	2.56	2.80

Barriers

The second quarter of 2021 shows an increase in the number of grievances, which the CCOs indicate are due in part to the effects of the continuing pandemic. The Access to Care category increased 17.8% from the first quarter of 2021 and shows a 56.3% over the past year as clinics, offices and services began to return to a normal level. The Interaction with Provider/Plan category shows an increase of 8.8% from Quarter 1, 2021 with an overall increase of 18.7% over the past year. Quality of Care issues showed a slight increase of 2.5% from Quarter 1, 2021 with an increase of 9.5% over the past year. FFS data shows the highest number of complaints are again the Billing category, with Access to Care the next highest category.

Interventions

CCOs –CCOs are reporting grievances due to the rapid revisions in vaccination and COVID precaution protocols as providers work to keep up with and communicate changes to their patients. Some CCOs are reporting some grievances are related to providers using telehealth and limited available appointment times. One CCO reported that grievances around dental visits have increased due to the influx of delayed dental work during the pandemic. Some CCOs are reporting increases in membership and decreasing available providers makes it difficult to know if grievances are decreasing. CCOs are reporting continued work on NEMT issues including Covid19 safety precautions. CCOs continue to report they have established committees and taskforces specifically to address provider capacity within their networks. Some CCOs report they have increased care coordination and are providing more health navigators to assist members in making appointments, attending appointments, etc. to improve services to members. CCOs report they are

continuing to monitor on a regular basis any trends and working to reduce the numbers of issues related to members requesting to change providers.

Fee-For-Service – The number of complaints from members who were on Fee for Service coverage during the Apr -Jun quarter was 94. An additional 295 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 59 complaints from members enrolled in Dental Care Organizations. 8893 informational calls were received asking for a variety of information, such as information about their coverage, CCO enrollment, request ID cards, etc.

Statewide rolling 12-month Complaints totals
This chart includes the total of all complaints reported statewide by CCOs and FFS.

Complaint category	Jul – Sep 2020	Oct – Dec 2020	Jan – Mar 2021	Apr – Jun 2021
Access to care	847	1,044	1,086	1,324
Client billing issues	343	266	236	278
Consumer rights	256	281	247	301
Interaction with provider or plan	1,079	1,244	1,186	1,281
Quality of care	455	494	487	498
Quality of service	201	200	195	213
Other	0	0	0	0
Grand Total	3,181	3,529	3,437	3,895

Related data
Reports are attached separately as an Appendix.

Notices of Adverse Benefit Determination (NOABD)
The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs during each quarter. The NOABDs are listed by reason, as per 42 CFR 438.400(b)(1-7) and are the total number of NOABDs issued, regardless of whether or not an appeal was filed. During this quarter CCOs report that the highest number of NOABDs issued were Pharmacy related. Specialty Care was the next highest and issues related to Behavioral Health issues were the third highest. Over the past year Pharmacy, Specialty Care and Behavioral Health subcategories showed where the highest numbers of NOABDs were issued. In addition, CCOs report that eligibility remains one of the highest reasons for denials. Some CCOs are working to provide information about OHP members who are terminating to assist the provider in reducing confusion and the numbers of requests for services that end in denials. CCOs continue to monitor NOABDs to ensure written notices are sent to members in easily understood language and includes the appropriate citations. Tracking for timeliness, as well as reviewing for utilization and appropriateness of care are processes CCOs report they are doing to ensure NOABDs are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	**Jul – Sep 2020**	**Oct – Dec 2020**	**Jan – Mar 2021**	**Apr – Jun 2021**
a) Denial or limited authorization of a requested service.	27,215	29,315	28,984	29,931
b) Single PHP service area, denial to obtain services outside the PHP panel	286	459	771	490

c) Termination, suspension, or reduction of previously authorized covered services	81	109	118	129
d) Failure to act within the timeframes provided in § 438.408(b)	10	10	12	15
e) Failure to provide services in a timely manner, as defined by the State	40	55	43	28
f) Denial of payment, at the time of any action affecting the claim.	58,588	56,932	56,909	64,915
g) Denial of a member's request to dispute a financial liability.	0	0	1	0
Total	86,220	86,880	86,838	95,508
Number per 1000 members	86	84	81	86.8

CCO Appeals

The table below shows the number of appeals the CCOs received over the past twelve months. There was an 11.7% increase in the number of appeals in the second quarter of 2021 over the first quarter. The data shows the numbers fluctuated slightly over the past year with a decrease of 4.9% between the fourth quarter of 2020 and the first quarter of 2021. An additional decrease of 4% is shown between the third and fourth quarters of 2020. For the second quarter of 2021, CCOs reported the highest number of appeals were issues with Outpatient services. Pharmacy was the next highest category and appeals related to Specialty Care were the next highest. Over the past year, Pharmacy, Outpatient and Specialty care were the subcategories where the highest numbers of appeals were filed. CCOs report they review the overturn rates which leads to more in-depth discussions and reviews, monitoring and process changes. Some CCOs are reporting that Peer Reviews with Providers is resulting in improvements to services. CCOs report they are continuing to do activities such as staff education and monitoring for providers to improve understanding of the appeal process. CCOs also work with members to assist them in finding services they need or assist them with finding alternative covered options.

CCO Appeals	Jul – Sep 2020	Oct – Dec 2020	Jan – Mar 2021	Apr – Jun 2021
a) Denial or limited authorization of a requested service.	1,055	1,078	1,031	1,145
b) Single PHP service area, denial to obtain services outside the PHP panel.	6	15	36	7
c) Termination, suspension, or reduction of previously authorized covered services.	3	2	1	10
d) Failure to act within the timeframes provided in § 438.408(b).	0	2	0	0
e) Failure to provide services in a timely manner, as defined by the State.	2	0	0	1
f) Denial of payment, at the time of any action affecting the claim.	438	346	293	357
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	1,504	1,443	1,361	1,520
Number per 1000 members	1.5	1.4	1.27	1.38
Number overturned at plan level	475	432	379	436

Appeal decisions pending	5	10	0	9
Overturn rate at plan level	31.58%	29.94%	27.85%	28.68%

F. CCO activities

1. New plans

Oregon awarded 15 CCO contracts under a procurement conducted in 2019. All of the CCOs are previously existing plans, one of which was approved to expand into two new service areas. CCOs began serving members under the terms of the new contract effective January 1, 2020.

One of the previously existing plans – Trillium Community Health Plan – had applied to continue in its historical Lane County service area and to expand into Clackamas, Multnomah, and Washington Counties (the Tri-County). OHA denied Trillium a notice to proceed in the Tri-County and gave until June 30, 2020, for Trillium to demonstrate a sufficient provider network in the Tri-County or that service area would be removed from its contract. On August 14, 2020, OHA approved Trillium's expansion into the Tri-County, effective September 1, 2020. This expansion is subject to a Corrective Action Plan.

2. Provider networks

After an extensive RFA process, OHA signed contracts with 15 CCOs in October 2019. One of the previously existing plans – Trillium Community Health Plan – had applied to continue in its historical Lane County service area and to expand into Clackamas, Multnomah, and Washington Counties (the Tri-County). OHA denied Trillium a notice to proceed in the Tri-County and gave until June 30, 2020, for Trillium to demonstrate a sufficient provider network in the Tri-County or that service area would be removed from its contract. On August 14, 2020, OHA approved Trillium's expansion into the Tri-County, effective September 1, 2020. This expansion is subject to a Corrective Action Plan. Oregon Health Plan members in the Tri-County area (Multnomah, Clackamas, and Washington) will have an additional option for CCO enrollment. Through the CAP imposed on Trillium Community Health Plan, OHA will continue to monitor key areas in the network development to ensure the network of contracted providers is sufficient to serve assigned members and meet time and distance standards for access outlined in OAR 410-141-3515 and per federal authority under 42 CFR 438.68(b). Trillium must ensure that its members have the same access to certain services as other patients in the service area.

There were no other substantive impacts to provider networks impacting access to physical, behavioral, and oral health networks.

3. Rate certifications

The Oregon Health Authority (OHA) contracts with Coordinated Care Organizations (CCOs) to manage and deliver integrated services that include Physical Health, Behavioral Health, and Dental Services to over 90% of Oregon's Medicaid population. OHA pays CCOs with actuarially sound capitation rates that are developed on an annual basis. Capitation rates pay an amount per month depending on the individual's age and OHP eligibility category. In addition to CCOs, OHA also retains five Dental Only (DCO) contracts where capitation rates are developed separately.

In 2019, OHA underwent a procurement process to determine participating CCOs which resulted in changes in service areas and member choice for some of the returning CCOs. These changes were effective January 2020 and resulted in a member choice period that inserted some uncertainty into the original 2020 capitation rate development.

During the time period of July 2020 through June 2021, OHA conducted a mid-year review of capitation rates to ensure that the final member attribution was reflected within the CY2020 rates. This mid-year rate review was retrospective back to 1/1/2020-12/21/2020 and impacted analyses such as regional factors and health-based risk adjustment, both of which are budget-neutral rate adjustments from a statewide perspective. OHA also considered impacts of the COVID-19 pandemic when conducting the mid-year review of the CY20 capitation rates and developed two adjustments in response to the disenrollment freeze resulting from the Families First Coronavirus Relief Act.

In September 2020, the new Trillium Community Health Plan was introduced into the TriCounty region (Portland metro area), OHA began working with affected CCOs to establish initial payment models as well as retroactive rate changes for 2020 through 2022.
Finally, OHA expects to submit the CY2022 Capitation Rates certification package to CMS in October 2021 for review. OHA continues to monitor the COVID-19 pandemic closely and working with CCOs in a partnership in maintaining our healthcare system.

4. Enrollment/disenrollment

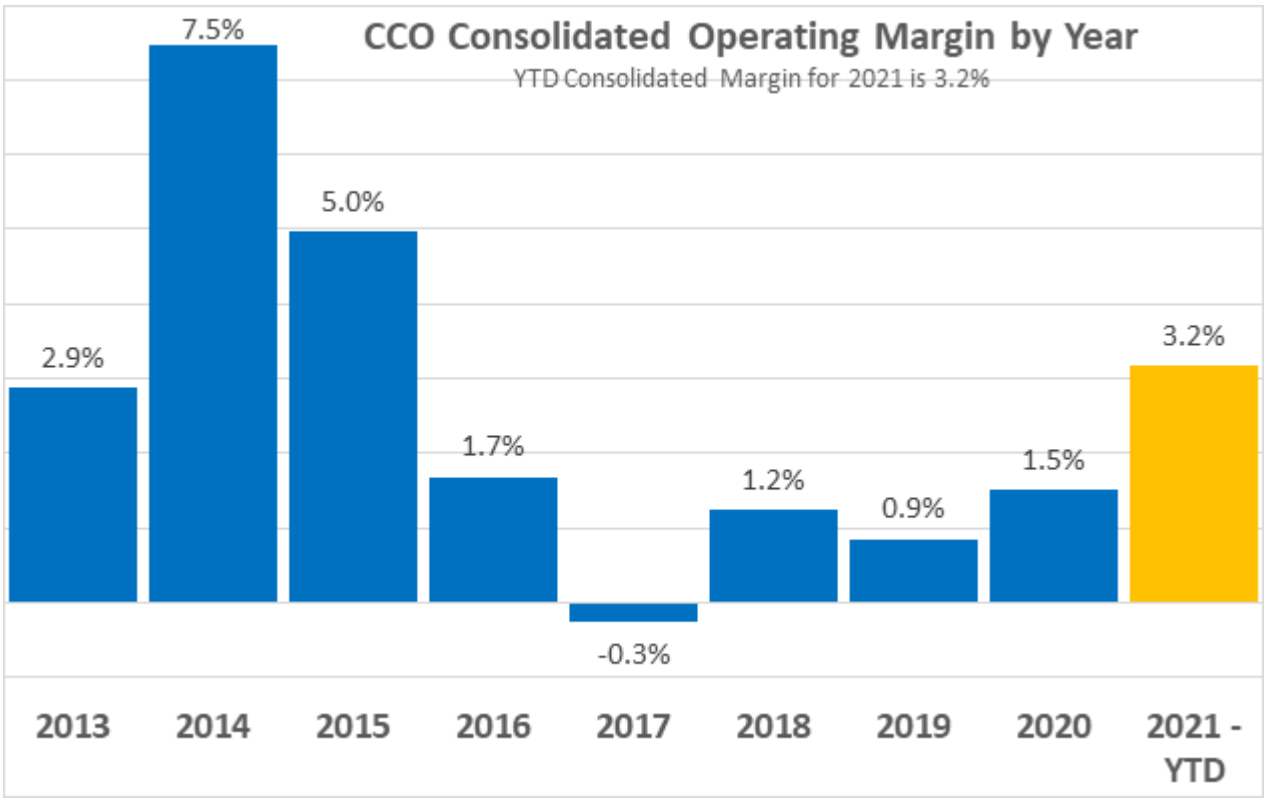
During this reporting period the COVID-19 Public Health Emergency continued drive steady increases in enrollment.

5. Contract compliance

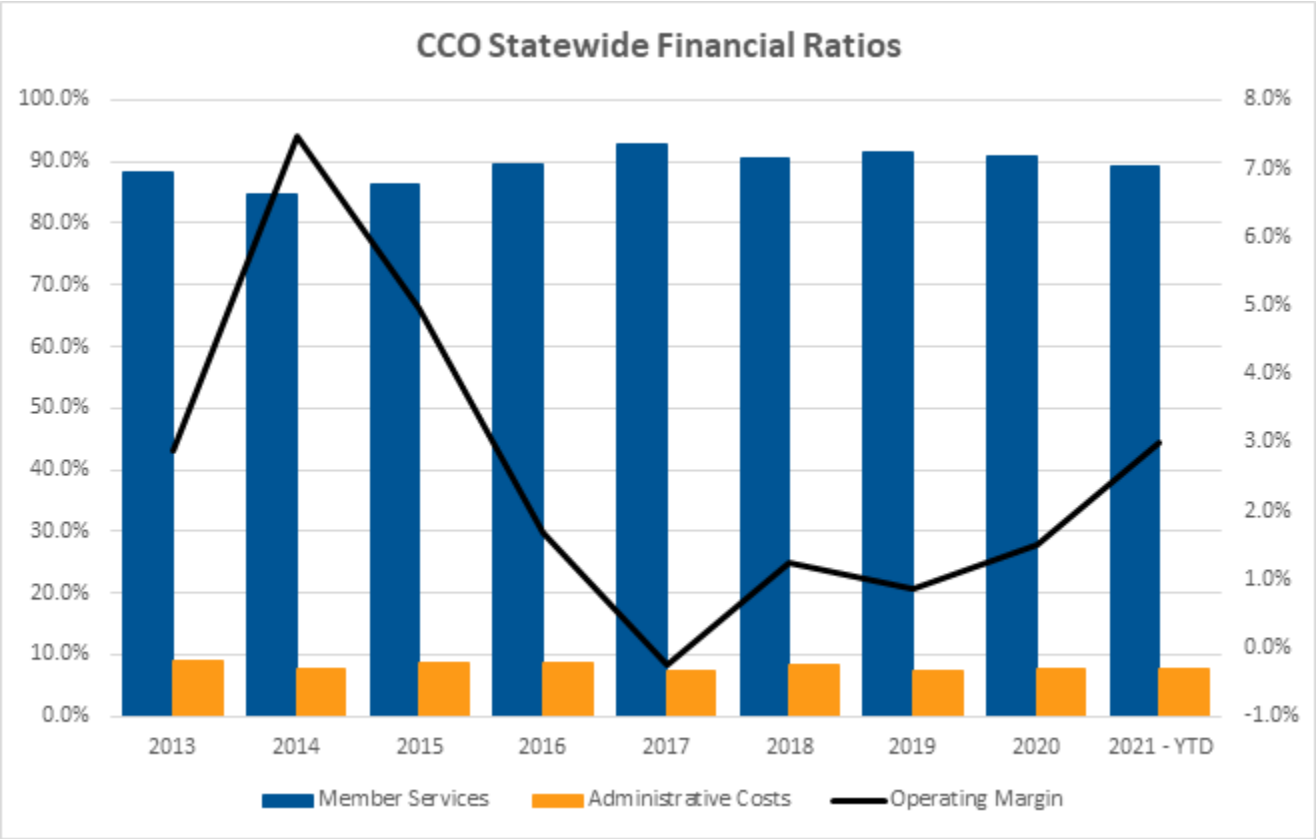
There are no issues with CCO contract compliance other than as described in the Corrective Action Plans section.

6. Relevant financial performance

CCOs achieved a statewide operating margin of 3.2% through the three months ending March 31, 2021. This is a strong start to the year, coming off of a year with an overall margin of 1.5% for the reporting year of 2020.



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (this includes medical, behavioral, dental and health-related services, reinsurance premiums and recoveries, and other adjustments) as a percentage of total revenue. A breakdown of key statewide financial ratios by year indicates that the Member Services component as a percent of the payments which CCOs received has remained relatively consistent over the last two years. Through the first three months of 2021, spending on Member Services was at 89.0%, which is 0.4% lower than the average Member Services expense from the previous 8 years. Administrative costs of 7.8% through the first three months of 2021 is only a slight increase from the prior year average of 7.7%.



For the 3-months ended March 31, 2021, the majority of the 16 CCOs met or exceeded the 85% target for MSR, a key indicator for MLR (2 CCOs were below the 85% MSRs, and 2 of the CCOs had MSRs above 90%).
The Risk Based Capital (RBC) Formula was developed as an additional tool to assist with financial analysis of insurance companies. The purpose of the formula is to establish a minimum capital requirement based on the types of risks to which a company is exposed. The RBC formula developed for Health Insurance providers reflect the risks associated with the economic environments of these companies.

1. Asset Risk
2. Underwriting Risk
3. Credit Risk
4. Business Risk

Under the RBC system, regulators have the authority and statutory mandate to take preventive and corrective measures that vary depending on the capital deficiency indicated by the RBC result. These preventive and corrective measures are designed to provide for early regulatory intervention to correct problems before insolvencies become inevitable, thereby minimizing the number and adverse impact of insolvencies. An RBC ratio of 200% is the minimum surplus level needed for a health insurer to avoid regulatory action.
The reporting period ended December 31, 2020 was the first year that RBC was measured for the CCOs. This initial calculation of RBC resulted in all CCOs calculating an RBC greater than 200%, and above the regulatory action level.
For additional CCO financial information and audited financials please follow the link below - http://www.oregon.gov/oha/FOD/Pages/CCO-Financial.aspx

7. Corrective action plans

During the reporting period, one CCO continued to be on a Corrective Action Plan (CAP) and another CCO was placed on a CAP.

Continuing CAP

• Entity name: Health Share of Oregon (HSO)

• Purpose and type of CAP: Non-compliance with CCO contract and Oregon Administrative Rule. CCO was not providing reliable non-emergency medical transportation (NEMT) services to covered appointments, resulting in disruption to members' access to care.

• Start date of CAP: October 14, 2019

• End date of CAP: Original end date: April 14, 2020. First extended end date: October 31, 2020. Second extended end date: April 30, 2021. Current end date: When OHA determines the remaining areas for improvement can be "closed".

• Action sought: Development and implementation of a plan for correcting the issues identified by OHA; submission of weekly reports to OHA for the duration of the CAP. Weekly reporting changed to monthly reporting effective for the report due in February 2021.

• Progress during year: The areas for improvement identified in the CAP are provider (driver) no-shows, on-time (pick-up) performance, call wait times, call abandonment, and member grievances. In a letter dated January 29, 2021, OHA formally notified HSO that it is satisfied with the improvements made in four of the five areas; the CAP is considered "closed" for those areas. HSO is required to continue to submit monthly progress reports for the area of member grievances as well documentation relating to specific NEMT concerns identified through member grievances.

New CAP

• Entity name: Trillium Community Health Plan

• Purpose and type of CAP: Original CAP: Insufficient compliance with CCO contract, Oregon Administrative Rule, and federal regulations regarding network adequacy, language access, health equity, and community engagement for the Tri-County service area. Amendment to CAP: Insufficient compliance with CCO contract and Oregon Administrative Rule regarding timely access to Intensive Care Coordination services for the Tri-County service area.

• Start date of CAP: March 5, 2021

• End date of CAP: No earlier than September 5, 2021, which is six months from the start date.

• Action sought: Development and implementation of a plan for correcting the issues identified by OHA; submission of monthly reports to OHA for a period of at least six months.

• Progress during year: The areas for improvement identified in the CAP are network development, health equity and language access, community engagement, and intensive care coordination. OHA's review of Trillium's progress reports for March-June 2021 indicate limited progress in the areas of health equity, language access, and community engagement. Substantive progress was demonstrated in the area of intensive care coordination, although it was insufficient to close out this area of the CAP. No progress was demonstrated in the area of network development.

8. One-percent withhold

This annual report is for data from July 1, 2020 through June 30, 2021.

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of January 2020 through December 2020. All CCOs except for two met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

One CCO did not meet the Administrative Performance (AP) standard for the months of January and February 2020 subject months no 1% withhold was taken as the CCO was testing claims. OHA did not recommend a withhold for these months.

One CCO did not meet the Administrative Performance (AP) standard for the months of March and April 2020 subject months no 1% withhold was taken as the CCO put remediation in place to ensure ongoing compliance and a decision was made by OHA leadership that due to the current pandemic affecting recent submissions, no withhold would be applied.

9. Other significant activities

COVID-19 Impact on CCO Activities

In 2020, the COVID-19 pandemic greatly impacted Oregon's Medicaid population, operations, priorities, and activities. Many CCO reporting requirements were altered, delayed, or waived by OHA in alignment with federal guidelines and State leadership directives in order to allow the State and its MCEs to prioritize resources and responses to the needs stemming from COVID-19. Oregon declared a "State of Emergency" due to COVID-19 on March 8, 2020, only three months into the newly redesigned "CCO 2.0" contract period, with multiple organizational and administrative changes enacted statewide, including the transition of hundreds of thousands of members between CCOs. In response to COVID-19 exigencies and federal relief legislation and guidance, OHA implemented multiple temporary policy changes intended to help existing OHP members retain their coverage during the epidemic and to simplify the application process for Oregonians that were newly eligible for OHP. These temporary policy actions included:

- Preventing benefits closures except for voluntary closure, deaths, incarcerations, or out-of-state residency.
- Accepting self-attestation of eligibility criteria without additional verification beyond citizenship or immigration status.

- Discounting federal stimulus payments and unemployment benefits when making income-based eligibility determinations.

MCEs made a plethora of administrative and operational adjustments to serve the Medicaid population and support State efforts, including such things as:

- Waiving all preauthorization requirements during the early stages of the pandemic.
- Investing in critical infrastructure, staffing, and communities.
- Automatically expediting reviews of grievances or appeals on member or provider request.
- Leveraging NEMT for wellness checks, social determinants of health (SDOH) needs, and natural disaster evacuation and relief efforts.
- Improving and expanding the availability of telehealth services.
- Automatically refilling necessary durable medical equipment (DME) and pharmacy prescriptions.
- Pooling electronic, staffing, economic, communication, data, and physical resources for COVID-19 prevention, relief, and vaccination efforts.

Metrics and Scoring Committee 2021 Incentive Program

In October 2020 meeting, the Metrics and Scoring Committee (M&SC) finalized benchmarks for the 2021 incentive program. Given the COVID-19 pandemic, M&SC made the following decisions regarding the 2021 benchmarks:

- Use 2019 as a baseline for assessing quality improvement in 2021 (as 2020 is inappropriate to use in assessing quality improvement);
- Rather than increasing benchmarks, roll forward the original 2020 benchmarks into 2021; and,
- Drop floors for improvement targets, making it easier to attain targets.

M&SC also chose to formally note that the benchmarks for individual measures may be reassessed if predetermined criteria related to extenuating external factors are met. High-level benchmark reopening criteria from M&SC are:

1. School opening (e.g., X% of schools statewide still in Comprehensive Distance Learning)
2. County reopening phases (e.g., X% of counties move back to baseline)
3. Governor's state of emergency (e.g., extended dates)
4. Suspension of elective procedures and preventive visits (e.g., tied to Governor's executive orders)
5. COVID cases per 100,000 people part of phased reopening (e.g., based upon reopening criteria for different phases)
6. Rescission or reduction of Oregon Health Plan expansion of telemedicine coverage, no longer aligning with specifications for some measures.

For measures meeting the criteria, M&SC will decide if the benchmark should be revisited, and if so, the degree to which reductions might be made. This will be done on an individual measure basis, using indicators tied to each criterion. The Oregon Health Authority (OHA) will not make changes to how it calculates individual measures – the only potential changes are revisions to benchmarks for the impacted measures meeting the indicators.

Emergency Outcome Tracking for COVID-19

In response to the disproportionate burden of COVID-19 on Black, Indigenous and People of Color and Tribal communities, OHA created a special "Emergency Outcome Tracking for CCO Panel COVID-19Vaccination"

(EOT) measure that would reward CCOs for making substantial progress in vaccinating their members, with a particular focus on achieving outcomes across all race/ethnicity groups.

Funds for EOT will come from the existing Quality Pool (QP) funds. The 4.25% set aside for calendar year 2021 will be segmented into 0.5% for EOT and 3.75% for the QP. Any funds remaining after EOT payout will be placed in the Challenge Pool of the Quality Pool and paid out as part of the Challenge Pool process defined by the Metrics and Scoring Committee for calendar year 2021 CCO incentive metrics. The entire 4.25% will be released to CCOs through the EOT and QP by June 2022. OHA is also exploring upfront payments related to EOT from other sources of funding. If identified, these funds would be made available as soon as possible.

A CCO can earn up to 90% of EOT funds by achieving the benchmark or improvement target for members age 16 or older and can earn 10% of EOT funds by achieving the benchmark for members age 12 to 15.

CCO members at least 16 years old as of January 1, 2021
To qualify for 100% of this portion of EOT payment, CCOs must reach either a benchmark or a CCO-specific improvement target overall and for all race/ethnicity groups. To qualify for partial payment of this portion, CCOs must reach the benchmark or CCO-specific improvement target overall and must reach at least a 42% vaccination rate for all race/ethnicity groups.

- To receive 100% of EOT payment for this age range, the vaccination rate overall and for each race/ethnicity group within the eligible CCO panel must reach:
    - The 70%benchmark or
    - A CCO-specific improvement target, based on 60% progress from the baseline overall vaccination rate among the CCO's members as of4/1/21 toward the 70% benchmark.
- Alternatively, a CCO can earn partial EOT payment based on the percentage of race/ethnicity groups for which the benchmark or improvement target is met. To receive a partial payment, the CCO must reach:
    - The benchmark or CCO-specific improvement target overall and
    - At least a 42% vaccination rate for each race/ethnicity group. (The achievement floor of 42% represents 60% progress from a zero baseline toward the 70% benchmark as explained by the improvement target methodology below.)

Improvement targets are an adaption of the CCO quality improvement metrics improvement target methodology to drive rapid increases in vaccination rates. The improvement amount is calculated by subtracting the CCO-specific baseline from the statewide 70% benchmark and then multiplying by 0.60 to reflect the percentage of expected progress toward the benchmark. The improvement target is calculated as the CCO-specific baseline plus improvement amount.

CCO members age 12 to 15 as of January 1, 2021
CCO members age 12 to 15 years became eligible to be vaccinated on May 13, 2021, and the American Academy of Pediatrics has recommended administering other childhood and adolescent immunizations at the same time as COVID vaccinations. OHA used a starting point of 0% in the methodology above to calculate a benchmark of 42%. Therefore, to qualify for this portion of EOT payment, the CCO must achieve a 42% vaccination rate for members aged 12 to 15.

Because this age range includes a relatively small number of CCO members, breaking out populations by race/ethnicity is not feasible. Accordingly, payment will be based on meeting the benchmark for this age range overall, without additional race/ethnicity group analysis. As described above, no additional age groups will be included in this measure.

CCO Contract Restatement
Beginning in March 2021, OHA worked with CCOs and Oregon Health Authority (OHA) Units/Programs to collect and organize all proposed changes to the 2022 Coordinated Care Organization (CCO) contract. Changes included significant, minor, and technical revisions to the Contract. For proposed significant changes to the 2022 CCO contract, the process established by the OHA required the internal subject matter expert to present each change to CCOs before presenting it to OHA's leadership team for consideration. All significant changes were presented to CCOs and approved by OHA.

G. Health Information Technology

Medicaid Electronic Health Record (EHR) Incentive Program
The Medicaid EHR Incentive Program (also known as the Promoting Interoperability Program) offers qualifying Oregon Medicaid providers federally-funded financial incentives for the adoption or meaningful use of certified electronic health records technology. Eligible professional types include physicians, naturopathic physicians, pediatric optometrists, nurse practitioners, certified nurse-midwives, dentists, and physician assistants in certain settings. As of June 30, 2021, more than $211 million in federal incentive payments have been dispersed to 60 Oregon hospitals and 3,857 Oregon providers... Between July 2020 and June 2021, 421 providers received $3,574,481 in incentive payments. The program sunsets December 31, 2021.

CCO Health IT Roadmap & Data Reporting
Per the CCO 2.0 Contract, CCOs are required to draft and maintain an OHA-approved health information technology (HIT) Roadmap describing how they use/will use HIT to achieve outcomes including population health management and value-based payment (VBP) arrangements, and how they will support physical, behavioral, and oral health providers with EHR adoption and health information exchange (HIE) for care coordination and hospital event notifications (as well as CCO use of hospital event notifications). CCOs submit their Updated HIT Roadmaps to OHA annually on March 15th for review and approval starting in 2021. Between July and December of 2020, OHA developed an Updated HIT Roadmap template to help streamline CCO responses and reduce burden. CCOs used this template to complete their Updated HIT Roadmaps and submit to OHA March 2021. In June 2021, OHA completed an initial review of the Updated HIT Roadmaps and has approved some, while requesting additional information from CCOs on others. OHA anticipates that all CCOs will have an approved Roadmap by October 2021.

Starting in 2022, CCOs will be required to set targets for increasing EHR adoption and access to HIE for care coordination and hospital event notifications among their contracted physical, behavioral, and oral health providers, and report on their annual progress toward reaching targets within their HIT Roadmaps. To support this requirement, between January and June 2021, OHA developed expectations and an initial plan for HIT Data Collection and Reporting. The plan includes developing a survey (in partnership with CCOs) that CCOs can distribute in the fall of 2021 to their contracted provider organizations to collect EHR and HIE information. This information will be used to inform CCO efforts to support their providers with health IT adoption and use to increase care coordination and engagement in value-based payment models.

HIT Commons
The HIT Commons is a public/private partnership to coordinate investments in HIT, leverage funding opportunities, and advance HIE across the state. HIT Commons is co-sponsored by the Oregon Health

Leadership Council (OHLC) and OHA, and is jointly funded by OHA, hospitals, health plans and CCOs. For more information see the HIT Commons website.

EDie and the Collective Platform (formerly known as PreManage)
The Emergency Department Information Exchange (EDie) allows Emergency Departments (EDs) in real-time to identify patients with complex care needs who frequently use the emergency room for their care. In addition to utilization alerting, EDie also provides succinct but critical information to ED physicians, such as: security alerts, care guidelines entered by the patient primary care home, and contact information for case managers. All hospitals with emergency departments (except the VA) in Oregon are live with EDie.

The Collective Platform (aka PreManage) is a companion software tool to EDie. The Collective Platform brings the same real-time hospital event notifications (ED and Inpatient Admit, Discharge, and Transfer (ADT) data) to those outside of the hospital system, such as health plans, Medicaid coordinated care organizations (CCOs), providers, and care coordinators. In Oregon, Physician Orders for Lifesaving Treatment (POLST) forms are available to view for clinics, Skilled Nursing Facilities (SNFs), payers, and hospitals who receive EDie alerts through paper/fax.

EDie and the Collective Platform are in use statewide and adoption for Collective continues to grow. All of Oregon's CCOs receive hospital notifications through the Collective Platform (and all CCOs are extending their Collective subscriptions down to their contracted providers), as are most major Oregon health plans, and all of Oregon's Dental Care Organizations. About 2/3^{rds} of Oregon's Patient-Centered Primary Care Homes, many behavioral health and community mental health program clinics, tribal clinics and others are participating, as well as state programs for Oregon's Department of Human Services' Aging & People with Disabilities and Developmental Disabilities.

Recent highlights:

- As of July 9, 2021, COVID-19 positive case data from OHA's Oregon Pandemic Emergency Response Application (Opera), the state's COVID-19 case investigation system, is being shared with all users of the Collective Platform. A flag is visible on a patient's record if they had a confirmed positive COVID-19 test result in the last 42 days. This information is also included in EDie notifications across 63 Oregon hospitals. More information about this initiative is available here. See the COVID-19 Data Sharing Initiative section below for more information on COVID-19 data sharing.
- OHA, HIT Commons, and Collective Medical partnered to bring statewide COVID-19 vaccination information from the state's ALERT Immunization registry into EDIE/the Collective platform. As of April 2021, population reports are available via the platform for all CCO and health plan users, which allow for quickly assessing members who have received no vaccine, as well as identifying the manufacturer and dose of vaccines that have been administered.
- The HIT Commons EDIE Steering Committee met on June 25, 2021. Topics of discussion included product and support updates from Collective Medical, EDIE/Collective Platform use cases under development, ED utilization dashboards and updates on the HIT Commons/OHA effort to re-energize Assertive Community Treatment (ACT) team utilization of the Collective Platform. Materials from that meeting are available here. The Committee's next meeting is August 27, 2021.
- OHA is collaborating with partners on several initiatives to share COVID-19 data in support of response and recovery efforts. • OHA is now sharing COVID-19 positive case data to users of EDie and the Collective platform, and to clinical and health plan/CCO users of Reliance eHealth Collaborative's Community Health Record. • COVID vaccine data reports are now shared weekly with CCOs for their members. Additionally,

COVID-19 vaccine data are flowing into EDie/the Collective platform and to the Reliance HIE. Collective platform COVID Vaccine Population Reports allow for quickly identifying members who have received no vaccine, as well as identifying the manufacturer and dose of vaccines that have been administered. Updates on Health IT Policy and Efforts, Oregon Health Authority (August 2021) Page 7 of 8 • Oregon efforts to integrate Public Health COVID-19 data into HIT and HIE will be discussed and assessed at monthly meetings of the Public Health Data Sharing Workgroup, convened by HIT Commons in partnership with OHA.

Public Health Data Sharing Workgroup HIT Commons, in partnership with OHA, has convened a Public Health Data Sharing Workgroup to discuss and assess efforts to integrate public health data into HIT or HIE systems, and make policy and operational recommendations to HIT Commons and OHA. Workgroup membership includes representation from OHA's Public Health Division, payers/CCOs, health systems, and providers. The kick-off meeting took place on July 15th, and the group plans to meet monthly through the end of 2021.

Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative
Oregon's PDMP Integration initiative connects EDie, Reliance eHealth Collaborative health information exchange (HIE), EHRs, and pharmacy management systems to Oregon's PDMP, which includes prescription fill information on controlled substances, and is administered by OHA's Public Health Division. HIT Commons is overseeing the PDMP Integration work with guidance from the Oregon PDMP Integration Steering Committee and in coordination with OHA's Public Health PDMP program. Legislative updates and the latest PDMP implementation reports can be found on the HIT Commons website. Recent highlights include:

- 222 organizations have integrated access to Oregon's PDMP data – either through their EDie alerts, or through one-click access at the point of care (EHR or HIE), with a total of 15,702[1] prescribers active in the 18 months leading up to March 31, 2021. 11 retail pharmacy chains (across 895 sites) and 1 rural pharmacy are also live.
- 24 new organizations went live with PDMP integration in Q2 2021Recent efforts to encourage small and rural clinics to integrate their EHR access to PDMP have proven fruitful, and HIT Commons expects to bring on a number of new organizations in 2021.
- House Bill 2074 was passed by the 2021 Oregon Legislative Assembly. This bill increases annual PDMP fees from $25 to $35 and is critical to maintaining continued operations and support of the PDMP Integration initiative.
- The PDMP Integration Steering Committee met on July 8, 2021. Topics of discussion included updates to the group's charter, PDMP Integration metrics, Q1 2021 progress on integrations, updates from Public Health PDMP staff, and new reporting functionality

Direct Secure Messaging Flat File Directory
OHA will be ending the Flat File Directory service in August 2021.

The Flat File Directory (FFD) served as Oregon's address book for Direct secure messaging addresses since 2014. The purpose of the FFD was to enable participants to find or "discover" Direct addresses for providers outside their own organizations. In 2020, the Interoperability and Patient Access final rule from CMS established a requirement for providers to list and update their digital contact information in the National Plan and Provider Enumeration System (NPPES).

Health IT Stakeholder Groups

Health IT Oversight Council (HITOC)

HITOC is tasked with setting goals and developing a strategic health information technology plan for the state, as well as monitoring progress in achieving those goals and providing oversight for the implementation of the plan. The HITOC HIT 2017-2020 Strategic Plan was approved by the Oregon Health Policy Board in October 2017 and provides a roadmap for Oregon's HIT work ahead.

Annual priorities: HITOC reported on 2020 progress and 2021 annual priorities at the February Oregon Health Policy Board (OHPB) retreat. Priorities include Health IT needed to support COVID response and recovery, Strategic Plan Update work, and further work related to health IT and social determinants of health and health equity.

Highlights from HITOC's meetings this past year:

- August 2020:
  - Received an update about COVID impacts on OHA and the implications for OHA's HIT work
  - Heard updates from Oregon HIT organizations supporting COVID needs, including HIT Commons, Reliance eHealth Collaborative, OHA's COVID Wraparound
  - HITOC members provided updates and highlights about COVID's impact on HIT including successes and challenges, lessons learned, and needs and priorities
  - Considered preliminary COVID-related implications for the Strategic Plan Update, including HITOC goals, workplan, and priorities
  - Received an update on legislative and regulatory changes including HB 4212: race, ethnicity, language, and disability reporting requirements; state Legislative update; and CMS/ONC Interoperability Final Rules
  - October and December 2020 meetings were canceled
- February 2021:
  - Received an update about COVID impacts on OHA and the implications for OHA's HIT work
  - Heard updates from Oregon HIT organizations supporting COVID needs, including HIT Commons, Reliance eHealth Collaborative, OHA's COVID Wraparound
  - HITOC members provided updates and highlights about COVID's impact on HIT including successes and challenges, lessons learned, and needs and priorities
  - Considered preliminary COVID-related implications for the Strategic Plan Update, including HITOC goals, workplan, and priorities
  - Received an update on legislative and regulatory changes including HB 4212: race, ethnicity, language, and disability reporting requirements; state Legislative update; and CMS/ONC Interoperability Final Rules
- April 2021:
  - Updates on OHA activities related to telehealth. Explored the tribal and rural perspectives with HITOC members sharing their experiences.
  - Oregon's Office of Broadband presented on their current and upcoming activities, as well as the state and federal funding opportunities.
  - Updates on COVID data sharing around positive cases and vaccine status was discussed.
  - OHA updated HITOC on REALD data collection activities.
- June 2021 meeting was canceled

HITOC Membership: On July 6, 2021 OHPB approved the appointment of five new members and renewal of five members to HITOC. The new members fill important gaps in oral health, social determinants of health, public health, rural health, and academic perspective. As well as adding racial and ethnic representation and maintaining geographic diversity. Seats remain open to fill additional gaps in representation.

Strategic Plan Update: At the beginning of 2020, HITOC began efforts to update the Oregon HIT Strategic Plan. In February and March, OHA conducted a series of public listening sessions and collected helpful input to inform the strategic plan. Given the pandemic's impact on the healthcare system, remaining listening sessions were canceled and Strategic Plan Update efforts were placed on hold. HITOC resumed Strategic Plan Update work in the summer of 2021 starting with a kick-off meeting at the August 5th HITOC meeting.

The Strategic Plan Update will center equity in its recommendations and process, and it will focus on the HIT strategies needed to support health system transformation and achieve health equity, including prioritizing efforts that support Medicaid priorities (as identified in CCO 2.0, 1115 waiver renewal), legislative priorities (including demographic data collection of race, ethnicity, language, disability (REALD) and sexual orientation and gender identity (SOGI), behavioral health investments), and broader priorities identified in the State Health Improvement Plan. The list of topics identified for the strategic plan currently include:

- EHR Adoption*
- Health Information Exchange* and leveraging new federal rules and policies (Cures Act, TEFCA)
- Social Determinants of Health (SDOH) and Community Information Exchange*
- Health IT and health equity with a focus on demographic data (REALD/SOGI)
- Consumer/Patient access/engagement through health IT (patient portals, consumer apps)*
- Telehealth and Broadband
- Public health preparedness
- Behavioral health

Once drafted, the plan will be submitted to the Oregon Health Policy Board. Target date for completion is January 2023.

*Oregon state House Bill 3039 was considered this legislative session but was not passed. It would have directed HITOC to explore technology, funding, incentives, and policy options for statewide community information exchange (CIE), statewide health information exchange (HIE), patient access to data, and incentivizing EHR adoption. HITOC will consider exploring these areas under the Strategic Plan Update.

ONC Information Blocking and CMS Interoperability Final Rules

On May 1, 2020, the U.S. Department of Health and Human Services (HHS) published two health information technology (IT) final rules requiring implementation of new interoperability policies: the ONC 21st Century Cures Act Final Rule and the Centers for Medicare and Medicaid Services (CMS) Interoperability and Patient Access Final Rule

- OHA has hosted three webinars related to these rules to inform the public and CCOs. The most recent public webinar was a CCO/DCO Final Rules Follow-up Webinar in January focusing on the newly released Interoperability and Prior Authorization final rule and CCO/DCO information sharing and coordination. Recordings and materials for these webinars and additional resources (e.g., webinar Q&As, links to federal websites and documents) can be found on the Office of Health IT final rules webpage.

- OHA hosted work sessions with CCOs and DCOs to allow focused time on each area of the rules and giving them the opportunity to ask questions of OHA's health IT consultant.

Partnering with the HIT Commons OHA has hosted meetings for a Payer Interoperability Collaborative (PIC) for CCOs, DCOs, and Medicare Advantage plans to focus on alignment and implementation of the CMS Interoperability and Patient Access Rules.

Health Information Exchange (HIE) Onboarding Program

OHA developed the HIE Onboarding Program to connect key Medicaid providers to community-based HIEs that provide meaningful HIE opportunities and play a vital role for Medicaid in their communities. The Program is to support the costs of an HIE entity to onboard providers, with or without an EHR, and to offset the onboarding costs to organizations.

Reliance eHealth Collaborative was the selected community-based HIE to onboard priority physical, oral, and behavioral health Medicaid providers according to a work plan developed in consultation with CCOs. OHA launched the onboarding program in January 2019 and has approved Reliance workplans to onboard providers contracted with nine CCOs, covering 14 Oregon counties. As of June 30, 2021, there are 13 behavioral health practices, four oral health clinics, 52 critical physical health entities, and five major trading partners (hospital/health system) participating in the Program. Between July 2020 and June 2021, a total of 47 entities began participating. The Program ends June 30, 2021.

Community Information Exchange (CIE)

Community information exchange (CIE) is a network of healthcare and human/social service partners using a technology platform with functions such as a shared resource directory, "closed loop" referrals, reporting, social needs screening, and other features to electronically connect people to social services and supports. CIEs are developing rapidly across the state with two main CIE vendors: Aunt Bertha and Connect Oregon (Unite Us). To learn more, see the OHA CIE webpage.

In 2020-2021, OHA funded HIT Commons work around CIE to include:

- A mapping of CIE activities in Oregon continues to be updated.
- An Oregon CIE Advisory Group was chartered to engage stakeholders statewide to discuss components of an effective CIE, assess opportunities for alignment of regional CIE efforts, and to develop a CIE Roadmap for Oregon by the end of 2020. The Advisory Group was on pause due to COVID-19 and re-engaged in September 2020. COVID-19 has been an accelerator in Oregon for health care organizations to lean into contracting discussions with CIE vendors on an expedited timeline. Because of that, and the CIE efforts are unfolding in real-time, the Oregon Advisory Group is considering rescoping and determining the critical areas of focus where there may be value for statewide alignment/work. The roadmap is expected to be completed by the end of 2020.

OHA/ODHS activities: OHA explored how CIE tools can assist with the COVID-19 response by leveraging existing CIE implementations. In summer 2020, OHA began exploratory work in coordination with the Oregon Department of Human Services. After engaging with internal and external stakeholders, OHA shared support for interested community-based organizations, local public health authorities, and Tribes to join existing CIEs offered by CCOs and health plans. OHA developed a flyer and presented at multiple community forums to educate and show support.

On April 29, 2021 OHA held an informational webinar to explore what CIE is, how it may be valuable, and to hear about successes and challenges faced. Representatives from AllCare CCO, Project Access Now, Cascade Health Alliance, and Sky Lakes Medical Center shared their experiences using CIE. Materials can be found on the CIE webpage.

H. Metrics development

1. Kindergarten Readiness

This developmental work comprises a multi-year measurement strategy:

1) Adopt two metrics for the 2020 CCO incentive measure set:

• Well-child visits for children 3-6 years old

• Preventive dental visits for children 1-5 years old

2) Adopt a CCO-level attestation metric focused on children's social-emotional health once specifications are finalized (i.e., for 2022 for 2023 CCO incentive measure set).

3) Replace the existing developmental screening metric with a new follow-up to developmental screening metric in 2022 or 2023.

The Metrics & Scoring Committee implemented the first part of the strategy by voting to include both Well-child visits for children ages 3-6 and Preventive dental visits for children ages 1-5 in the 2020 Quality Incentive Program. OHA then continued its partnership with Children's Institute, with technical expertise from the Oregon Pediatric Improvement Partnership (OPIP), to develop the other components of the multi-year-multi-measure strategy.

In Q1-Q2 the multi-partner workgroup developing the second component of the strategy (a CCO-level measure to improve the social-emotional health of young children) continued meeting monthly as a team (consisting of Children's Institute, OPIP, and OHA). The team also continued engagement with technical advisors from the Robert Wood Johnson Foundation funded Aligning Early Childhood and Medicaid (AECM) initiative, of which Oregon is receiving technical assistance to support development of this measure. Oregon continued working with the AECM team, which kindly made additional technical assistance available through the end of the year. The Oregon team also presented on its work at the AECM convening of all grantee states in September 2020.

Their work focused on three main areas:

• Strategic Planning for Measure Specification Development. Including engagement with partner agencies and governing boards, reviewing specifications and tools for equity impact; and securing presentation/engagement with Oregon metrics committees.

• Measure Analytics. Creating data analysis plan and running initial data pull for behavioral health reach metric; and researching consultants to aid in developing recommendations and tools for attestation scoring.

• Communications. Drafting communications tools explaining what social emotional health is and why it is important.

In Q2 the Metrics & Scoring Committee reviewed measure progress and supported moving into piloting to broaden testing base and collect data to assess feasibility, reliability, and validity.

The vision for the metric is that children from birth to age 5, and their families, have equitable access to services that support their social-emotional health and are the best match for their needs.

The purpose is to drive CCOs to address complex system-level factors that impact the services kids and families receive and how they receive them, and for which there may be payment or policy barriers that need to be addressed.

The metric includes a glide path that builds over multiple years. In year 1, the focus is on building a data foundation by assessing current reach of services. Years 2 to 5 are for building on that foundation to enhance capacity and services.

Young children and families have faced barriers to accessing social-emotional health services that they critically need, and the need is growing during the pandemic.

Discussion included:

• How the measure addresses racial equity. In addition to looking at asset mapping and looking at capacity by language, race ethnicity, and region, the development team is thinking about how to incorporate those pieces as the CCO, with community partners, makes a plan to address key gaps for target populations in the region.

• How gaps will be addressed, including schools, and the need to pull in community sectors and brainstorm innovative ways providers can provide services.

• Ensuring that the measure pushes for trauma informed care.

• Metrics & Scoring Committee members expressed support for the measure, and the chair and vicechair said they would champion the measure.

In Q3, the partnership team provided a high-level background and measure overview presentation to the Health Plan Quality Metrics Committee, with an opportunity for one-on-one follow-up for additional context. Eleven CCOs volunteered to engage in piloting of the measure beginning in February 2021 and continuing into the next quarter.

In the last quarter partners from Children's Institute, OPIP, and OHA the measure was presented to both the Health Plan Quality Metrics and Metrics & Scoring Committees. At its April 2021 meeting the Health Plan Quality Metrics Committee voted unanimously to include this measure in the menu of measures available for use in the CCO Quality Incentive Program. This gives the Metrics & Scoring Committee the opportunity to include it in the 2022 incentive program.

Partners from Children's Institute, OPIP, and OHA presented the measure at the May 2021 Metrics & Scoring Committee meeting. This included an overview of the measure and pilot findings; how the measure meets measure selection criteria and health system transformation priorities; and highlighting the need to include the measure in the 2022 measure set. It was noted that this type of measure provides a foundation for assessment beyond kindergarten and the important of support for children at an early age to help drive towards success in adulthood. In June the Metrics & Scoring Committee tentatively added this measure to the 2022 Quality Incentive Program; the final decision will occur in July 2021.

2. SDOH/Health-related Social Needs Measure

The public Workgroup initially planned to begin meeting on April 1, 2020. However, given the pandemic, the Workgroup's meeting was paused. OHA implemented a plan to ensure the Workgroup can accomplish its goal of providing a social needs screening metric concept by the end of the year, while balancing the current priorities of OHA and our partners to address the COVID-19 pandemic.

In Q1, a smaller Expanded Planning Team met (virtually) in the interim and created a set of options for the Workgroup to consider. This group includes representatives from: OHA; consultants from Nancy Goff & Associates and the Oregon Rural Practice-based Research Network (ORPRN); DHS; the Oregon Community Information Exchange; and, our national advisors from the National Committee for Quality Assurance. The Expanded Planning Team first met in May 2020, with monthly meetings set through September 2020. The team was charged with reviewing the Oregon context, national context, other states work, background research, measurement and feasibility aspects, and finally recommending 3-5 measure concepts for the Workgroup to consider. As the Expanded Planning Team's work neared completion, a smaller subgroup also met to consider the feasibility of the concepts under consideration. In addition, initial plans were made for a smaller group to review tools which might be included in the final metric.

In the end the Expanded Planning Team sent four high level measure concepts to the Workgroup for consideration (see: https://www.oregon.gov/oha/HPA/ANALYTICS/SDOHDocs/SDOH-measure-concepts-FINAL-10.7v2.pdf). Finally, the internal core team planned for handing the baton from the Expanded Planning Team to the formal Workgroup, which first met in Q2. This included solidifying the four measure concepts from the Expanded Planning team noted above, as well as finalizing a set of resources in which to ground the Workgroup, including: Workgroup Charter; Guiding Principles; completion of a series of three webinars on social needs screening and measurement from Bailit Health; completion of a crosswalk of social needs screening measurement across states by Bailit Health; completion of background research and an environmental scan and supporting documents from the Oregon Rural Practice Research Network (see https://www.oregon.gov/oha/HPA/ANALYTICS/SDOHDocs/Resources-for-OHA-SDOH-MeasurementConcept-Workgroup.pdf).

The full workgroup started meeting in Q2 and met 4 times from October through December 2020. The workgroup roster, meeting materials, and meeting recordings all are available on the workgroup page here: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx. All of the workgroup meetings were open to the public, and public comment was invited at each meeting.

In the October 7th meeting, the workgroup went over Oregon's CCO Incentive Program, an overview of social needs screening on a national level and a review of the measure concepts from the Expanded Planning Team.

At the November 2nd meeting, the workgroup saw a presentation on an environmental scan done by ORPRN and had both small and large group breakout discussion about the measure concepts.

At the November 19th meeting, the workgroup continued its discussion of the measure concepts incorporating additional information that the workgroup members requested from OHA including scope of measure, implementation of measure and possible data sources for measure.

At the December 8th meeting, the workgroup reviewed the results of a survey completed by workgroup members. The survey evaluated each of the 4 measure concepts based on the guiding principles of the workgroup (Equity, Alignment, Feasibility). Measure Concept 1 (any data source) received the highest rating. The survey also asked members to prioritize several screening domains by high, medium and low priority. The screening domains that received the highest priority rating were food insecurity, housing insecurity and transportation. Finally, members voted on a measure concept to send to consideration to the Metrics and Scoring Committee. The measure concept decided on was the rate of social needs screening in the total member population from any data source. The numerator would be CCO members screened while the denominator would be total CCO membership. The measure concept includes a multi-year glide path, beginning with a structural measure to ensure that screening is done in an equitable and trauma-informed way and that systems are in place for sharing data and making referrals to meet identified social needs.

In Q3, the workgroup held an extra meeting in Feb 2021. They reviewed recommendations from a subcommittee on screening tools and questions, discussed next steps in measure development, and shared closing thoughts. The Workgroup's final report, including the recommended measure concept and glide path for implementation, was posted to their webpage and shared with stakeholders. Following the completion of the Workgroup's work, information on the recommended measure concept was presented to the Metrics and Scoring Committee at their February 19, 2021, meeting. The committee unanimously voted to endorse the measure concept to move forward to pilot testing

OHA staff then presented to the CCO Metrics Technical Advisory Group (TAG) at their March 25 meeting about the pilot testing process and began recruiting participants for the pilot. During this time, OHA staff also worked with a consulting firm to draft detailed measure specifications, based on the recommended measure concept, for pilot testing.

Pilot testing was scheduled for the spring and summer of 2021 so that the draft specifications can be refined and presented to committees and other stakeholders in the late summer and fall.

Pilot testing began in the fourth quarter. Nine CCOs participated in the pilot, which was conducted by OHA with contracted technical assistance from the Oregon Rural Practice-based Research Network (ORPRN) measure specification support from CedarBridge Group. Pilot activities included:

- Meetings with participating CCOs

- Kick-off
- Mid-point check-in – to explore progress and challenges in initial work with specifications and data
- Wrap-up – Learn from further experience with specs and data; overall thoughts and impressions
- Post-pilot survey – Additional reflections and suggestions for improvement
- Technical assistance ran throughout pilot

From May – June the above pilot meetings and surveys were conducted with the nine CCOs participating in the pilot. In the next quarter (July – August) the OHA team and consultants will review the results of the pilot with stakeholders and Tribes and make modifications to the draft specifications as needed. This will be followed by presentation and consideration of the finalized metric by the Health Plan Quality and Metrics & Scoring Committees in the latter part of 2021.

As the measure was piloted in the fourth quarter, the various metrics committee were apprised of progress:

The Health Plan Quality Metrics Committee received an update on the measure concept and piloting plans at its April 2021 meeting.

In May the CCO Metrics Technical Advisory Group, comprised of quality improvement staff from CCOs and clinics, received an update on the measure concept and pilot plans.

3. Evidence-based Obesity Measure Workgroup (Developmental measure workgroup)

In early 2018, the Metrics and Scoring Committee and Health Plan Quality Metrics Committee requested the development of an incentive metric focused on obesity using evidence-based strategies. Since May 2018, the Oregon Health Authority has been working on the development of an evidence-based obesity prevention measure for use in the state of Oregon. Workgroup membership includes Oregon Health Authority staff from the Public Health Division and the Health Policy and Analytics Division, and CCO and Local Public Health representatives.

The evidence-based obesity measure has two parts:

Part One addresses obesity prevention and reducing the prevalence of obesity through evidence-based multisector community interventions.

Part Two, an outcome measure, will rely on BMI measurement and interventions completed to assess the decrease in obesity prevalence.

At the July 2020 Metrics and Scoring Committee meeting, the multi-sector community intervention part of the measure was recommended by OHA to be included in the 2021 CCO incentive measure set. After much discussion, the committee ultimately did not select the it for 2021. Public Health Division staff have engaged with community groups about revisions to the measure. The workgroup plans to reconvene in 2021 to begin reworking the measure based on community and stakeholder feedback. Although work on this measure has been delayed by other priorities, particularly COVID response, OHA has continued discussions about how to move forward on meaningful and equitable measure development.

4. Health Equity Measurement Workgroup (Development measure workgroup)

In early 2018, the Oregon Health Policy Board tasked the Oregon Health Authority with developing recommendations for measuring health equity in Oregon's healthcare system. The workgroup was co-chaired by the Director of OHA's Equity and Inclusion Division, and the Director of the OHA Office of Health Analytics and meet in 2018-2019.

The health equity metric measures the proportion of visits with spoken and sign language interpreter needs that are provided by OHA qualified and certified interpreters. The goal of the measure is to ensure meaningful language access to health care services for all CCO members through quality language services and the delivery of culturally responsive care.

In Q1, at the July 2020 Metrics and Scoring Committee meeting, the measure was recommended by the OHA to be included in the 2021 CCO incentive measure set. The committee selected the measure for the 2021 measure set. Effective January 2021, Oregon will be the first state to use a Medicaid pay for performance measure focused on health equity. The measure is called Meaningful language access to culturally responsive health care services. It measures the proportion of visits with spoken and sign language interpreter needs that were provided with OHA qualified or certified interpreter services. Having concluded its measure development work, this workgroup is no longer meeting.

I. Budget neutrality

Refer Budget Neutrality Reports attached separately.

J. Legislative activities

Oregon's Governor convened the first ever Racial Justice Council (RJC) to change how we listen to, engage with, respond to, and support Black, Indigenous and People of Color (BIPOC) and Tribal Communities in Oregon. Many of the health equity investments and initiatives listing in this report reflect RJC priorities. Through them, the legislature provided OHA and its partners new opportunities to center health equity and work to eliminate health inequities. Together, the bills and budget investments discussed below reflect a deeper commitment to health equity by OHA and in the legislature.

As OHA implements these commitments and investments, its work will be guided by collaboration with community partners, especially those individuals and communities most harmed by health inequities stemming from contemporary and historical racism, oppression, discrimination, bigotry and bias.

Overview of an Historic and Transformative Budget

The top-line numbers for OHA's 2021-2023 budget, including the main budget bill plus several standalone bills, are:

- $30.2 billion in total funds, up from $25.6 billion last biennium.
- $3.5 billion in state general funds, up from $2.4 billion.

- 4,763 positions, up from 4,440.

A legislative report describing OHA's budget in more detail can be found at (https://olis.oregonlegislature.gov/liz/2021R1/Downloads/CommitteeMeetingDocument/245640).

HB 5024 – the main budget bill – fully funds OHA's current service levels. That means, for the coming biennium, OHA generally will provide the same services it provided last biennium to Oregonians who need them. In particular, the Oregon Health Plan (OHP) is fully funded with no service cuts, even though membership has increased greatly due to COVID-19. Fully funding OHP is a critical element of working towards eliminating health inequities by 2030.

In addition, the budget makes other major investments in health equity, behavioral health, and public health. Through these investments, the legislatively approved budget for OHA will allow for important transformations in how the agency delivers services, thereby enabling OHA to better serve and meet the needs of Oregonians. (Dollar amounts are from the state general fund unless noted. Also, many of the bills discussed below have their own funding separate from HB 5024.)

Health Equity

- $6.8 million ($5.5 million state general fund, $0.5 million other state funds, $0.9 million federal) to build and sustain health equity infrastructure.
- $400,000 ($288,000 state general fund, $24,000 other state funds, $47,000 federal) to create a Tribal Traditional Health Worker category.
- $15 million ($1.4 million state general fund, $13.5 million federal) to operate Indian Managed Care Entities.

Behavioral Health

- $130 million ($65 million state general fund, $65 million federal) to increase residential treatment, services and housing for people with behavioral health needs.
- $121 million ($24.5 million state general fund, $96.5 million federal) for certified community behavioral health clinics (CCBHCs).
- $50 million for transformation and system alignment in the behavioral health system.
- $31 million to open two, 24-bed patient units at Oregon State Hospital.
- $21.5 million ($19.2 million state general fund, $2.3 million federal) for community services for "Aid & Assist" patients.
- $20 million set aside for Oregon State Hospital staffing.
- $302 million (other funds) for addiction and recovery services called for in Ballot Measure 110, and backfills the $70 million that Ballot Measure 110 had redirected from other critical behavioral health services.

Public Health

- $45 million for public health modernization.

- $7.8 million ($4.6 million state general fund, $3.2 million federal) for universally offered home visiting for newborns.
- $2.2 million for initial implementation of psilocybin services established by Ballot Measure 109.
- $1.2 million to restore funding to the Oregon WIC Program and Oregon Farm Direct Nutrition Program, which serves low-income seniors and WIC families.

Improving Access and Quality of Behavioral Health Services and Decreasing Behavioral Health Inequities

Behavioral health received critical attention in the legislature this year, in several wide-ranging bills. Furthermore, the new OHA budget includes the legislature's largest ever investment focused on behavioral health. Taken together, several initiatives aim to provide needed behavioral health services, while also transforming the entire behavioral health system to one that is simple, responsive, and meaningful for the people it serves. OHA will do this with active involvement of the people and communities who have faced behavioral health challenges and inequities.

1. Increase Accountability and Quality of Behavioral Health Services (HB 2086)

Beginning with the recommendations of Governor Brown's Behavioral Health Advisory Council, over the course of the legislative session HB 2086 became an even more comprehensive behavioral health bill. The bill calls for: enhanced support for culturally-specific peer led services, including support for tribal-based practices; integrated treatment for co-occurring disorders (substance addiction and mental health disorders together); reduction of administrative burdens in behavioral health clinical documentation and reporting; an analysis of pay and equity disparities affecting the behavioral health workforce; high quality and rapid access to alcohol and drug treatment as guided by the Alcohol & Drug Policy Commission; specialized housing navigation assistance; expansion and enhancement of the child, family and adolescent behavioral health system specific to access of services at all levels of care that is driven by real-time data; and more. All of these enhancements are intended to be linked to a new accountability program that takes up the Governor's Behavioral Health Advisory Council's system transformation recommendations and creates new requirements, structures and incentives for OHA, payors, and providers to engage with people they serve and work together to make the behavioral health system function better as a whole. The accountability program is designed to apply directly to both payors and providers with stronger oversight by OHA and the Oregon Health Policy Board (OHPB). It provides greater transparency and accountability not only for new investments but also for OHA's existing behavioral health infrastructure. The program is directly linked to OHA's 2021-2023 budget, HB 5024. The metrics and outcomes defined by the HB 2086 process will be integrated into contracts and grants provided by the regional development and innovation fund established in HB 5024. Furthermore, the rules and contracts involved in this effort will be written and negotiated with input from people with lived experience, communities, and providers.

2. Fund Behavioral Health Housing (HB 5024-OHA Budget)

OHA's budget includes $130 million ($65 million general fund and $65 million from the federal American Rescue Plan Act) for capital, start-up, and operational costs related to increasing statewide capacity of licensed

residential facilities and housing for people with behavioral health needs. A budget note establishes a planning grant process and criteria related to these funds.

3. Fund Certified Community Behavioral Health Clinics (HB 5024-OHA Budget)

OHA's budget includes $121 million ($24.5 million state general fund, $96.5 million federal) for certified community behavioral health clinics (CCBHCs). These funds will enable existing CCBHCs to provide services through the 2021-23 biennium. Also, OHA will evaluate the CCBHC model in Oregon and report findings to the legislature.

4. Strengthen the Crisis Care System (HB 2417)

HB 2417 aims to build upon and improve Oregon's statewide coordinated crisis system. It outlines the expectations for local mobile crisis intervention teams, crisis stabilization centers, and other behavioral supports. This includes a 9-8-8 phone line (like 9-1-1 but focused on behavioral health) to provide behavioral health crisis intervention services and crisis care coordination anywhere in the state 24 hours per day, seven days per week, 365 days per year.

5. Support Drug Addiction and Recovery Services (HB 5024-OHA Budget, SB 755)

In November 2020, Oregon voters approved Ballot Measure 110, which aims to establish a more health-based, equitable, and effective approach to treating substance use disorders by shifting the response to drug possession from criminalization to treatment and recovery. The legislature funded the $302 million for addiction and recovery services called for in the measure, and also backfilled the $70 million that Ballot Measure 110 had redirected from other needed behavioral health services. In addition, SB 755, which was developed cooperatively with advocates of the measure, clarified several aspects of the new law so that it can be implemented more effectively.

6. Strengthen the Behavioral Health Workforce (HB 2949)

Oregon needs a behavioral health workforce that is stronger, more diverse, more culturally responsive, and better supported. HB 2949 provides incentives to increase the recruitment, retention, and diversification of the behavioral health workforce in addition to using incentives to increase Oregonians' access to culturally responsive services. The types of incentives specified in the bill include pipeline development, scholarships for undergraduates and stipends for graduate students, loan repayments, and retention activities. It provides $60 million to increase training for diverse behavioral health professionals, both licensed and non-licensed, and $20 million for a grant program to licensed behavioral health professionals to provide supervised clinical experience to associates or other individuals who have the necessary education but need supervised clinical experience to obtain a license to practice. The bill also requires OHA to coordinate with the Higher Education Coordinating Commission in considering investments in the behavioral health workforce.

7. Promote Peer Respite Services (HB 2980)

HB 2980 provides $6 million for peer-run organizations in the Portland metropolitan area, southern Oregon region, Oregon coast, and eastern and central Oregon region to operate peer respite centers. These peer respite services aid individuals with behavioral health challenges or trauma response symptoms who experience acute distress, anxiety, or emotional pain that may lead to need for higher level of care. At least one of the peer respite centers must participate in a project designed specifically to provide culturally responsive services to historically underrepresented communities.

8. Ensure Mental Health Parity (HB 3046)

HB 3046 aims to ensure that treatment and services for mental health and substance use disorders are provided in a broadly similar manner to comparable physical health services, including provider reimbursement. The bill requires CCOs to provide information to OHA on treatment limitations and denials of behavioral health services and requires OHA to annually report on CCO compliance with federal parity law, adequacy of provider networks, and coverage of behavioral health services.

9. Maintain the Prescription Drugs Monitoring Program (HB 2074)

The Prescription Drug Monitoring Program (PDMP) allows prescribers to be fully informed of the prescription history of their patients when prescribing controlled substances. Since it was created in statute in 2019, the PDMP has expanded substantially in both function and size. Various enhancements brought the PDMP in line with legislative mandates and with emerging best practices, including interstate data sharing, health information technology (HIT) integration, improved user interface, and collection of additional drugs and fields for clinical use and research purposes. However, this growth increased the cost of operation so that it is no longer covered by the $25 annual fee paid by Oregon healthcare licensees. HB 2074 increases that fee to $35, to maintain sufficient capacity for program operations and database functions.

10. Funding Aid and Assist Community Services (HB 5024-OHA Budget)

OHA's budget includes $21.5 million for community restoration and clinical services, rental assistance and wraparound support, and OHA operations for supporting individuals who have been ordered by a court to receive services enabling them to "aid and assist" in their own criminal defense. The goal is to allow these patients to be served in their communities, when medically appropriate, in order to serve better them, avoid having them staying in local hospitals or jails, and free up space at the Oregon State Hospital for patients who need to be served there.

11. Oregon State Hospital Funding (HB 5024-OHA Budget)

OHA's budget includes $31 million general fund and 110 positions to open two 24-bed patient units at the Oregon State Hospital Junction City campus. These units will enable the Salem campus to make available more bed space to admit additional "aid and assist" patients. Separately, it establishes a $20 million appropriation to the Emergency Board to be available for supporting state hospital staffing levels contingent on OHA working with staff and other stakeholders to establish a sustainable plan. In addition, the capital budget includes funds for several deferred maintenance projects at the state hospital.

12. Oregon State Hospital Technical Corrections (SB 72)

SB 72 provides two statutory changes to ensure appropriate and efficient procedures at Oregon State Hospital (OSH). 1) A technical fix to ORS 127.720 to include ORS 426.701 to the list of types of commitments cited in the statute. ORS 426.701 took effect after ORS 127.720 was last amended and therefore was inadvertently excluded. 2) Allowing OSH to include outpatient services in the cost of care to a patient while at the state hospital. While OSH has a medical and dental clinic, patients at OSH come to the hospital with a variety of medical needs, some of which require sending patients to receive care at a facility outside OSH.

Reducing Barriers to Health and Addressing Health Inequities in our Communities

Health inequities are created by a variety of issues, most notably systemic injustices that lead to inequitable outcomes due to societal barriers related to race, ethnicity, tribal affiliation, gender, gender identity, sexual orientation, and disabilities. The local circumstances in which each of us lives – including local public health services, environmental conditions, and availability of healthy housing, food, and recreation opportunities – can affect our health even more than access to healthcare services, but access to healthy communities is not equitable in Oregon. Critical needs include improved equity in communicable disease and emergency preparedness, more community voice in public health decision making, and climate mitigation strategies that center equity. Building healthier communities in large and small ways, together, especially in those places where people experience worse health outcomes and inequities, will help Oregonians be healthier and better advance health equity.

13. Modernize Public Health (HB 5024-OHA Budget)

For the past two biennia, the legislature has invested in modernizing state, local, and Tribal public health to more nimbly respond to emerging health issues. This biennium, the legislature added $45 million general fund to continue this work. Coupled with the $15 million general fund appropriated in the last biennium, which is now part of the base budget, there will be a total of over $60 million available for public health modernization. The funding will largely support local public health authorities, community-based organizations, and Tribes to improve health outcomes through communicable disease control, emergency preparedness and response, health equity initiatives, and environmental health.

14. Build Health Equity Infrastructure (HB 5024-OHA Budget)

OHA's budget devotes $6.8 million to build and sustain health equity infrastructure within OHA and throughout Oregon. The addition of 17 new positions in the Division of Equity and Inclusion ensures that OHA has the programmatic, resource, operational, and staffing capacity that is critical to the goal of eliminating health inequities in Oregon by 2030. Among other things, this additional staff capacity buys increased expertise and capacity for community engagement and outreach. Investing in continuous and meaningful community engagement is essential to build trust and relationships with communities that experience the greatest health inequities due to structural and institutionalized oppression and racism. These include communities of color, people with disabilities, LGBTQ communities, immigrants, refugees, people with limited English proficiency, Tribes, and communities at the intersection of these identities. It is critical that OHA shift away from models

where interactions with communities are transactional and largely occur only when the agency needs input or feedback for its own initiatives. The difference, from the perspective of those communities, lies in the opportunity to share in setting the agenda and making the decisions on policies and distribution of resources. Building on past work, this new investment will enable OHA to understand better the social determinants of health and health inequities, invest in continuous and meaningful community engagement, identify and prioritize community needs, and ultimately – with partners – develop innovative and sustainable solutions to achieve health equity. (Also, this funding is separate from a recent $33.9 million federal grant to advance health equity, which will establish 17 positions in the Public Health Division and provide resources to community-based organizations and Tribes. The budget bill formally incorporates that grant into OHA's budget.)

15. Expand Regional Health Equity Coalitions (SB 70)

SB 70 expands the statewide Regional Health Equity Coalition (RHEC) program, and also defines RHECs and the RHEC model in statute to ensure that they meet the same standards in serving their regions. The RHECs have the expertise based in lived experience to identify the most critical and regionally specific health equity issues, while crafting policy, system, and environmental solutions. Meaningfully impacting these issues and health inequities requires sustained, long-term efforts with dedicated funding. Specific benefits of sustained and expanded funding include: increased opportunities for coordinated care organizations (CCOs) to partner with RHECs and to offer technical assistance and training to build CCO capacity around health equity and the social determinants of health; providing coalitions the level of autonomy needed to improve health equity in meaningful and appropriate ways that ensures anti-racist priorities are not compromised; growing the necessary capacity of Oregon to address health equity in culturally specific and effective ways; and creating additional opportunities to sustainably address policy and system barriers.

16. Expand and Sustain Tribal Traditional Health Workers (HB 2088)

HB 2088 creates a sixth traditional health worker (THW) category specifically for and at the request of Tribes. Tribes are already providing critical health services to Tribal members, but many of these providers and practices do not fit within the five existing THW categories. Creating a sixth, separate THW category for Tribes would allow the Tribes and urban Indian health program to receive reimbursement using Tribal based practices and curricula developed by the Tribes themselves.

17. Recognize Racism as a Public Health Crisis (HR 6)

Some communities in Oregon, notably African American and Black, Native American and Alaska Native, Asian and Pacific Islander, and Latino/Latina/Latinx and Hispanic communities, experience consistently poorer health outcomes as measured in higher prevalence of chronic diseases, higher rates of infant and maternal mortality, shorter lifespans, and more. These health inequities fundamentally result from a history of systemic and contemporary racism in our society, and from current policies that perpetuate racist systems. HR 6 is the legislature's first explicit recognition of racism as a public health crisis.

18. Create Tobacco Retail Licensure (SB 587)

Even as tobacco use remains the top preventable cause of death and disability in Oregon, no state license has been required to sell tobacco products or inhalant delivery systems (IDS). In 2019, 16% of Oregon tobacco retailers illegally sold a tobacco product to a person under the age of 21. Without a state license, there is limited capacity to effectively enforce tobacco sales laws such as the minimum legal sales age. Through SB 587, tobacco retailer licensure will ensure retail store owners are following other state and local tobacco regulations and are held accountable for illegally selling tobacco to underage persons. Tobacco retail licensing fees allow for sustainable administration and enforcement of the program, including regular inspection. Enforcement action is taken on the retailers, not on the underage buyer. Other states with tobacco retail licenses show that it can reduce youth access to tobacco products.

19. Prohibit Remote Sales of Inhalant Delivery Systems (HB 2261)

Another important way to reduce the impact of tobacco products is to prohibit online and telephonic sale of inhalant delivery systems (IDS, also known as vaping products or e-cigarettes). From 2017-2019, use of inhalant delivery systems by Oregon 11th graders increased 80%. HB 2261 will reduce access and availability of IDS by removing online and retail sales mechanisms for purchasers in Oregon. It also means the rules for IDS sales will be the same as for cigarettes.

20. Improve Home Health Care Oversight (HB 2072)

Home health agencies provide skilled nursing services and other therapeutic services to patients in their homes. OHA is responsible for ensuring the quality of client care, conducting complaint investigations, and undertaking triennial surveys. Current fee levels do not support the cost of the regular surveys and complaint investigations. HB 2072 raises fees to support the necessary regulation of home health licensees and in doing so to protect Oregonians receiving their services.

21. Establish Healthy Homes Program (HB 2842)

HB 2842 establishes a Healthy Homes Program to provide financial assistance for repair, rehabilitation, and health and safety upgrades to residential housing occupied by members of low income and environmental justice communities. It provides a $10 million Healthy Homes Repair Fund and directs OHA to award grants to local governments, non-profit organizations, Oregon's nine federally-recognized Tribes, and nonprofit housing assistance programs, who in turn can provide financial assistance to low income households to repair and rehabilitate dwellings.

22. Sustain Radiation Protection Services (HB 2075)

Radiation Protection Services (RPS) is the state radiation control program protecting Oregonians from unnecessary or harmful exposure from radiation and promoting beneficial uses of radiation. The program regulates over 4,200 registrants and licensees who provide services to patients and the public using 14,000 radiation devices and sources for medical, industrial, academic and research applications. Without additional funding to meet increasing demand, RPS will not be able to complete facility inspections of all registrants to ensure radiation devices/sources are being used safely and within manufacturer specifications. HB 2075 raises

several fees paid by registrants and licensees, which will also better align Oregon's fee structure with the Washington and California tube-based fee models and ensure that registrants are paying a fee based on the cost of inspection.

23. Remediate Lead-Based Paint Hazards (HB 2077)

Lead-based paint continues to be a critical environmental health risk that impacts brain development particularly for young children. Despite having delegated authority to enforce federal regulations on lead-based paint, OHA does not have the authority to require property owners, schools, or childcare centers to properly assess and decontaminate a residence or facility. OHA can issue a citation if work was performed by uncertified firms or if lead-safe work practices were not followed, but it cannot mandate cleanup or issue stop-work orders in case of ongoing unsafe work. HB 2077 adds statutory authority for OHA to compel cleanup of a lead-contaminated site when OHA has determined that a property owner has violated lead-based paint requirements, and to issue a stop-work order if necessary.

24. Fund Universally Offered Home Visiting (HB 5024-OHA Budget)

OHA's budget includes $7.8 million (including $4.6 million general fund) to continue the phased roll-out of universally offered home visiting program approved in 2019.

25. Technical Fixes for Public Health (SB 64)

SB 64 contains several minor fixes to ease implementation of public health laws, including: bringing state law into alignment with federal regulations on lead-based paint remediation; clarifying the definitions of "health officer" and "local public health administrator"; and allowing School Health Services Planning Grant Sites to pursue either a School-Based Health Center (SBHC) or an alternative model (school nursing) as best fits their community needs.

Reducing Health Inequities in the Healthcare System and Realizing Better Care, Better Health, and Lower Costs

Oregon's overall health care system can be a powerful tool to reduce health inequities, improve care, and help Oregonians be healthier, all at a lower cost. This year, the legislature took several initiatives aimed at ensuring that the entire system – including public and private payors – works better for the people of Oregon.

26. Maintain Current OHA Services (HB 5024-OHA Budget)

HB 5024, OHA's budget bill fully funds OHA's current service levels. For the coming biennium, OHA generally will provide the same services it provided last biennium to Oregonians who need them. Most notably, the Oregon Health Plan (OHP) is fully funded, with no service cuts, even though membership has increased greatly due to COVID-19. (Under emergency public health rules members have automatically been kept enrolled, whereas normally some would leave OHP every month.) The bulk of OHA's overall budget increase is tied to this caseload increase, as well as to inflation in OHP and other programs.

27. Cover All People (HB 3352)

HB 3352 expands the existing Cover All Kids program into the Cover All People program to provide affordable healthcare access to Oregonians who would be eligible for the Oregon Health Plan but for immigration status. The COVID-19 pandemic demonstrated again the importance of access to healthcare coverage, as people without access for testing and treatment suffered worse health outcomes. This was especially true among undocumented Oregonians, who are the largest remaining group in the state without access to coverage. The Cover All People concept was a priority recommendation of the Racial Justice Commission. The bill provides $100 million to fund the program for the next two years and directs OHA to develop an implementation plan that centers input from impacted communities. Legislators expressed an intent to review the program to determine appropriate funding levels for future biennia.

28. Collect Complete and Diverse Data (HB 3159)

Better, more complete data are critical to understanding health inequities and directing resources to eliminate them. Granularity in data collection assures that populations most affected by inequities are recognized, resourced, and supported in shaping policies and programs to address the inequities. Again, the COVID-19 pandemic highlighted the need for better data, especially relating to African American and Black, Native American and Alaska Native, Asian and Pacific Islander, and Latino/Latina/Latinx and Hispanic communities; whenever the data allowed for distinguishing smaller populations distinct from the overall population, it exposed the differential impacts on some populations and thus the need for greater and different responses required to serve those populations. HB 3159, known as the Data Justice Act, ensures that all surveys, data bases, and programs of OHA and the Oregon Department of Human Services collect complete data on race, ethnicity, language, and disability (REALD) and sexual orientation and gender identity (SOGI). It also requires health care providers, insurers, and CCOs to submit REALD and SOGI data to a registry developed by OHA. With the passage of this bill, Oregon leads the nation in data collection in areas of disability, sexual orientation, and gender identity, and goes above and beyond minimum federal standards for collecting race and ethnicity data.

29. Expand Telehealth Services (HB 2508)

During the pandemic, providing health services via telehealth became necessary. When done appropriately, telehealth can be highly effective and also cost-effective. HB 2508 expands coverage of, and reimbursement for, telehealth services in Oregon. Among other things, it requires the Oregon Health Plan and commercial insurance carriers to cover and reimburse telehealth services at the same rates as in-person services, requires health plans to ensure meaningful access to telehealth, and ensures that interpreters are reimbursed at the same rates as in-person.

30. Improve Language Access and Health Care Interpreters (HB 2359)

Quality language access services can improve health outcomes for patients who speak languages other than English or people who use sign language. HB 2359 requires OHA to train and certify or qualify health care interpreters and to maintain a central registry of certified or qualified health care interpreters. Health care

providers are required to work with health care interpreters from that registry. This needed step further professionalizes Oregon's health care interpreter workforce and ensures that a stable supply of quality trained interpreters is available across the state, especially in rural communities experiencing growth in populations who speak languages other than English.

31. Declare Access to Health Care a Right (SJR 12)

SJR 12 places a constitutional amendment on the 2022 general election ballot for consideration by voters. If approved, it would require the state to ensure that every resident of Oregon has access to cost-effective, clinically appropriate, and affordable health care as a fundamental right. This obligation must be balanced against the public interest in funding public schools and other essential public services.

32. Plan a Public Option (HB 2010)

HB 2010 directs OHA, in collaboration with the Department of Consumer and Business Services (DCBS), to develop a plan for implementing a public option health care plan to be offered to consumers on the individual market, and potentially in the small group market, for enrollment in 2024. OHA and DCBS are to report to the legislature on the implementation plan by January 1, 2022.

33. Provide Managed Care for Tribal Members (HB 5024-OHA Budget)

OHA's budget includes $15 million ($1.4 million state general fund, $13.5 million federal) to operate Indian Managed Care Entities. These entities will provide care coordination similar to how CCOs work for members of Oregon's nine federally recognized Tribes and Alaska Natives on the Oregon Health Plan, but specific to the needs of Tribal members.

34. Enforce Cost Growth of Health Care (HB 2081)

HB 2081 provides OHA with authority to implement mechanisms to hold insures and providers accountable for containing health care costs and meeting the annual 3.4% cost growth target established by SB 889 in 2019 and adopted by the Oregon Health Policy Board. SB 889 directed the OHA to work with stakeholders and consumers to set a Sustainable Health Care Cost Growth Target that would apply to insurance companies, hospitals and healthcare providers, so that healthcare costs do not outpace wages or the state's economy. HB 2081 adds Performance Improvement Plans as the first accountability mechanism for payers and provider organizations that exceed the cost growth target and provides for financial penalties.

35. Expand Dental Therapy Licensure (HB 2528)

HB 2528 expands dental therapist licensing, under the supervision of a dentist, to provide for services to underserved populations and patients in dental care health professional shortage areas. This expansion of services ensures broader and more timely access in communities where dental care services are lacking.

36. Leverage the Purchasing Power of the Marketplace (SB 65)

Currently, the Department of Consumer and Business Services (DCBS) administers the Health Insurance Exchange (the Marketplace) for purchasing health plan coverage under the Affordable Care Act (ACA). SB 65 moves responsibility for running the Marketplace to OHA. This will allow OHA to coordinate improving quality and reducing cost in health care coverage across Medicaid, public employee plans, and ACA plans sold through the Marketplace. It will significantly enhance OHA's ability to align new payment methodologies and expand on models for better coordinating patient care and health equity.

37. Review Health Care Mergers and Acquisitions for Access and Equity (HB 2362)

In order to ensure Oregon's private market health care system transformation aligns with the state's core priority health care principles of better care, better health, and lower costs – and the health equity strategic goal – HB 2362 provides enhanced regulatory authority over certain proposed mergers and acquisitions involving major health systems in Oregon. The process will guarantee transparency and provide an opportunity for public input on whether a proposed merger and acquisition is warranted, to protect against loss of access to health care services and increased costs.

38. Support Ground Emergency Medical Transport Services (HB 2910)

HB 2910 allows OHA to seek approval from the federal Centers for Medicare and Medicaid Services (CMS) for a supplemental payment program for privately operated ambulance service agencies. If approved, OHA will annually assess a quality assurance fee on each emergency medical transport provided by a private ambulance service. Ambulance service agencies will be reimbursed for an emergency medical service transport by a formula prescribed in the bill. A portion of the reimbursement funds must be used to increase wages and benefits of employees. Additionally, the bill raises ambulance service and ambulance vehicle licensing fees to support regulatory oversight of the agencies and vehicles.

39. Technical Fixes for Health Policy and Analytics (HB 2078)

HB 2078 makes minor technical corrections to implement existing statutes as intended. The changes include: repealing the Common Credentialing program; eliminating the requirement for the Pain Management Commission to perform curriculum reviews; revising requirements for licensed professionals to periodically complete a pain management education program; and amending PEBB's statute so it aligns with the Affordable Care Act regarding the coverage of temporary employees.

40. Oregon Essential Workforce Health Care Program (SB 800)

SB 800 establishes Oregon Essential Workforce Health Care Program in OHA to provide supplemental payments, as approved by CMS, to long term care facilities, residential facilities and in-home care agencies that elect to participate and meet specified requirements, to be used to provide health care benefits to employees of facilities.

41. Requirements for CCO Equity Investments (HB 3353)

HB 3353 requires OHA to seek federal approval of amendment to state Medicaid demonstration project to permit CCOs to use portion of global budgets to improve health equity, improve overall health of community or enhance payments to providers who advance health equity to provide services improving overall health of community and to allow such expenditures to be counted as medical expense in CCO's base medical budget and in calculation of global budget and flexible spending for given year.

K. Litigation status

Family Care v. OHA
A former coordinated care organization (CCO), FamilyCare, has filed a lawsuit making the following claims against OHA and its former Director: a federal civil rights claim against the former Director; breach of a settlement agreement between OHA and the CCO; and breach of OHA and the CCO's contract governing the CCO's participation in the Oregon Health Plan. A motion to dismiss the last claim is presently pending. The case is set for trial beginning on April 25, 2022.

Bay Area Hospital v. Oregon Health Authority
In December of 2019, Bay Area Hospital, formed by a health district, filed an administrative appeal to challenge a supplemental assessment on hospitals to support the Oregon Health Plan. According to the request for hearing, the supplemental assessment constitutes a tax that may not be imposed on hospitals created by health districts absent an affirmative legislative declaration. Hospital sought refund with interest. A final order denying the hospital's appeal was issued July 30, 2020. Hospital has petitioned for review in the Oregon Court of Appeals, and oral argument is expected November 18, 2021.

Connecticut v. Generic Drug Manufacturers and Wisconsin v. Indivior
These are multi-state antitrust suits that include the State of Oregon in its enforcement capacity (not the agency specifically). Among other claims, the suits allege pharmaceutical manufacturers illegally colluded to raise prices on certain drugs. There is potential for recovery for the agency for purchases/reimbursements of the drugs at issue; the State is working with the agencies to collect the applicable data.

Sarepta Therapeutics Inc. v. OHA
This is a petition for judicial review of the agency's prior authorization criteria that are the rule for determination for Oregon Health Plan coverage of the prescription medication Exondys 51.
The parties submitted briefs regarding the validity of the prior authorization criteria, and the case was argued before the Oregon Court of Appeals on March 12, 2021. A decision by the court is presently pending.

Cal. et. al v. Azar.
Oregon is a co-plaintiff in litigation challenging CMS's Rule revision which removed the ability of the state Medicaid agency to deduct union dues and other voluntary deductions such as health insurance premiums from the providers' payment for services and direct those moneys to third parties. A recent NPRM effectively reverses CMS's Rule revision, which has been enjoined in California et al. v. Azar, 501 F.Supp.3d 830 (N.D. Cal. 2020).

L. Public forums

Medicaid Advisory Committee (MAC)

The Medicaid Advisory Committee is a federally mandated body that advises the State Medicaid Director and the Oregon Health Policy Board on the policies, procedures, and operation of Oregon's Medicaid program through a consumer and community lens. The MAC met nine times between 7/1/20 and 6/30/21; details of public comment at each meeting along with agenda topics are summarized below.

July 29, 2020 Meeting:
Public Comment: The committee received public comment regarding asset or income limitations for people with disabilities for Medicaid and a suggestion to consider Washington's Apple Health as a model for workers with disabilities legislation.
Committee members discussed the following topics:

- MAC Charter Revisions
- DHS/OHA Updates
- Ombuds Program Report
- MAC Workplan overview

September 30, 2020 Meeting:
There was no public comment.
MAC members discussed the items below; of note was an in-depth discussion about screening for social needs

- Screening for Social Needs Development
- Consumer Assessment of Health Providers and Systems (CAHPS) – 2019 Findings
- Senate Bill 1041: Overview and MAC Role
- DHS/OHA Update

October 28, 2020 Meeting:
There was no public comment.
MAC members discussed the following

- Review of MAC bylaws
- State Health Improvement Program
- Behavioral Health Support Programs & CARES Act Funding
- DHS/OHA Agency Update
- Ombuds Program Quarterly Update

December 2, 2020 Meeting:
There was no public comment.
MAC members discussed the following topics:

- COVID-19 – Impact on Social Needs
- Medicaid Quality Strategy
- Community Advisory Council – Panel Discussion
- Innovator Agent Update

January 27, 2021 Meeting:
Public Comment:
1. An OHP member who is enrolled in a coordinated care organization (CCO) commented on challenges with the CCO grievance and appeal process, including a lack of continuity across interactions, misinformation or conflicting information from staff members, and written notices that require legal assistance to understand.

2. A billing manager for a medical supply company asked if there are any COVID-related changes or waivers to ensure patient access to DME; due to COVID, fewer patients are receiving in-person care which has made it more challenging to get provider signatures on orders and/or renewal, resulting in DME fulfillment delays or access challenges for patients.

Meeting topics included:

- Agency updates from DHS and OHA
- Legislative Update
- Advancing Consumer Experience – Subcommittee Update
- Health-related services Spending Trend for CCOs*
- Oregon Health Policy Board Retreat and MAC

February 24, 2021 Meeting

There was no public comment.

MAC members discussed the following:

- Agency Updates for OHA and DHS
- Healthcare Interpreter Report Findings
- Medicaid Quality Strategy
- Telehealth Workgroup
- Oregon Health Policy Board Retreat

April 28, 2021 Meeting

Public Comment: The committee received a comment expressing appreciation for the Ombuds program report, particularly about access to mental health and substance use disorder (SUD) services and consumer understanding of plan benefits.

The MAC discussed the following:

- 1115 Waiver Renewal
- Legislative Update ODDS and APD
- OHA Legislative Update
- Advancing Consumer Experience Subcommittee Findings

May 26, 2021 Meeting

There was no public comment.

The MAC discussed the following:

- CCO Health Equity Report Findings
- COVID Vaccination Discussion
- OHA CCO 2.0 Update
- 1115 Waiver Renewal

June 30, 2021 Meeting

There was no public comment.

- The MAC discussed the following:
- Equity-centered Program Design & COVID Vaccine Complaint Unit
- MAC Letter (Draft) – COVID Vaccination Barriers
- Ombuds Quarterly Report
- 1115 Waiver Renewal Concept Papers
- Advancing Consumer Experience – Draft Report

Health Evidence Review Commission (HERC)
August 13, 2020
This testimony concerned coverage of Cologuard.

Melissa Wood from Exact Sciences joined the meeting. She said she was unaware that HERC would be taking up this topic in the afternoon. She thought the decision this morning was *to table* discussion. She added that the cost information the Commission was working with needed to be updated. She said that everyone in the state of Oregon is covered for Cologuard except Medicaid.

This testimony concerned the Guideline Note 60 for Opioids for Back and Neck Pain.

Amara M. is a volunteer advocate for the Oregon Pain Action group and declared no conflicts of interest. She said she is a persistent pain patient recently diagnosed with Ehlers-Danlos syndrome (EDS). She said Oregon is now one of the worst states to live in for someone on Medicaid who lives in intractable pain. She said Guideline Note 60 is an over-reach. She urged HERC to delve into this further.

Koa Kai is an advocate and an ambassador for the chronic disease coalition and declared no conflicts of interest. She said Guideline Note 60 was created based on expert opinion and not on evidence. Many would argue it is a case-study in conflicts of interest and lack of ethics. HERC has never performed patient outcome research regarding Guideline Note 60. She said without this critical data we must rely on antidotal evidence, including public comments. According to the Oregon's Death with Dignity Act data, the number of patients who used this program in 2019 who cited inadequate pain control or had concerns about it increased 33% from the year prior. This shocking data alone should cause HERC to repudiate the guideline note. Although the clause "when clinically indicated" was added in the middle of aggressive taper language, the rest of the guideline note instructions are confusing for the providers and that clause is likely to be overlooked. The overall sentiment has not changed: *Do not prescribe opioids and taper patients who are on them*. The taskforce is exceeding its authority by essentially requiring physicians, through its aggressive policy language, to forego clinical judgement for a one-size-fits-all barrier to medically necessary treatment for the most vulnerable and medically complex patients. Complementary and medication treatments should both be offered to patients.

Stephen Hix is a chronic pain patient and an advocate for himself and others. He agreed with both speakers who came before him. He reminded the Commission that Dr. Beth Darnell offered to give HERC a free pain program and that wasn't taken advantage of. He said that the CDC said the guidelines have been drastically misinterpreted. He said he is praying for the day that doctors can practice medicine. He said he was functional on narcotics for a decade before it was taken away from him.

This testimony concerned the Coverage Guidance on Planned Out-of-Hospital Birth (OOHB) being recommended by the Evidence-based Guidelines Subcommittee and corresponding changes to the Prioritized List discussed by the Value-based Benefits Subcommittee (VbBS).

Silke Akerson CPM, LDM declared no conflicts of interest. She said the Evidence-based Guidelines Subcommittee (EbGS) process had been very robust. The revised coverage guidance and guideline will improve access to care and choice for patients. She said Oregon is one of the few states that has accurate data on outcomes for planned OOHB. Many of the studies quoted are nationwide studies and some show

increased neonatal mortality; however, in Oregon, the data shows rate of perinatal mortality 2015-2018 was similar to planned hospital delivery. She said national data on risk of severe hemorrhage, evidence is not that there is increased risk of severe hemorrhage but that is only in states where midwives don't have access to anti-hemorrhagic medications.

HERC Value-based Benefits Subcommittee
August 13, 2020

This testimony concerned polydactyly of the foot, flat foot, and tarsal coalition.

Testimony was heard from Dr. Justin Roth, a pediatric orthopedist. He agrees with the staff proposed coding changes and guideline. He noted that polydactyly of the foot occurs in about 1 in 1,000 children. The older treatment was rubber band amputation, which can result in painful neuroma. Orthopedists now do surgical correction of the condition to avoid nerve issues. Many of these patients are getting care currently at the Shriner's hospital, which is likely why this has not been brought to the HERC as an issue in the past.

Dr. Roth also addressed flat foot and tarsal coalition. The only way to get to a calcaneovalgus foot is to have a tarsal coalition that is untreated. Tarsal coalition "locks" the foot up and interferes with foot growth and development. Treatment of tarsal coalition is a more common procedure done by pediatric orthopedics. Calcaneovalgus repair is a large surgery that takes multiple hours of anesthesia. Tarsal coalition can be done in an ambulatory surgery center and is less invasive. He recommends coverage for children aged 14 or 15 and under. He noted that the foot becomes painful and more rigid about age 10 or so. After age 15, deformity becomes more rigid and person has learned to live with deformity. He will try to put together evidence regarding these conditions and bring this to HERC staff for consideration of these topics in the future. Olson wanted information on the data on rate of progression from calcaneouvalgus as part of that future review.

This testimony concerned the Guideline Note 60 for Opioids for Back and Neck Pain

Amara M, **Steven Hicks** and **Koa Kai** offered similar testimony as they did at the Health Evidence Review Commission meeting held the same day.

This testimony concerned coverage of Cologuard

Testimony was heard from **Dr. Paul Limburg,** from Exact Sciences, who receives royalties related to Cologuard. Colorectal cancer (CRC) is a major public health concern. MT-sDNA (also known as FIT-DNA) can increase the screening uptake in the population. Screening can result in treatment to prevent cancer or detection of a cancer diagnosis at a lower stage where there are better outcomes. Screening needs to be promoted. About one third of all screen eligible adults are not up to date on CRC screening. USPSTF and NCCN recommend choice and judge all screening modalities as equivalent. The Imperiale study found Cologuard outperformed FIT in all areas. Specificity for FIT is 95% per year, Cologuard is 87% per three years. At 3 years, the number of false positives are same between Fit and Cologuard. He reported that there are additional costs with FIT testing of $153. Cologuard has navigation support that increases the adherence rate for follow up. About 71% of patients with a Cologuard order follows up on their order. Home based screening options are better than screening modalities requiring a provider visit during COVID times.

Limburg noted that Cologuard can be a completely home-based option, which is important in the COVID epidemic. The Medicare reimbursement rate is $508.87.

This testimony concerned the Coverage Guidance on Planned Out-of-Hospital Birth (OOHB) being recommended by the Evidence-based Guidelines Subcommittee.

Silke Akerson, CPM, LDM offered similar testimony as she did at the Health Evidence Review Commission meeting held the same day.

HERC Evidence-based Guidelines Subcommittee
September 10, 2020

Testimony concerning the Multicomponent Interventions to Improve Screening for Breast, Cervical or Colorectal Cancer was heard.

Melissa Wood, manager of the Government Relations, noted that her conflict of interest was working for the manufacturer, Exact Sciences, of Cologuard. Ms. Wood stated that she can take any questions regarding this report and the coverage of Cologuard for OHP. Gingerich said that the full HERC may reconsider Cologuard coverage at the time that the full HERC reviews this report. Kansagara thanked Ms. Wood for her comments.

Health Evidence Review Commission (HERC)
October 1, 2020

This testimony concerned coverage of Cologuard.

Melissa Wood, from Exact Sciences, the developer and marketer of Cologuard, provided testimony. She did not describe any other conflicts of interest. She said their patient adherence program, where they follow up with the patients, is included in the price of the test. She said they have a complete database of who has been screened and can appropriately rescreen in three years, taking that work necessity away from the providers. She said there is a 20% delta between screening rates for Medicaid and Medicare patients, for many socioeconomic reasons.

This testimony concerned Guideline Note 60 Opioids for Conditions of the Back and Spine.

Koa Kai is a patient-ambassador for the Chronic Disease Coalition and stated she has no conflicts of interest. She said the most concerning part of Guideline Note 60, for patients, is the policy overreach from what the committee's given task was: from solely deciding coverage to making requirements that demand doctor's performance of treatments, often against the doctor's best clinical judgement. Kai said this policy interferes in the patient-doctor relationship to provide appropriate medical treatment and can cause patient harm and disability. She said the guideline is not scientifically supported. Although the clause "when clinically indicated" was added in the middle of aggressive taper language, the rest of the guideline note renders that statement moot.

OHA, to date, has not acquired any patient outcome data for this unprecedented policy so we are forced to rely on anecdotal evidence such as the 33% rise in deaths of Medicare/Medicaid patients in the last year alone in the Death with Dignity program due to lack of pain control. The OHA's Ombuds office was forced last year to seek emergency funding to add additional workers to deal with the increased number of concerns and complaints about the continuity of pain medication. She said doctors need to be able to use their best clinical judgement without fear of regulatory attention or retribution. Kai said patients are continuing to be harmed by this radical policy that needs to be revoked immediately.

November 12, 2020

This testimony concerned Expanded Carrier Screening (ECS).

Devki Nagar testified about Expanded Carrier Screening (ECS). Ms. Nagar is a Myriad Genetic's genetic counselor and was otherwise silent on conflicts of interest. She applauded the Commission for continuing to review this topic. She feels that ECS provides equity across ethnicities. Ms. Nagar said there are a wide range of panels, including panels with 15 genes or more. Some labs are publishing data stating that their tests align with American College of Obstetricians and Gynecologists (ACOG) recommendations. ACOG supports this approach so that patients have a choice which would align with their values and preferences. Based on the information, patients are making appropriate changes for their current or future pregnancies.

This testimony concerned Guideline Note 60 Opioids for Conditions of the Back and Spine.

Koa Kai from the Chronic Disease Coalition stated no conflicts of interest. Ms. Kai lauded the changes to Guideline Note 60 (GN 60). She said it is imperative to provide options for pain relief and patient safeguards from harm. She said one of the misperceptions HERC seems to have is that GN 60 is merely a guideline but in the past, this policy has been aggressively implemented without regard to patient safety. It is imperative to recognize the patient harms caused by the unintended consequences from the history of GN 60 and to recognize the organization's responsibility to remedy the resulting harms from forced tapers and denials of pain medication. It is also important to recognize the damage this policy has done to the doctor-patient relationship. She urged HERC to make small changes and evaluate the outcomes and adjusting policies based on those assessments in a timely manner. There are other issues from the creation of GN 60 which must be acknowledged including one multi-committee member's excessive participation in the policy's conception authorship, voting, promotion, and subsequent review participation. The additional destruction of the taskforces public records and the various taskforce member's undisclosed conflicts of interest has allowed for a lack of public transparency and consideration of public input in the creation of public health policy.

Wendy Sinclair, founder of the Oregon Pain Action Group, declared no conflicts of interest. Ms. Sinclair said she appreciated the proposed changes to Guideline Note 60. She has been involved with this issue for some time. She said people have reached out to her to share that they have been taken off their medication and are contemplating suicide as they try to cope with pain as they are unable to manage. Guideline Note 60 has caused a lot of harm to people. She said she was able to read letters given to doctors stating that opioids are not safe or effective for back pain, so you need to taper your patient. This has caused entire clinics to eliminate opioids for back pain for all Medicaid patients, sending patients into turmoil. She said she appreciates the language has changed but she is concerned that this new language will not get the same level of promotion as the taper-language notice did. She would like to see providers notified of these changes.

Steven Hix testified; he declared no conflicts of interest. Mr. Hix said he is a pain patient and an advocate for pain patients. He thanked the Commission for hearing the concerns brought forward about GN 60. He asked if he would now get his medication paid for a whole month rather than seven days. He said he agreed with the first two speakers about the damage that has been done with the implementation of the original GN 60 and there is a lot of repair work that needs to be done.

Amara M, a mother, advocate for human rights and co-founder of the Oregon Pain Action Group testified. Ms. M. declared no conflicts of interest. She commended HERC for making significant positive changes to GN 60. She said she hopes the gravity of the effect the policy has had on patients is looked into further. She said she was a patient at a clinic when GN 60 was first enforced. All Medicaid patients with back conditions, regardless of severity, were handed a letter to inform them that patients would be force-tapered off their opioid medication in six weeks. Amara said her regular doctor at the clinic decided to retire rather than be instructed to go against her Hippocratic Oath. She said she had many meetings with the new clinic director and that led her to the underlying guideline note that caused the forced tapers. She then started attending meetings. She said she would like to see promotion and clarity of the new language given to the CCOs. EOCCO has force-taper language live on their website right now. She said an analysis of the Health Authority's ombuds program said that the volume and acuity of client calls from pain conditions significantly increased in the last two years, more than doubled. The number one concern is continuity of care for pain management.

This testimony concerned facial feminization surgery.

Mareinna (Shawn) Kangiser offered comments about facial feminization surgery (FFS). Ms. Kangiser said she wanted to talk about changing facial feminization surgery from a cosmetic procedure to a medical necessity. Ms. Kangiser said that gender reassignment surgery (GRS) changes a person's relationship to their body and affects interactions with one's partner but argued that one's face is how a person is identified in society. She said that make up is cosmetic, meant to improve one's appearance, but FFS is meant to feminize one's appearance, not to make one more attractive. Part of the diagnostic criteria for gender dysphoria is the desire to live and be accepted as a member of the gender they identify as; the inability to achieve this can cause significant distress. That distress is why it's being treated, because of this need to be accepted as one's true gender. Part of treating gender dysphoria means helping one be accepted as their true gender. FFS is protective against violence and discrimination. Violence is often the result of being "visibly gender non-conforming," which has been found to elicit anti-transgender bias. She said when a trans woman has an appearance that conforms to the typical conceptions of gender, it serves as protection from violence and discrimination, and by extension reduces their risk of depression and suicide. The high rates of suicide in transgender people is largely due to their treatment by society. She said this treatment is even cost effective. California did an economic-impact analysis and found that removing transgender exclusions had an immaterial effect on premium costs, which were far exceeded by the benefits. Those benefits include improved health outcomes among transgender people such as reduced suicide risk, lower rates of substance use and increased adherence to HIV treatment. She said a recent study estimated that without the transition surgeries (a one-time cost) healthcare for a transgender person is, on average, $10,712 a year. Therefore, FFS is a cost-effective intervention, and it needs to be covered by insurance policies. She said the fact that GRS is covered and FFS is not shows that gender dysphoria and its implications are not being well understood by insurance companies. Until one is accepted in society as their true gender,

something necessary to function in our current American society, gender dysphoria will persist, and procedures such as FFS will still be medically necessary as a potential treatment of gender dysphoria.

HERC Value-based Benefits Subcommittee
October 1, 2020

This testimony concerned Guideline Note 60 Opioids for Conditions of the Back and Spine.

Koa Kai offered similar testimony as she did at the Health Evidence Review Commission meeting held the same day.

November 12, 2020

This testimony concerned Non-invasive prenatal screening for aneuploidies (NIPS).

Hannah Baer: Coalition for Access to Prenatal Screening (CAPS) representative. CAPS is a group sponsored by seven genetic testing companies. Ms. Baer testified that NIPS is a sensitive and specific screening tool that should be offered to all pregnant women. In 2020, Washington and Idaho Medicaid programs added NIPS for average-risk pregnancies. Other states' Medicaid program, such as Alaska and Delaware, changed their policy to cover NIPS for all pregnant women (CPTs 81420 and 81507). Additionally, Connecticut and Wisconsin made changes in their Medicaid policy based on Practice Bulletin 226 by the American College of Obstetricians and Gynecologists (ACOG, August 2020). Many private insurers cover NIPS testing for average-risk pregnancies. Six other state Medicaid programs (Iowa, Massachusetts, Louisiana, Maryland, Nevada, and Texas) are considering coverage for NIPS. Ms. Baer said these tests should be covered for all women regardless of age or risk.

Vanessa Nitibhon: Ms. Nitibhon is a certified genetic counselor employed by and speaking on behalf of Integrated Genetics. She was formerly a genetic counselor at OHSU. She testified that NIPS coverage ensured the most equitable care for all pregnant women. ACOG and SMFM support NIPS testing for all women per ACOG's Practice Bulletin 226. NIPS screening has the lowest chance for error and has the best detection rate for the common aneuploidies. Fewer false positive results means fewer invasive procedures. Ms. Nitibhon cited a paper by Norton (2015) which stated that the false positive rate is 100 times lower than standard serum screening. A reduction in false positive rates also reduces anxiety as well as complications from invasive testing. Ms. Nitibhon shared scenarios she encountered when counseling average-risk women in her practice, stating that those commercially-insured patients who had access to NIPS had more timely results than her Medicaid patients, leading to a division of care based on insurance coverage. Covering NIPS can also allow patients and families prepare for the arrival of a special needs baby. This test is more equitable, and, in rural areas, easier to access than fetal nuchal lucency ultrasound.

Ashley Svenson: Ms. Svenson is a policy specialist employed by Myriad Genetics. She was formerly a genetic counselor practicing at a large academic perinatology clinic. Ms. Svenson cited cost-effectiveness modeling studies that demonstrated NIPS as net cost effective when additional costs are taken into account such as increased number of ultrasounds, consults, amniocenteses, etc. Svenson stated that NIPS is also easier for women with low medical literacy or resource constraints, underscoring the anxiety and

emotional burden of a positive screening test. Svenson read a patient quote from "Stand Up for Accurate Prenatal Answers," a patient group. The patient quote recounted a women's second trimester of pregnancy while waiting for a diagnostic test result from a positive 20-week ultrasound. Ms. Svenson cited her own clinical experience stating that false positive results after traditional serum screening were common. Svenson concluded by citing an article from the "Healthy African American Families" patient group, who stated that disparities in coverage lead to racial disparities in aneuploidy screening, with women of color disproportionately not being screened. Svenson stated that non-white women are significantly less likely to pursue NIPS when coverage is unclear.

Kim Martin: Dr. Martin is an obstetrician-gynecologist and board-certified clinical geneticist. She is also a consultant to a genetics testing company but states she is not being reimbursed for her testimony today. Dr. Martin stated that the introduction of cell-free DNA in 2012 should have revolutionized aneuploidy screening for all women regardless of age or risk given the dramatically improved performance of the screen as well as the ability to perform it early in pregnancy. This test can be performed in the office during a routine OB visit. This is in contrast to the second most sensitive test, which is the nuchal translucency ultrasound, which requires a certified nuchal translucency provider. Oregon has 22 of these certified providers in Oregon, but the vast majority are not in rural areas. Martin states this disadvantages woman living in rural areas. Martin also states that over 80% of Asian and Caucasian women enter prenatal care in first trimester of pregnancy compared to <70% of women of color, leaving women of color with less access to tests like fetal nuchal lucency screening that need to be performed early in pregnancy. Another test, the quad screen, has poor accuracy if the dating is poor for the pregnancy. Martin stated that about 10% of women get poorly dated. NIPS is better for uncertain dates, as its results are independent of gestational age.

Nathan Slotnick: He is a medical geneticist and high-risk obstetrician, practicing in Nevada. Dr. Slotnick spoke about his clinical experience. He cited Norton's 2015 study that NIPS has a higher positive predictive value and a high negative predictive value. If the test is negative, the chance that the result is wrong is near zero, which makes this a powerful screening tool. Slotnick says that the question of screening then becomes a question of justice and equity. He noted the equity issue with limited access in rural areas.

This testimony concerned Expanded Carrier Screening (ECS).

Devki Nagar offered similar testimony as she did at the Health Evidence Review Commission meeting held the same day.

Kim Martin: Dr. Martin is an OB-Gyn who consults for a genetic testing company. Martin said that professional societies have recommendations regarding ECS coverage. She noted that the increasing diversity of the US population makes ethnicity-based testing more problematic given two societal changes: 1) individuals partnering with those of different ethnicities, and 2) individuals cannot or do not accurately report their ancestry, as defined by the ethnicity of the individual's four biological grandparents. Pan-ethnic expanded carrier screening results in identifying more at-risk couples, who are commonly missed. Martin concludes that professional societies have not acknowledged X-linked disorders (such as Fragile X), which should be included in pan-ethnic panels, as carriers of these disorders are at increased risk of premature ovarian failure, cardiomyopathies, and arrythmias, among other conditions.

This testimony concerned Guideline Note 60 Opioids for Conditions of the Back and Spine.

Koa Kai, Amara M and Wendy Sinclair offered similar testimony as they did at the Health Evidence Review Commission meeting held the same day.

This testimony concerned facial feminization surgery.

Mareinna Kansiger offered similar testimony as she did at the Health Evidence Review Commission meeting held the same day.

Health Evidence Review Commission (HERC)
January 21, 2021

This testimony concerned coverage of expanded carrier screening (ECS).

Devki Nagar: Ms. Nagar is an employee of Myriad Genetics, a genetic counselor, and representative of the Coalition for Access to Prenatal Screening (CAPS). Ms. Nagar appreciated the robust discussion earlier in the day at VBBS and had a few additional comments. The first comment was a clarification in that conditions screened are for autosomal recessive conditions. For these conditions, many carriers lack family history of the condition, so including family history as a requirement for screening would miss many potential carriers. These conditions occur in patients with diverse genetic backgrounds given the "blended" genetic diversity of Americans. Ms. Nagar asked if staff can remove the fragile X family history requirement, as that could exclude many fragile-X carriers. Similarly, Ms. Nagar requested the "high-risk ethnicity" requirement also be removed from the prenatal testing guideline for other conditions. Ms. Nagar concluded by thanking the Commission for their work.

This testimony concerned coverage substance use treatment. This topic was not on the Commission's agenda.

Erika Crable: Ms. Crable identified herself as a post-doctoral researcher from UC San Diego and wanted to ask which services HERC had covered for substance use treatment. HERC staff said they will email Ms. Crable a more detailed response to coverage for SUD.

March 11, 2021

This testimony concerned genetic screening tests.

Devki Nagar stated she was available for questions regarding genetic screening tests today and thanked the Commission for this opportunity.

HERC's Value-based Benefits Subcommittee
January 21, 2021

This testimony concerned coverage of expanded carrier screening (ECS).

Taylor Kane: Kane introduced herself as a carrier of a rare X-linked genetic disorder. She was diagnosed as a carrier at the age of 3 when her father was diagnosed with the disease as an adult. Any

children she has will have a 50/50 chance of inheriting her affected X chromosome. Ms. Kane affirmed that knowing her status has helped her make decisions about family planning. Carriers of genetic conditions have long faced obstacles in getting genetic testing to make decisions. Women face barriers to informed and knowledge about getting testing for genetic disease. Ms. Kane founded an organization in 2017 for women to get access to genetic screening. Knowing your genetic status prior to having children allows knowledgeable decisions about reproduction and Ms. Kane stated that she believes all women should have access to ECS regardless of their income level or source of health insurance. The emotional toll and financial toll of having a child with a genetic condition are high. Ms. Kane spoke about the disparities of women of color getting tested for genetic conditions.

Adria Decker: Ms. Decker identified herself as a geneticist and lawyer who is employed by the state but stated she is testifying as a family member of a person with an X-linked genetic disease that was identified through ECS. Her sister is a genetic carrier. Ms. Decker's nephew has a severe genetic illness, diagnosed at 18 months with a post-natal genetic screen. Ms. Decker waited eight months to see a geneticist; her private insurance covered her genetic testing and determined she is not a carrier. Had her sister been able to obtain ECS as a routine part of family planning, Ms. Decker stated her family would not have spent the first 18 months of her nephew's life trying to figure out what was wrong. Ms. Decker stated that information is power and that we must trust women to make decisions for their reproductive health. Making expanded carrier screening would not mandate it but would give women another tool in their toolbox.

Peggy Flanigan: Ms. Flanigan described how 34 years ago, during her first pregnancy, she and her husband were worried--Ms. Flanigan's two nephews had developmental delays and they wondered if that was a coincidence. Ms. Flanigan had a daughter without any developmental delays. After Ms. Flanigan's sister had a third son with developmental delays, the family learned that the three boys had fragile X. Upon greater testing, it was determined that Ms. Flanigan and all her sisters were carriers. The couple received genetic counseling and they now keep up with the literature to continue to monitor their family's health. Ms. Flanigan said their awareness of this family condition led to their decision to not have any more children. All patients need timely and accurate information to be able to care for themselves and their families.

Mike Flanigan: Mr. Flanigan continued Ms. Flanigan's testimony. Mr. Flanigan said they appreciate that Fragile X is now a covered prenatal screening test and said that the earlier a family can be aware of a condition, the better people are able to manage symptoms. He compared ECS to cholesterol testing or other bloodwork, saying ECS is similarly a preventive test that people should be able to use to make health decisions. As genetics is changing rapidly, expanded carrier screening can keep up with changing tests. Providers would only offer tests they feel comfortable with. They strongly recommend expanded carrier screening.

Devki Nagar: Ms. Nagar is an employee of Myriad Genetics, a genetic counselor, and representative of the Coalition for Access to Prenatal Screening (CAPS). She said that the core goal of prenatal care is identification of higher risk pregnancies, and current ethnicity-based screening creates bias. Providers have ability to screen for multiple conditions in one test. ACOG has two committee opinions (#690 and #691) that address carrier screening. Expanded carrier screening is an acceptable approach per ACOG, if conditions included in the screen meet certain criteria. A Blue Cross and Blue Shield Technology Evaluation Center (BCBS TEC) assessment found that expanded carrier screening improved health

outcomes [*Editor's note: This is a proprietary document*]. Coverage of ECS would not require providers to order them. Moving to pan-ethnic screening would make more equitable coverage for OHP patients. Nagar requested that the Commission cover the conditions in listed in ACOG committee opinions #690 and #691.

Michelle Erskine: Ms. Erskine is the mother of three, including a son with a rare X-linked condition. She discovered that several of her brothers also had this condition, but it was not diagnosed due to the fact that there was no knowledge of the condition when they were born. Ms. Erskine said that sometimes carriers express only mild symptoms of conditions. She said it is important that of women of all backgrounds have access to expanded carrier screening. Improvements in genetic testing have made this type of testing more affordable and more education of patients is available than in the past. Ms. Erskine was in favor of expanded carrier screening.

March 11, 2021

This testimony concerned prenatal genetic testing guideline equity.

Devki Nagar, a Myriad employee and genetic counselor, testified in favor of the proposed changes. These tests are standard prenatal screenings. Many patients with hemoglobinopathies (>50%) are not from a high-risk ethnic group.

This testimony concerned biomarkers for prostate cancer.

Melissa Stoppler, MD, Exact Sciences senior advisor: Dr. Stoppler testified that the score informs the patient of their risk of high-risk disease if radical prostatectomy is done. NCCN has newly released its 2021 guideline. The recommendation to use biomarkers is now a 2A category recommendation (uniform consensus among panelists). ASCO 2020 guideline states "biomarkers are reasonable in low risk men in whom management decisions will be affected by the results." Medicare, 8 Medicaid programs (including CA and WA), and most private payers cover these tests.

Jeffrey Lawrence, MD, retired medical oncologist, former employee of Genomic Health and current consultant for Exact Sciences, declared no compensation for this testimony: Dr. Lawrence testified about his personal experience with prostate cancer. When he was diagnosed, he requested Oncotype Dx; the score helped him make a decision about treatment. He went on to have a radical prostatectomy and was found to have high risk disease at surgery. He had adjuvant radiation therapy, hormonal therapy. He is doing well now. He feels that active surveillance would have been a big mistake in his case. He noted that two studies show Oncotype Dx is equal or superior to MRI for determining a patient's risk status.

Ashley Svenson, genetic counselor and policy specialist at Myriad, the company that markets Prolaris: Ms. Svenson testified that the ASCO guideline is based on a 2019 systematic review of the literature and recommends consideration of use of these tests in specific clinical scenarios. Ms. Svenson strongly encouraged the Commission to take the ASCO recommendation into account. MediCal, California's state Medicaid program, is evidence-based and covers these tests. An AHRQ review did not find studies on biomarkers that met inclusion criteria; the review did not find evidence of ineffectiveness. The Oregon Health Plan covers breast cancer prognostics but not prostate prognostics.

HERC Evidence-based Guidelines Subcommittee
April 8, 2021

This testimony concerned PANDAS/PANS/AE:

Sarah Lemley, Executive Director of the Northwest PANDAS/PANS Network: Ms. Lemley requested that the subcommittee seek national experts to inform the scope statement and coverage guidance report. She said that Oregon has no experts in these disorders and that none are part of Ms. Lemley's PANDAS/PANS network. She said that local providers lag behind the science for these conditions. The scope needs to focus on the current standard of care. She said the scope should ask, "what is the already established standard of care for these children?" and "What can be learned from centers of excellence about the best care for these children?" She concluded by introducing Paul Ryan and Molly Ochoa.

Molly Ochoa, Board Member of the PACE Foundation: Ms. Ochoa yielded her time to Paul Ryan.

Paul Ryan, President of the PACE Foundation: Mr. Ryan described the Centers of Excellence for PANDAS/PANS, particularly the University of Arizona who was the first Center, established in 2016. These clinics have multidisciplinary teams that see patients in a single day, including psychologists and neurologists. All patients are treated regardless of ability to pay, including Medicare and Medicaid beneficiaries. Those who are not diagnosed with PANDAS/PANS are referred to other specialty care. Mr. Ryan also said these centers conduct robust research into these areas, acting as education sources for their regions about what PANDAS is. Mr. Ryan said that if PANDAS/PANS is caught early, 90% of these children would never have to go to a clinic. Pamphlets and brochures are given to primary care and pediatricians to educate these providers. Demographically, clinics exist in all regions of the country, with the exception of the Pacific Northwest. Mr. Ryan said that Ms. Lemley has a lot of informational media to share with members if they are interested.

Kym McCornack, Outreach Coordinator of the NW PANDAS/PANS Network: Ms. McCornack requested that definitions used in the population description of the scope statement should be revised with definitions from the NIMH website. She requested further definition of the comparators, and the outcomes and harms of these comparators. Important outcomes should include suicidality, suicide, ER visits, mental health/police crisis calls, inpatient psychiatric treatment, inability to attend school, out of pocket expenses, as well as caregiver and family outcomes.

Roxy Mayer on behalf of Rep. Rachel Prusak's office: Ms. Mayer stated Oregon Representative Prusak wants the committee to know her support of evidence-based discussion of this topic and she is pleased to see that the HERC is addressing this topic. Rep. Prusak is in support of access for children to the needed treatments for these disorders and will be monitoring the process.

Health Evidence Review Commission (HERC)
May 20, 2021

This testimony concerned breast cancer index:

Max Salganik, PhD, of Biotheranotics: Salganik is the Associate Director of Medical Affairs for the manufacturer of the breast cancer index test. He said there have been two studies published since the panel's most recent review of breast cancer index. Dr. Salganik said these studies demonstrate that the breast cancer index is predictive. He pointed out both studies include node-negative and node-positive patients. One study is entirely composed of node-positive patients; and the other is 70% node-positive patients. He said the NCCN breast cancer guidelines recently recognized the breast cancer index for its ability to predict which patients will benefit from longer duration chemotherapy and that this predictive ability extends to both node-negative and node-positive patients. Salganik said there are separate recommendations for the prognostic component of the breast cancer index do guide decisions about adjuvant chemotherapy, which does extend to node-negative patients. He said he is happy to provide any supporting materials upon which to base a decision.

This testimony concerned PET scans for breast cancer:

Holli Thomas: Thomas said she is currently a triple negative breast cancer victim. She said while her testimony is personal, it also affects the thousands of women in Oregon who are currently not covered for PET scans during breast cancer therapy. Thomas asked the Commission to involve the Governor and the Oregon House of Representatives to vote on a waiver to allow PET scans for breast cancer therapy, stating that PET scans show the molecular movement within the cancer cells in lymph nodes. Ms. Thomas said she has been denied a PET scan by her CCO six times.

This testimony concerned facial electrolysis:

Petra Wilson: Wilson said she is a transsexual woman who is currently seeking coverage for facial electrolysis. She said OHSU does not provide facial electrolysis, nor has it since the establishment of the exception to the rule policy in Oregon regarding coverage of facial feminization. She said she is unable to appeal because OHSU will not accept her physician's referral. Ms. Wilson showed slides of her face and neck to show scarring and lesions. She said she plans to contact the Governor's office and seek counsel to represent her if she is unable to resolve the dispute between her physician and OHSU. Ms. Wilson said folliculitis is a barrier to transition that must be clinically mitigated by permanent hair removal to ensure safe and effective social adaptation following the expression of feminine secondary sexual characteristics in male-to-female transsexual women.

HERC's Value-based Benefits Subcommittee
May 20, 2021

This testimony concerned PET scans for breast cancer:

Holli Thomas, a breast cancer patient: She said she has no conflicts of interests, other than that she currently has breast cancer. She said that the Commission's guideline D22 on PET scans is outdated. She said she has the most deadly form of breast cancer but has outrun it multiple times. She said that a PET scan would show the molecular movement of her cells. She had a recurrence of her cancer last year, and her PET scan showed cancer in her lymph nodes. She has had multiple CT scans, but is being denied PET scans. She requested that VbBS recommend to HERC a coverage of PET scans for breast cancer. She said that NCCN has changed their guidelines regarding PET scans for breast cancer. She requested that PET be covered for breast cancer, not for initial staging, but they should be allowed to be

used for initial staging. Since it's not covered for initial staging, the plan won't cover it for treatment monitoring. She said she has been told that the CCOs have the ability to approve as an exception, but her CCO is denying that.

HERC Evidence-based Guidelines Subcommittee
June 3, 2021

This testimony concerned a draft coverage guidance for High Frequency Chest Wall Oscillation Devices:

Gary Hansen, Director of Scientific Affairs for RespirTech (manufacturer of devices): Hansen expressed appreciation for the evidence presentation and requested reconsideration of the recommendation against coverage for bronchiectasis and neuromuscular diseases. Hansen said he previously submitted other evidence for consideration before the meeting and hopes that the subcommittee members will consider his evidence. He expressed concern that there was no mention of the administrative rulebook or fee schedule in the evidence presentation. He said there is a paucity of randomized controlled trials (RCTs) and comparative studies for HFCWO devices. There is a good reason for this, as it is difficult to recruit patients for these studies and there is little consensus on end-point outcomes, such as sputum production or exacerbations. Hansen summarized the pre-post study design trials he submitted to the committee. Hansen stated that a 50-70% reduction of hospitalizations was achieved with his company's device, based on studies submitted as testimony. He said the benefits of vest therapy have been amply demonstrated with real world studies.

Jeff Anderson, Senior Clinical Education Specialist for Hill-Rom Respiratory Health (manufacturer of HFCWO devices): Anderson said he was a respiratory therapist and discussed a 2020 conference abstract which found significant improvement in outcomes such as hospitalization, bronchoscopies, chest x-rays and labs, oral and intravenous antibiotics, pulmonologist visits, and overall cost. This was a pre-post study. Anderson discussed a second conference presentation of a pre-post study which found reductions in office visits, bronchoscopies, all-cost outcomes, emergency room visits, and antibiotic use. He noted that in his experience, positive expiratory pressure (PEP) devices need the ability to make a good seal to close their mouth on a device, which can be difficult particularly in patients with neuromuscular diseases.

This testimony concerned electrolysis for transgender-related care:

Petra Wilson: Wilson gave public testimony regarding OHP coverage for electrolysis for transgender-related care. She said she is a patient of Washington State Medicaid. She said the policy of coverage for gender dysphoria adopted in 2015 has been problematic. She said the current system requires a patient to have a psychosocial condition in order to obtain non-covered services under the comorbitiy rule. She urged the committee to review the full WPATH standards of care when it is released. She said that is important that gender-related care include electrolysis.

Metrics and Scoring Committee
July 17, 2020

The Committee reviewed 22 pieces of written public testimony and heard oral testimony from 13 people. Written testimony is available on the Committee webpage:

https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx. Written testimony was received from:

- Children's Health Alliance
  - Re: 2020 and 2021 CCO Incentive Measure Benchmarks for Childhood and Adolescent Health
- Children's Health Alliance
  - Re: COVID-19 impact on 2020 CCO Incentive Program
- Children's Health Alliance
  - Depression Screening and Follow-up Benchmark Rebasing
- Central Oregon Health Council
  - Re: Decision-making timeline for matters related to the 2020 Quality Incentive Measure program in the context of the COVID-19 crisis
- Central Oregon Pediatric Associates
  - Re: Impact of COVID-19 on the 2020 Medicaid Quality Incentive Measure Program
- Rodney Todd, MD
  - Re: COVID-19 impact to 2020 metrics
- Mosaic Medical
  - Re: COVID-19 impact on 2020 CCO Incentive Program
- National Association of Chronic Disease Directors
  - Re: Support for Obesity prevention through multi-sector interventions measure
- Oregon Primary Care Association
  - Re: COVID-19 impact on 2020 CCO Incentive Program
- One Community Health
  - Re: COVID-19 impact on 2020 CCO Incentive Program
- Oregon Council on Health Care Interpreters
  - Re: Support for Equity measure: meaningful language access to culturally responsive health care services.
- Health Equity Committee
  - Re: Support for Equity measure: meaningful language access to culturally responsive health care services.
- Oregon Medical Association
  - Re: Support for Obesity prevention through multi-sector interventions measure
- Umpqua Community Health Center
  - Re: COVID-19 impact on 2020 CCO Incentive Program and 2020 benchmark achievement; 2021 incentive measures.
- Cascade Summit
  - Re: COVID-19 impact on CCO Incentive Program and benchmark achievement
- Healthy Active Oregon Coalition
  - Re: Support for Obesity prevention through multi-sector interventions measure and Equity measure: meaningful language access to culturally responsive health care services.
- Health Share
  - Re: continuing 2020 measures into 2021; delay Equity measure: meaningful language access to culturally responsive health care services and Obesity prevention through multi-sector interventions measure; select benchmarks and targets that account for impact of COVID-19; develop program contingency plan.
- Pacific Source

- Re: Concerns about to using 2019 as baseline for 2021 improvement targets; suggested changes to Equity measure: meaningful language access to culturally responsive health care services specifications; support for Obesity prevention through multi-sector interventions measure.

- Care Oregon
  - Re: Concerns about Obesity prevention through multi-sector interventions measure
- CCO Oregon
  - Concern with using 2019 as baseline for 2021 improvement targets; workforce challenges and online resources; telehealth; preventive dental services.
- Coalition for a Healthy Oregon
  - Re: Concerns about Equity measure: meaningful language access to culturally responsive health care services.
- El Programa Hispano & Coalition of Community Health Agencies
  - Re: Support for Equity measure: meaningful language access to culturally responsive health care services.

Verbal public testimony provided during meeting:

- Ana Miramontes (OHP member from Jackson and Josephine County)
  - Importance of health care interpreters
- Yadira Gomez (OHP member from Jackson and Josephine County)
  - Importance of certified health care interpreters
- Stick Crosby (All Care Health – Director, Network and Health Equity, Oregon Health Care Interpreter Council)
  - Importance of health care interpreters and support for Equity measure: meaningful language access to culturally responsive health care services
- Krista Collins (Health Share of Oregon)
  - Referenced written testimony; asking that no new measures be added for 2021. If any added, of two proposed new measures, support addition of the Equity measure: meaningful language access to culturally responsive health care services over Obesity prevention through multi-sector interventions measure.
- Annie Valtierra-Sanchez (Equity Coalition Director, OHA Health Equity Committee)
  - Support for Equity measure: meaningful language access to culturally responsive health care services.
- Will Brake (COO for All Care CCO, former Metrics & Scoring Committee chair)
  - Support for Equity measure: meaningful language access to culturally responsive health care services.
- Ryan Bair (Rogue Community Health)
  - Support for Equity measure: meaningful language access to culturally responsive health care services.
- Felicity Ratway (Chair of Policy and Advocacy Workgroup, Certified Medical Interpreter)
  - Support for Equity measure: meaningful language access to culturally responsive health care services.
- Dr. Zeenia Junkeer (Director of Oregon Health Equity Alliance)
  - Support for Equity measure: meaningful language access to culturally responsive health care services; concerns about Obesity prevention through multi-sector interventions measure.
- Julie Harris (Children's Health Alliance)

- Make both 2020 and 2021 reporting only; do not add any clinic-based improvement measures during pandemic.
- Samantha Shepherd (CCO Oregon)
  - Consider current workforce challenge; additional time may be needed to implement new metrics; trainings & certifications should be available online; ensure telehealth is counted; reconsider preventive dental measure numerator criteria in relation to services provided in primary care.
- Yesi Castro (Oregon Community Health Workers Association)
  - Support for Equity measure: meaningful language access to culturally responsive health care services
- Ping (Immigrant & Refugee Community Organization)
  - Support for Equity measure: meaningful language access to culturally responsive health care services.

August 2020 – No meeting

September 18, 2020
Written public testimony was sent out to the committee members, and is available on the webpage:
- Felicity Ratway (not received in time for July meeting)
  - Support equity measure
- CCO Oregon
  - Preventive dental measure
- Children's Health Alliance
  - 2021 targets
- Health Share
  - 2021 targets
- Community Health Centers of Lane County
  - 2021 targets
- Oregon Primary Care Association
  - 2021 targets
- OHSU Family Medicine at Richmond
  - 2021 targets
- Yakima Valley Farm Workers clinic
  - 2021 targets

Julie Harris and Dr. Resa Bradeen Children's Health Alliance (speaking to written testimony) raised concerns about using 2019 as baseline and setting achievable targets.

October 16, 2020
The Committee reviewed 7 pieces of written public testimony and heard oral testimony from 2 people.
Written testimony is available on the Committee webpage:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx.
Written testimony was received from:
- Outside In
  - Re: 2021 CCO Incentive Metrics and 2021 Benchmarks and using 2019 as a benchmark year for targets.
- One Community Health

- Re: 2021 CCO Incentive Metrics and 2021 Benchmarks and using 2019 as a benchmark year for targets.
- Mid-Valley Medical Center
  - Re: CCO Diabetes Incentive Measure Benchmarking and using 2020 benchmarks for diabetes measure
- Children's Health Alliance
  - Re: 2021 CCO Incentive Metrics and 2021 Benchmarks and setting benchmarks for immunization measures
- CCO Oregon
  - Re: Provider disparity in the Preventive Dental Services measure for children
- CCO Oregon
  - Re: Definitions for Oral Health Services and Providers related to the Preventive Dental Services measure
- Rinehart Clinic
  - Re: 2021 CCO Incentive Metrics and 2021 Benchmarks and using 2019 as a benchmark year for targets

Verbal public testimony provided during meeting:

- Julie Harris Children's Health Alliance
  - Raised concerns that 2021 targets for childhood and adolescent immunizations apply to care that was provided in 2020 and provided input on preventive dental measure, including that while dental home should be led, services from primary care providers should be counted in the metric.
- Samantha Shepherd CCO Oregon
  - Spoke to written testimony supporting expansion of preventive dental measure such that services from any primary care provider should count towards the metric.

November 20, 2020

The Committee reviewed 3 pieces of written public testimony and heard oral testimony from 5 people. Written testimony is available on the Committee webpage: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx.
Written testimony was received from:

- Children's Health Alliance
  - Re: 2021 CCO Incentive Metrics and 2021 Benchmarks and setting benchmarks for immunization measures
- CCO Oregon
  - Re: Preventive Dental Services measure for children
- All Care CCO
  - Re: Kindergarten Readiness Metric

Verbal public testimony provided during meeting:

- Dr. Logan Thomas Clausen – Central Oregon Pediatric Associates
  - Re: Children's Social Emotional Health Metric
- Robin Hill-Dunbar – Ford Family Foundation
  - Re: Children's Social Emotional Health Metric
- Jeanne McCarty – EOCCO
  - Re: Children's Emotional Health Metric

- Susan Fischer-Macki - All Care Health
  - Re: Children's Social Emotional Health Metric
- Samantha Shepard - CCO Oregon
  - Re: Preventive Dental Services measure

December 2020 – No meeting

January 2021 – No meeting

February 19, 2021
The Committee reviewed 3 pieces of written public testimony and heard oral testimony from 5 people.
Oral testimony:

1. Maggie Klein, Director of Care Integration and Coordination for OHSU Health Services
   - Re: Social determinants of health (health related social needs) measure
2. Courtney Rivera, Supervisor of Quality Improvement for the Eastern Oregon CCO
   - Re: Social determinants of health (health related social needs) measure
3. Elise Darnell, Senior Manager of Operations for Providence Medical Group in Yamhill County
   - Re: Social determinants of health (health related social needs) measure
4. Ginger Scott – Jackson Care Connect in Jackson County
   - Re: Social determinants of health (health related social needs) measure
5. Rachel Smith – Program Manager, Providence Health and Services Patient Health
   - Re: Social determinants of health (health related social needs) measure

Written testimony is available on the Committee webpage:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metric-Scoring-Committee-Archives.aspx
Written testimony was received from:

1. Matthew Mitchell, Data Analytics Manager, Member of the SDOH measure concert workgroup, Central City Concern
   - Re: Social determinants of health (health related social needs) measure

2. Gary Plant MD FAAFP, Madras Medical Group
   - Re: Social determinants of health (health related social needs) measure

3. Carly Hood-Ronick MPA, MPH, Project Access NOW (PANOW)
   - Re: Social determinants of health (health related social needs) measure

March 2021 – No meeting

April 16, 2021
No public comment

May 21, 2021
Written public comments in support of the kindergarten readiness social-emotional health measure were submitted by the following individuals and can be found in the meeting materials here:
• Susan Fischer-Maki, AllCare Health
• Donna Mills, Central Oregon Health Council

• Suzanne McClintick, Childhood Health Associates of Salem
• Oregon Early Learning Council (submitted by Sue Miller, Chair, on behalf of Council)
• R. J. Gillespie, Oregon Pediatric Society

Oral testimony in support of the social-emotional health measure:
• Sherri Alderman, Oregon Pediatric Society (speaking to written testimony)
• Suzanne McClintick, Childhood Health Associates of Salem (speaking to written testimony)
• Andrew Riley, OHSU, clinical psychologist
• Kevin Shaw, Bright Ways Counseling Group
• Karen L. Ayers, Oregon Child Development Coalition
• Richard Barsotti, Metropolitan Pediatrics Kirk Foster also provided comments on difficulties with non-emergent medical transportation and advocated for a measure in this area.

June 18, 2021
Written testimony was provided by Joel Lampert of Childhood Health Associates of Salem expressing support for the kindergarten readiness social-emotional health measure.

Verbal testimony was provided by:
• David Ross, Comagine Health, voiced support for the kindergarten readiness social-emotional health measure.
• Tanveer Bokhari, Umpqua Health, support for the kindergarten readiness social-emotional health measure.

Health Plan Quality Metrics Committee
No public comment in July, August, or September 2020. The Health Plan Quality Metrics Committee did not meet between July 1, 2020 and September 30, 2020 as a result of OHA suspending non-critical committee meetings while our health care partners focused on the COVID-19 response.

No public comment in October, November, or December 2020. The Health Plan Quality Metrics Committee did not meet in October or November as a result of OHA suspending non-critical committee meetings while our health care partners focused on the COVID-19 response. The committee did meet on December 21, 2020 and there was no public comment at this meeting. The committee will resume a monthly meeting schedule in January 2021.

January 26, 2021
The Committee reviewed 1 piece of written public testimony and heard oral testimony from 1 person.
Oral testimony:
Laura McKeane, Director of Oral Health Services, Co-Chair of the CCO Oregon Oral Health Workgroup, from AllCare CCO
- Re: In support of recommendation brought to Metrics and Scoring Committee to expand the providers included in the preventive dental measure.

Written testimony is available on the Committee webpage:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Quality-Metrics-Committee-Archive.aspx
Written testimony was received from:
CCO Oregon on behalf of CCOs, DCOs, and provider partners
- Re: In support of proposed preventive dental specification change brought to the Metrics and Scoring Committee to expand the providers that count towards the measure.

February 23, 2021
There was no public comment at this meeting.

March 30, 2021
There was no public comment at this meeting.

April 27, 2021
Oral testimony
Samantha Shepherd, Executive Director for CCO Oregon
- Re: Support for new Dental Quality Alliance measure specifications.

Written testimony was received from:
CCO Oregon Oral Health Workgroup
- Re: Support for new Dental Quality Alliance measure potential addition to Oregon's measure menu by the Health Plan Quality Metrics Committee.

May 25, 2021
No public comment

June 22, 2021
No public comment

IV. Progress toward demonstration goals

A. Improvement strategies

Oregon's Triple Aim: Better health, better care, and lower costs

To meet the goals of the three-part aim, Oregon's coordinated care model and fee-for-service (FFS) delivery systems rely on six key levers to generate savings and quality improvements and accelerate spread across the delivery system. These levers drive Oregon's transformation. Along with the actions that the Oregon Health Authority will take in the form of the stimuli and supports described below, they comprise a roadmap for achieving Oregon's vision for better health, better care, and lower costs.

Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient- centered primary care homes (PCPCH)

Patient-Centered Primary Care Homes

In January 2021, the Oregon Health Authority implemented revised PCPCH recognition standards based on the recommendations from the PCPCH Standards Advisory Committee, a multi-stakeholder body that provides OHA with policy and technical expertise for the PCPCH model of care, and input from other community partners and subject matter experts. Notable revisions include the addition of new measures to address oral

health, social determinants of health and substance use disorders, as well as language to improve health equity in all standards.

After suspending all site visits to PCPCHs due to the impact of the COVID-19 pandemic during the last quarter of the previous reporting period, the PCPCH program resumed site visits virtually in July 2020. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address barriers. As of June 30, 2021, the PCPCH program completed 37 virtual site visits.

As of June 30, 2021, 634 clinics were recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Seventy-three PCPCHs have been designated as 5-STAR, the highest tier in the PCPCH model.

Certified Community Behavioral Health Clinics

During this past year, Oregon Health Authority (OHA) continued participating in the federal Certified Community Behavioral Health Clinic (CCBHC) demonstration program. Following a one-year planning grant (2015- 2016), the CCBHC demonstration program was launched in Oregon on April 1, 2017 and though originally set to end March 31, 2019 has been extended to through December 2023 both federally and most recently though state legislature.

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

For this demonstration period, Oregon continued to pay a daily rate to participating clinics, using the selected the Prospective Payment System (PPS-1) model and through federal legislation was granted an extension to participate for additional years. The rate for each CCBHC is unique to each organization and was developed based on analysis of cost reports submitted to OHA during the planning grant. Among the key successes for this year:

- Updated cost reports were submitted to CMS for Demonstration Year 4
- Clinics were able to utilize telehealth infrastructure in place to responds to service needed during Covid-19 pandemic
- One re-certification compliance visit was completed with OHA, bringing total number of current clinics to 10
- Continued meeting with other demonstration states as program expands nationally
- Additional reporting and evaluation around quality metrics & service changes submitted to national evaluators

Tribal Care Coordination

The State of Oregon and the nine Federally-recognized Tribes are the first in the nation to advance tribal care coordination via the 100% FMAP Savings and Reinvestment Program. This program allows the state to claim

100% federal match for services that would otherwise be paid at the usual federal/state match percentage, for services received outside of an IHS or tribal 638 facility for AI/AN Medicaid beneficiaries. To be eligible for 100% federal match, the care received outside of the IHS/tribal facility must be requested and coordinated by the IHS/tribal facility.

The claiming of 100% federal match is made possible by CMS guidance contained in State Health Official Letter SHO #16-002 (2/26/16). The disbursement of these savings to the tribes is allowed per Governor Brown's letter to the tribes on 9/7/16.

Services eligible for this program include any covered Medicaid services. These services are typically covered at 100% FMAP when provided at IHS/tribal facilities, but SHO #16-002 allows 100% funding for services outside of IHS/tribal facilities as long as the care is coordinated by the IHS/tribal facility. The state then claims the enhanced federal match, subtracts a small administrative fee, and returns the difference to the IHS/tribal health program that coordinated the care. As of September 2021, seven tribes participate in the 100% FMAP Savings and Reinvestment Program.

To further assist in efforts to expand coordination of care for tribal members, the Oregon Health Authority has contracted with CareOregon to provide care coordination services for the roughly 28,000 AI/AN people enrolled in the Oregon Health Plan who are fee for service patients. CareOregon's model of care coordination was led and developed by the tribes during discussions taking place in 2016. The tribes requested establishment of a program that focused on culturally-responsive health care and took into account the unique nature of the AI/AN health care delivery system. During the first 11 months of the program 766 members enrolled in the program, and 1,336 calls were received by CareOregon's call center. 140 of these tribal members were enrolled in one of Oregon's nine federally recognized tribes; 346 individuals were enrolled in an out of state tribe. CareOregon reports high rates of member satisfaction with the program, which has been renewed for a second year.

In July 2021, OHA received approval of a State Plan Amendment to allow tribes and the urban Indian health program to form Indian Managed Care Entities (IMCEs). OHA is currently in contract discussions with the IMCEs and is conducting and documenting IMCE readiness reviews before operations will begin. Once operations start, these IMCEs will provide tribal care coordination services to approximately 15,000 of the 28,000 fee for service AI/AN Oregon Health Plan members.

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

Comprehensive Primary Care Plus (CPC+)

The Transformation Center manages the Medicaid fee-for-service implementation of CPC+. Per-member, per-month (PMPM) care management fees and performance-based payments are key components of the CPC+ payment model. Track 2 alternative comprehensive primary care payment launched in January 2021.
The quarterly hybrid payment includes a prospectively paid PMPM payment and a corresponding FFS claims reduction on payments for specific claims submitted during the program year. Track 2 practices selected their hybrid payment ratio for CMS in the fall of 2020, and OHA is using the same payment ratio.

The Oregon CPC+ payers met six times in the reporting period to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers discussed telehealth, opportunities to reduce low-value care, evaluation, equity, and opportunities to align with the Primary Care Payment Reform Collaborative. The payers reviewed quality data trends for 2015–2018 which indicate that primary care quality measure performance in Oregon is improving for CPC+ practices and non-CPC+ practices. The payers also discussed and finalized Data Bytes documents including the comparison data on quality, cost, and utilization across commercial and Medicaid payers for 2019. The payers discussed sustainability of the CPC+ payment model beyond the model completion at the end of 2021. Payers plan to continue, and in some cases go beyond, components of the model. Medicaid fee-for-service is still evaluating options. Only one Oregon CPC+ payer is participating in Primary Care First and no additional payers applied for the second RFA.

Value-based payment (VBP) innovations and technical assistance

The center began a two-part VBP webinar series, directed to CCOs, and focused on critical aspects of developing VBP models. Speakers included experts with firsthand local experience and extensive national experience practicing and advising others working under similar VBP payment models.

The center contracted with the Oregon Rural Practice-based Research Network (ORPRN) to deepen understanding of frontline physical, behavioral, and dental providers' understanding and perceptions of VBP. Specifically, OHA sought to 1) understand experience and perceptions of VBP contracting models; 2) assess what resonates regarding language and principles relating to VBP; and 3) learn how to engage providers with VBP and payment reform information. ORPRN staff conducted a mixed-methods evaluation between April and June 2021. Evaluation data included an online survey and 1:1 interviews/focus groups with physical, behavioral, and dental providers. Forty-three participants completed the survey. Thirty-one (69%) of these individuals participated in one of nine focus group sessions (n=26) and five completed interviews. Participants represented physical (76%), behavioral (18%) and dental (7%) settings, spanned urban and rural geographies, and represented 11 of Oregon's 16 CCOs. Understanding of VBP was limited across all provider types, and generally defined in contrast to FFS arrangements. Participants with more experience and understanding of VBP tended to be in administrative roles compared to practicing providers; physical providers had more exposure to VBP than behavioral or dental informants. ORPRN identified eight factors that could facilitate or impede VBP implementation, including goal alignment, staffing and flexibility. Whether these factors were facilitators or impediments was often related to differences in understanding or resources in each setting.

Finally, the center conducted the contractually required annual VBP interviews with CCO leadership during this period. The interviews provide CCOs an opportunity to share successes and challenges of the past year and to highlight TA that the center could provide to support their efforts. Staff from the OHSU Center for Health Systems Effectiveness (CHSE) conducted the interviews and will be using information collected as part of a larger evaluation effort of the CCO 2.0 VBP Roadmap.

Value-based Payment Compact

The Oregon Value-based Payment Compact represents a collaborative partnership to advance the adoption of VBPs across the state. As part of Oregon's legislatively mandated initiative to contain growth in health care costs, payers and providers are working together to advance payment reform and move to VBP. The Oregon VBP Compact is a voluntary commitment by payers and providers to participate in and spread VBPs, meeting specified targets and timelines over the next four years. This effort will increase the impact of the CCO VBP

work by spreading VBPs across other payers. The compact, jointly sponsored by the Oregon Health Authority and the Oregon Health Leadership Council, already has 46 signatories, covering 75 percent of the people in Oregon. Signatories include commercial, Medicaid and Medicare Advantage payers.

The VBP Compact Work Group, charged with ensuring the Oregon VBP Compact is successfully implemented, met for the first time on June 30. The work group will identify paths to accelerate the adoption of VBP across the state; highlight challenges and barriers to implementation and recommend policy change and solutions; coordinate and align with other state VBP efforts; and monitor progress on achieving the compact principles, including the VBP targets. The 15-member work group includes representatives from health plans, hospitals, independent practices (large and small providers), primary care providers, safety net providers, specialists, labor, employers, and the Oregon Health Authority.

Primary Care Payment Reform Collaborative
OHA convenes the Primary Care Payment Reform Collaborative, a legislatively required multi-stakeholder advisory group tasked with assisting OHA to develop and implement a Primary Care Transformation Initiative. The purpose of the initiative is to develop and share best practices in technical assistance and reimbursement methods that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care.

The collaborative met in June to discuss opportunities to incorporate health equity into primary care payment reform through value-based payment for traditional health workers and changes to Oregon's Patient-Centered Primary Care Home Program standards. The collaborative's Implementation and Technical Assistance Workgroup will meet in July to develop draft recommendations.

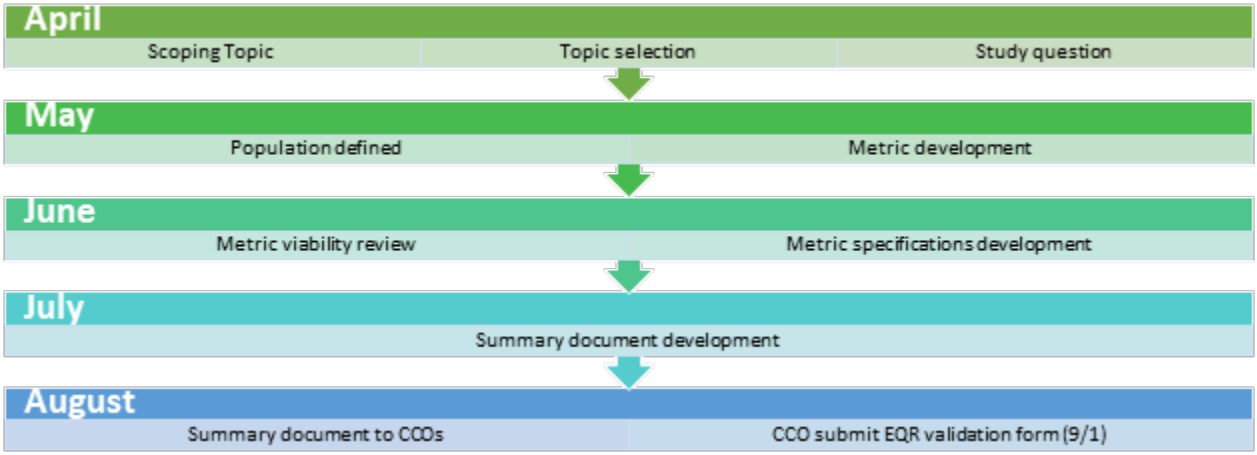
Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care

Statewide Performance Improvement Project (PIP)
As reported in previous quarterly reports, OHA made the decision to move away from the acute opioid prescribing topic as a statewide PIP. The previous 2019-2020 statewide PIP topic, Acute Opioid Prescribing, will not move pass design phase as a statewide PIP and may be picked up individually by CCOs to implement interventions in their respective communities.

The lessons gained from the COVID-19 epidemic further highlighted the needs and barriers in Oregon's behavioral health systems and therefore the statewide PIP topic will focus on behavioral health access under the physical health and behavioral health integration focus area in OHA's 1115 Waiver Quality Strategy.

OHA convened internal and external partners from across the policy, measurement, and health system expertise in 2021 to develop the "Design Phase" of the Behavioral Health Access statewide PIP.

2021 Design Activities



2021-2024 Statewide PIP Metric: Mental Health Services Access Monitoring
Description: Percent of members with a mental health service need who received outpatient mental health service in the measurement year.

Adapted from the Washington State Department of Social and Health Services measure (https://www.dshs.wa.gov/sites/default/files/rda/reports/cross-system/DSHS-RDA-Medicaid-MH-svc-pen-broad.pdf), with National Drug Code (NDC) value sets from Healthcare Effectiveness Data and Information Set (HEDIS) MY 2020 version.

Population: 2 years and older as of December 21 of the measurement year. Age and race and ethnicity stratifications for reporting.

Denominator: The eligible population.

Numerators: Members receiving at least one outpatient mental health service meeting at least one of the following criteria, applied by claim line, in the 12-month measurement year, and after the denominator event.

Measure specifications will be available on the OHA Statewide PIP website: https://www.oregon.gov/oha/HPA/DSI/Pages/Performance-Improvement-Project.aspx

CCO specific PIPs
Quarterly summary report can be found on the web here: https://www.oregon.gov/oha/HPA/DSI/QIDocs/CCO-PIP-Quarterly-Summary.pdf. The summary includes the PIP focus area and the PIP topic by CCO.

Fall 2020, OHA held individual technical assistance calls with each CCO to discuss the CCO's specific PIPs. The call covered the PIP status, COVID impacts on quality improvement, specifically PIPs, and next steps for the CCO specific PIPs. Next steps included but not limited to continuation, adoption of PIP as standard work and selection of new topic, lessons learned and abandon the topic for a new topic. The CCO PIP quarterly summary listed above is updated regularly to reflect new PIPs for CCOs.

Quarterly Reports: April 1, 2021 through December 31, 2020

OHA and CCOs are updating the statewide PIP topic for 2021 to reflect a behavioral health integration focus. CCOs will be submitting EQR PIP validation for 2021 in September 2021 to be reported in April 2022 technical report.

Quarterly Report: July 1, 2020 through September 30, 2020
Statewide Performance Improvement Project (PIP)
For the period of July 1, 2020 to September 30, 2020 OHA explored the trajectory for the statewide PIP due to the lessons gained from the COVID-19 epidemic. COVID-19 has further highlighted the needs and barriers in Oregon's behavioral health systems and therefore OHA is exploring changing the statewide PIP topic to center on behavioral health access under the physical health and behavioral health integration focus area in OHA's 1115 Waiver Quality Strategy. The previous statewide PIP topic, Acute Opioid Prescribing, will not move pass design phase as a statewide PIP and may be picked up individually by CCOs to implement interventions in their respective communities.

Additional conversations with internal and external stakeholders will be in the coming quarter. Regular updates with Oregon's external quality organization (EQRO), Health Services Advisory Group (HSAG), are discussed to ensure compliance with EQR expectations

Oral Health Roadmap
The OHA Public Health Division convened a workgroup of school oral health program stakeholders from June through August 2020 to develop guidelines for school oral health programs to continue to safely provide oral health services in the school setting during the COVID-19 pandemic. Participants developed OHA guidance documents applicable to any medical or dental programs interested in providing oral health services (e.g. dental screenings, fluoride varnish, silver diamine fluoride, dental sealants, etc.) in schools.

• OHA Guidance on Resumption of Dental Services in School Settings (posted here: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3318A.pdf)
• OHA Guidance for Certified School Dental Sealant Programs (posted here: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3318.pdf)

While these services are available to children beyond those served by OHP, the primary population receiving these services are OHP members. The new guidance will help keep OHA meet our Roadmap goal of increasing access to school oral health and dental sealant programs.

Oregon was accepted into the Medicaid/CHIP Oral Health Affinity Group and will receive technical assistance from CMS to improve the rates of delivery of topical fluoride varnish in primary care settings. OHA, through the Transformation Center, will work with coordinated care organizations (CCO) to use this opportunity to increase integration of dental care into primary care and strengthen ties between the two systems of care. The Metrics and Scoring Committee recommended a change to the existing CCO incentive metric to allow topical fluoride varnish applied by physical health care providers to count in the numerator of the metric.

The Transformation Center also kicked off a series of trainings in quality improvement that uses the CCO incentive metric regarding oral health exams for adults with diabetes as a tool for learning. Training participants receive four hours of instruction and up to five hours of follow-up one-on-one technical assistance.
The Public Health Division conducted a Certification Training for School Dental Sealant Programs on November 17, 2020 that provided dental hygienists and program staff with technical assistance around the CCO

incentive metrics for the 2020-21 school year and COVID-19 guidelines for operating in schools. Most of the children they serve are covered by Medicaid.

Oregon kicked off its work as part of the Medicaid/CHIP Oral Health Affinity Group to build a learning collaborative with CCOs to increase integration of dental care into primary care and strengthen ties between the two systems of care. Staff from the Health Systems Division (which houses Medicaid/CHIP), Transformation Center, and Public Health met with CMS three times, with separate prep meetings, during the quarter to lay the groundwork for the larger learning collaborative, slated to start in July 2021.

The Transformation Center completed a series of trainings in quality improvement that uses the CCO incentive metric regarding oral health exams for adults with diabetes as a tool for learning. Seventy-four participants from 45 clinics or health systems received four hours of instruction and up to five hours of follow up one-on-one technical assistance. To date, 33 clinics have been involved in follow up technical assistance.

Using resources from the HRSA Oral Health Workforce Grant, the Primary Care Office (PCO) facilitated the partnership of Advantage Dental and Coast Community Health Center in the rural coastal town of Port Orford. Advantage Dental is now sending an expanded practice dental hygienist (EPDH) to render preventative oral health services at facility and to refer patients with more complex cases to dentists within their network. This is the first time the town has had dental services in over 20 years.

The PCO has also worked with the Oregon Office of Rural Health to tailor the Health Care Provider Incentive Program to enable community-based providers, including traveling EPDHs, to receive incentive awards like loan repayment. The goal is to increase the retention time of these types of providers and expand the number of community-based providers providing services via teledentistry.

The PCO is also reviewing federally-designated Dental Health Professional Shortage Areas (HPSAs) to determine trends and changes to the dental FTE relative to the population in different areas of the state.
The Public Health Division's (PHD) Oral Health Program updated COVID-19 guidance documents to provide school oral health services (e.g. dental screenings, fluoride varnish, silver diamine fluoride, dental sealants, etc.), as some schools in Oregon began providing in-person instruction in January 2021. The state required all public schools to offer universal access to in-person learning by March 29, 2021, for K-5 students and April 19, 2021, for students in grades 6-12.

- OHA Guidance on Resumption of Dental Services in School Settings
- OHA Guidance for Certified School Dental Sealant Programs

The PHD Oral Health Program is also hosting regular, brief "Spotlight Segments" on training topics pertaining to certified school dental sealant programs, such as infection control, sealant placement, retention, etc. Dental hygienists and program coordinators have attended six virtual spotlight segments so far from January 22 - April 9, 2021.

From April to June 2021, OHA's work as part of the Medicaid/CHIP Oral Health Affinity Group continued. The internal steering committee met monthly to identify stakeholders and develop communications and an outreach plan to recruit participants in the learning collaborative.

The Oregon legislature passed a bill enabling the licensing of dental therapists in the state. The Board of Dentistry will work with the Public Health Division and the Primary Care Office to develop rules governing the new provider type. Health Systems Division will put rules and operational pieces in place to allow dental therapists to bill Medicaid for their services as appropriate.

In addition, the Transformation Center worked with a consultant to conduct key informant interviews to better understand dental offices experience of electronic dental records and health information exchange in order to design technical assistance to address improved technical links among dental and physical/mental health care. Finally, OHA hired a new dental director, Kaz Rafia, DDS, who is slated to begin work with the agency in early July 2021.

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

Sustainable Relationships for Community Health program
Activities: Sustainable Relationships for Community Health (SRCH) is a grant funded opportunity for clinical and community partners to address chronic disease health disparities in the local community. This multi-sector approach to advance healthcare transformation in the state, provides space for teams of local public health authorities, Coordinated Care Organizations (CCOs), clinical partners and community-based organizations, to determine and build together shared health systems change goals and infrastructure, to be sustained and spread beyond the grant period.

In December 2020, OHA released a new flexible SRCH funding opportunity to support Tribes and Local Public Health Authorities (LHPAs) from January 1- June 30, 2021. This new SRCH funding is an opportunity to apply lessons learned from the COVID-19 pandemic to chronic disease prevention and management efforts and focus these efforts on addressing disparate health and social impacts experienced by communities in Oregon who are affected by higher incidences of chronic disease and COVID-19. One (1) Tribe and seven (7) LPHAs applied for the SRCH funding opportunity for (funding period 1/1/21-6/30/21) and all teams were awarded funds.

During Q4, the eight (8) SRCH teams implemented and concluded work on their proposed projects many of which demonstrated success in the area of diabetes prevention and management. The project strategies included, but were not limited to: convening health systems and community partners to explore and create a plan for implementation of Traditional Health Workers to support chronic disease prevention and self-management; cross-sector work to create an equity-focused chronic disease prevention community plan; increasing closed loop referrals to tobacco cessation services centering the Latinx community; expanding systems, infrastructure and programming across a tri-county area for diabetes prevention (National DPP). OHA-HPCDP and contractors provided technical assistance to support innovations in chronic disease disparities prevention and management to SRCH teams per their request. The technical assistance included: practice facilitation from Comagine Health for workflow development, EHR and other tool development and support for general collaborative/partner development and facilitation as well as support from OHA-HPCDP surveillance and evaluation staff for planning and implementation of evaluation activities.

Progress and Findings:

Following are some examples of what teams were able to accomplish with the flexible SRCH funding opportunity, training, and technical assistance to use innovative methods to prevent and address chronic disease disparities.

The Confederated Tribes of Siletz Indians SRCH team is piloting a virtual Diabetes Self-Management Education and Support (DSMES) Native cohort with the OHSU-Harold Schnitzer Diabetes Health Center. This work includes tribal adaptations to the DSMES curriculum, launch of a "Three-Touch" communications campaign to encourage people to visit their PCP for their annual screening, and establishing a closed loop referral between Siletz Tribal Health and OHSU.

The Central Oregon SRCH Team fully transitioned from using Compass Platform and EPIC EHR to Welld for program data management and billing for the National DPP. With the Welld platform being live, the Central Oregon SRCH team is working to partner with other entities to deliver National DPP and bill for the program. Their work also included training and onboarding of new lifestyle coaches to using Welld for new National DPP cohorts and they launched two new cohorts. During this quarter, Deschutes County executed an Umbrella Hub agreement with Crook County for delivery and billing for the National DPP.

The Tillamook SRCH team had 4 collaborative sessions with clinics, health systems and community-based organizations to understand and assess the roles of CHWs in Tillamook County, determine organizational capacity and commitment to CHW implementation, and identify sustainable system for CHWs to address chronic disease prevention and self-management. This is a priority project for the Tillamook County Wellness initiative, with the focus to reduce incidence of T2 diabetes throughout county via National DPP delivery.

OHA-HPCDP partnered with and awarded SRCH funding to the Multnomah County REACH (Racial and Ethnic Approaches to Community Health) program. REACH is planning for National DPP delivery throughout the county with community-based organizations and clinical partners. The REACH program is also in collaboration with OHA-HPCDP and Comagine Health implementing a blood pressure self-monitoring initiative, Healthy Hearts Ambassador (HHA) program.

Trends, Successes, or Issues:
The final reporting period illustrated that the SRCH teams with the most momentum and success were implementing projects focused on diabetes prevention and/or management. The successes and learning from the SRCH teams has led OHA-HPCDP to direct the next fiscal year funding for SRCH toward a sub-set of the current teams implementing diabetes prevention and management projects, further focusing the funding opportunity. Four (4) of the SRCH teams will receive continued funding and technical assistance from OHA-HPCPD in FY 2021-22.

The evaluation conducted by Rede Group on the SRCH model was a helpful first step for OHA-HPCDP to reexamine how the current SRCH model is meeting the needs of local and regional partners and also which aspects of the SRCH initiative are valuable in the current context of health systems transformation and public health modernization in Oregon. As the COVID-19 public health emergency evolves, OHA-HPCDP is assessing when and how best to adapt the SRCH model to support communities beyond the 2021-22 fiscal year.

Public Health Modernization and the State Health Improvement Plan (SHIP)
While Oregon's "Public Health Modernization" initiative was historically featured in waiver reporting, we have shifted emphasis to Healthier Together Oregon, Oregon's State Health Improvement Plan. This change is made in light of our work to improve social determinants of health and equity with our health system transformation efforts.

Last September, OHA finalized and released the 2020-2024 State Health Improvement Plan (SHIP), Healthier Together Oregon (HTO). HTO identifies our state's health priorities with strategies to advance improvement and measures to monitor our progress. The goal of HTO is to advance health equity for five priority populations: people of color and tribal communities, people who identify as LGBTQ+, people with low-income, people who live in rural areas, and people with disabilities. Five priorities were identified by the PartnerSHIP, a community-based steering committee; institutional bias, adversity, trauma and toxic stress, behavioral health, access to equitable preventive health care, and economic drivers of health (to include housing, transportation, and living wage jobs). The plan is intended to inform policies, priorities and investments of state agencies, and Community Health Improvement Plans (CHIPS) developed and implemented by CCOs, local public health authorities and non-profit hospitals.

Since launch of the plan in fall of 2020, OHA has been communicating about the plan with other state agencies, CCOs and community-based organizations. To support alignment of CHIPs, OHA hosted a series of webinars for CCOs, non-profit hospitals and local public health authorities to share information about HTO, and to solicit ideas from CHIP implementers on formation of learning collaboratives around HTO priorities and strategies. OHA also began hosting HTO in action events. These events are open to all partners who are working to advance health equity and provide opportunity to learn more about the priorities and strategies within the plan.

Communication efforts about HTO also took place via OHA Social Media, launching of the Healthier Together Oregon website, and presentations to a variety of partners such as the Oregon Health Policy Board and related committees, the We Can Do Better Coalition, and the Oregon Hunger Task Force. A monthly HTO update is also shared with over 7,000 subscribers.

In March 2021, OHA reformed the PartnerSHIP for implementation. The PartnerSHIP holds decision making authority for the SHIP. The PartnerSHIP includes representatives of priority populations and potential implementers of the plan, including CCOs, public health and hospital partners. The initial ask of the PartnerSHIP is to prioritize the 62 strategies for phased implementation. Initial meetings have been spent on relationship and trust building, identification of group processes and agreements, and level setting about the priorities and strategies of the plan.

Innovator Agents
Innovator Agents, (IAs) participated on the Telehealth workgroups that are engaging community members, advocates and those who do not speak English as a primary language to develop culturally and linguistically appropriate services for Oregon Health Plan members to access primary care and behavioral health (including substance use disorder) services. Telehealth services provide a more effective model of care during the current pandemic for those who chose to ensure their personal safety by not exposing themselves to people who could be ill at provider offices. Telehealth services are also proving to be helpful for those in rural communities that find it difficult to come into an urban center for routine care and would prefer to stay closer to home. Anyone

who has been exposed to COVID and needs to isolate has also found the options of telehealth services to be helpful in their recovery, should their symptoms be manageable at their home.

IAs ensured the voice and experience of OHP members, all stakeholders and beneficiaries of the public health programs could be effectively used to identify process improvements that allow OHA to achieve its triple aim with a priority on health equity. IAs promoted opportunities for systems to be more person-centered and assisted integrating, public health, behavioral health, social services, and community-based organizations. In this collaborative effort, the state is given greater purchasing and marketing power to begin tackling the issues of costs, quality, and access to care.

IAs understand the health needs of the regions, strengths, and gaps of the health resources in the CCO and articulated these needs and gaps to ensure statewide and local coordination. They looked at best strategies and practices for health care transformation in Oregon and nationally and worked to support uptake and innovation of these practices on the local level. They prioritized elevating Oregon Health Plan member voice within CCO's operations and, within the OHA, connecting OHA to better understand local community strengths, needs, and gaps and linking CCO – OHA – and community initiatives.

IA's acted as quasi local experts in the communities where the CCO they work with are located. They used relationships to connect OHA, local community organizations, and the CCO's they work with and ensure coordination across these groups. They helped good news travel faster by sharing innovation and successful practices with other CCO's with the OHA, and with national audiences. They played a key role in leading OHA's strategic priority of eliminating health inequalities by taking this statewide priority and worked with CCO's and local communities to translate statewide priorities to local adaptation and implementation. In particular they elevated and ensured that communities in Oregon who face health inequalities because of their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances are engaged in CCO and community health work.

IAs ensured safety and health equity across the state of Oregon. SB 698 required every pharmacy to provide written translation and oral interpretation for anyone with limited English proficiency (LEP) to receive their prescription instructions in both their language of choice (14 languages are legally required to be translated) and in English. The IAs have ensured this information has been shared amongst providers, OHP members, and with pharmacies across the state. This is a more effective model of care that ensures OHP members receive the correct instructions about their medication. IAs have worked with community partners, representatives from Refugee Assistance programs and CCOs to ensure these new standards are made available through every pharmacy in Oregon.

IAs continued to provide coordination and communication between OHA, CCOs, and LPHAs around COVID and related health activities. IAs continued to support COVID vaccine distribution efforts by providing CCOs community-based organizations, and public health with routine OHA updates. Innovator Agents leveraged their relationships in local communities to inform COVID-19 testing strategies and events, to support COVID-19 contact tracing and quarantine/isolation efforts and to plan for COVID-19 vaccination. By connecting local partners with CCOs and OHA and carrying current COVID-19 related information to the community level, IAs helped to assure universal communication and coordinated planning.

IAs provided information to Community Based Organizations to apply for funding to support testing, contact tracing, and social supports for quarantine and isolation. One IA served as an evaluator of grant proposals to OHA by CBOs.

IAs continued to "bridge" the work of the Oregon Incident Management Team for COVID and the development of the COVID-19 Response and Recovery Unit (CRUU) with the work of the Health Systems Division and Medicaid.

IAs have actively contributed to the process of notification of workplaces who have been identified to be listed in OHA's Weekly Outbreak Report working closely with the OHA Epi Team and serving as a consultant to answer questions from those businesses about the OHA process.

OHA updates are continually shared which has increased efficiency among the CCOs and partners. In addition, IAs have supported community organizations, public health, and OHP members with resources developed by OHA. IAs assisted and supported the CCOs in providing resources available through OPRIN and the Transformation Center which were stipulated in the CCO/OHA contract. They assisted in the implementation of innovative projects and pilots. They helped the CCOs in the development of strategies to support quality improvement and the adoption of innovations in care through facilitating collaboration and knowledge sharing across the state.

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

Health-Related Services

CCOs receive a global payment for each member, which provides CCOs the flexibility to offer health-related services (HRS) to improve the health of Oregon's Medicaid population. HRS includes both member-level services to improve member health (flexible services) and community-level services (community benefit initiatives) to improve population health.

Staff completed an initial assessment of the 2020 CCO-reported HRS spending to determine if spending met HRS criteria. In 2019 CCOs reported $26,082,997 of HRS spending compared to $39,099,217 in 2020. The initial assessment yielded a 72% acceptance rate for 2020, compared to a final 62% acceptance rate for 2019. With at least a 72% acceptance rate (likely will increase upon final assessment), CCOs will have spent $28,151,437. In comparison to 2019, this represents at least a 74% increase in accepted HRS spending. The final assessment to determine if 2020 CCO spending met HRS criteria will be completed by July 16. The final analysis and summary of 2020 HRS spending will be released by early fall.

To improve future use of and support potential increases to HRS spending, staff contracted with the Oregon Rural Practice-based Research Network (ORPRN) to hold a webinar for CCOs focused on housing supports and braided funding. The webinar recording is available here: https://us02web.zoom.us/rec/share/1IpvwRhT9UjzcuVgMXOQsbgOmFZ-eRgmGMajOv2Hs82jl-CbfjQdHySz2PlUgNoY.i53B5wDvYq9Al4kB?startTime=1619811977000.

The center also worked with ORPRN to host a virtual convening for CCOs: Using HRS for resilience and rebuilding after COVID-19. The convening was held in May with 96 attendees representing over 25 organizations, including staff from every CCO, community-based organizations, clinics, and public health. All event materials are now available on the center's HRS webpage: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/HRS-Event-May-2021.aspx.

All HRS guidance documents for CCOs and external partners are regularly updated and available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx.

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

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

Population health

Community Advisory Council activities

The center continued to host peer-to-peer meetings with community advisory council (CAC) members and CAC coordinators. Meeting topics this quarter included: CAC member recruitment, support of CAC governing board members, roles for CAC members in reviewing CCO spending on the social determinants of health, and language interpretation at CAC meetings. The center also completed its learning collaborative for CAC members serving on CCO governing boards and hosted a CAC office hour session focused on the CAC demographic report.

In June, the center hosted a virtual CAC conference, and 135 people attended from all 15 CCOs and 29 of 32 CACs. Topics included the social determinants of health and equity, community health improvement plans and CAC governing board member experiences. As one participant shared, "It was great to see real people sharing stories of how the CACs have impacted their lives in a positive way."

Community health assessment (CHA) and community health improvement plan (CHP)

The Transformation Center finished a series of virtual CHA/CHP trainings for CCOs and their CHA/CHP partners. Based on individual CCO requests, the center held two CHA/CHP overview trainings, three CHA-only trainings, and one CHP-only training.

The center hosted two additional webinars: 1) a CHA webinar with CCO staff presenting on "The Power of Storytelling as a Person-Centered Data Collection Method" (recording is available here: https://www.youtube.com/watch?v=yR0PP17xMCU); and 2) a webinar highlighting lessons learned from

developing a CHA and CHP shared by CCOs, local public health, and nonprofit hospitals (recording is available here: https://www.youtube.com/watch?v=ToJnPu1LJ6U).

Social Determinants of Health Measurement Workgroup

Pilot testing began on the proposed measure concept ("Rate of social needs screening in the total member population using any qualifying data source"). Nine CCOs and two affiliated health care systems participated in three pilot testing meetings organized by OHA staff. Consultants provided technical assistance to CCOs throughout the pilot, including one-on-one phone calls and weekly webinars on topics such as: creating plans for accessing member data; implementing structural measures; screening tools; avoiding over-screening; demonstration of Unite Us CIE platform; data collection from multiple sources; equitable and trauma-informed practices; and screening workflows.

Supporting Health for All through REinvestment: the SHARE Initiative

The SHARE Initiative comes from a legislative requirement for CCOs to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity. Based on their 2020 financials, CCOs designated $4,120,316 toward their SHARE Initiative investments. This information is publicly available in the CCO annual Exhibit L submissions here: https://www.oregon.gov/oha/FOD/Pages/CCO-Financial.aspx. CCOs will submit their spending plans by September 30.

The center contracted with ORPRN to begin TA for CCOs, which included a webinar for peer-to-peer sharing and office hours.

CCO Incentive Metrics Technical Assistance

Diabetes (HbA1C and a new oral health visit metric)

The Transformation Center continued its work with the Oregon Rural Practice-based Research Network (ORPRN) to increase quality improvement capacity in clinics by concentrating on two CCO incentive metrics: HbA1C poor control and dental exams for adults with diabetes. ORPRN completed follow-up one-on-one technical assistance calls between practice coaches and participating clinics. ORPRN also created a tool kit to support the two metrics and led a webinar to introduce the tool kit. The tool kit is available here: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Diabetes-Metrics-Toolkit.pdf.

Kindergarten readiness (well-child visits and preventive dental)

The Transformation Center partnered with Insight for Action to conduct an environmental scan to identify resources for parents of young children (ages 3–6) to promote their children's wellness. This scan aligns with the OHA CCO incentive metric focused on kindergarten readiness, which emphasizes the importance of well-child visits for 3-6-year-old children in improving school readiness. The resource list and introductory webinar are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/kindergarten-readiness.aspx.

The Transformation Center is leading a two-year learning collaborative in the state to increase rates of topical fluoride varnish applied in primary care and improve overall performance on the preventive dental care metric. This group will hold its kick-off meeting in July. Eleven CCOs, three DCOs, five county health departments, one tribal entity, the school of dentistry, a fee-for-service care coordination contractor, and the chief professional organization for primary care clinics in the state have joined the effort to date.

Meaningful language access to culturally responsive health care services

CCOs have a new incentive metric for 2021: meaningful language access to culturally responsive health care services. This will measure the provision of quality interpreter services and is based on the proportion of member visits with spoken and sign language interpreter needs provided with OHA qualified or certified health care interpreters.

The Transformation Center, in partnership with the OHA Division of Equity and Inclusion, hosted a five-session virtual learning collaborative for CCO staff focused on meaningful language access to culturally responsive health care services. Participants discussed language assistance efforts and services, and related components from CCO health equity plans. One hundred and thirty-five people attended. Participants reported that the inclusion and engagement of stakeholders was wonderful, and the meeting duration, cadence, and timeframe over several months was helpful to learn the information and build momentum. For more details, see the meaningful language access to culturally responsive health care services technical assistance webpage.

Oral health for patients with diabetes and HbA1C control

The center hosted a facilitated discussion with representatives from CCOs and DCOs to talk about moving the needle for HbA1C control and oral health exams for patients with diabetes. The objective was to learn from each other as participants shared what is working, discussed common barriers and brainstormed solutions. Fifteen people from nine organizations attended. All respondents pledged to take an action as a result of the conversation, and 80 percent of evaluation respondents found it valuable in supporting their work and effective for meeting the needs of their organization.

Screening, brief intervention and referral to treatment (SBIRT)

The Transformation Center is partnering with ORPRN to offer TA to primary care clinics in support of the SBIRT metric. The TA is a three-year study funded through the Agency for Healthcare Quality and Research (AHQR). The project is designed to address unhealthy alcohol use, chronic pain management and opioid prescribing in primary care. Moving forward, the TA is also addressing ramifications COVID-19 may have on SBIRT workflows and concerns about a rise in unhealthy alcohol and drug use concurrent with the physical distancing needed to suppress COVID-19. The project team is working with AHQR to propose extending the recruitment phase due to the barriers to recruitment over the past 18 months (due to COVID and clinical capacity). Forty-two clinics are participating.

Cross-cutting supports

COVID-19 vaccines: virtual learning series for providers

The Transformation Center, in partnership with the OHA Vaccine Planning Unit, hosted a 6-session learning collaborative for clinics newer to COVID immunizations to learn from subject matter experts and health center peers. Topics included operational workflows, allocations, targeting high risk populations, vaccine hesitancy and more. An average of 28 participants attended each session.

REALD (race, ethnicity, language, and disability) learning series

The center partnered with the OHA Equity and Inclusion Division to host a REALD learning series for phase 1 and 2 organizations. These sessions focused on hearing from partners on lessons learned while operationalizing REALD. The center also hosted two office hour sessions for phase 2 organizations. An average of 98 participants attended each learning session.

Traditional health worker (THW) learning collaborative

The Transformation Center, in partnership with the Division of Equity and Inclusion, completed a five-session virtual learning collaborative for CCO staff to advance health equity through the improved integration and increased utilization of traditional health workers. Throughout the learning collaborative, CCOs' THW liaisons described how each CCO was working with the different THW worker types and highlighted how CCO THW liaisons are the subject matter experts who can build bridges and relationships with and among OHA, their CCO, THWs and THW services, health care providers, social service providers and CCO members. Eighty-five people attended. Participants reported the discourse with other THW liaisons regarding payment models and best practices for integrating THW liaisons into health and behavioral health practices to be extremely helpful.

Transformation and quality strategy (TQS) technical assistance

OHA subject matter experts reviewed and scored CCO TQS submissions. CCOs received their written assessments in June. Out of 135 points possible, CCOs scored 85.25–119 points (63.1%–88.1%) with an average of 104.6 points (77.5%). While the total points possible changed since 2020, the average CCO score increased by 8.8 percentage points. CCOs were encouraged to continue projects to show progress, and 77% of projects were continued from the prior year (an increase from 52% in 2020).

While many project activities were affected or stalled by pandemic response, CCOs improved in their ability to describe work relevant to improving quality and pushing transformation; provide sufficient detail; and plan measurable and feasible monitoring activities to ensure meaningful progress.

2021 TQS submissions and written assessments are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx.

Patient-centered counseling trainings

The center hosted five virtual patient-centered counseling trainings for Medicaid providers, and 130 people attended. Examples drew from COVID-19 prevention and CCO metric-related topics. Evidence-based health communication models included motivational interviewing, the FRAMES model and Five As for tobacco cessation counseling. No-cost continuing medical education credits were available. Evaluation results were extremely positive, with 100% of respondents indicating the training was valuable to their work, and 100% planned to take some action as a result.

Two weeks after each training, the center asked participants to complete a post-test survey. Respondents indicated they were more confident facilitating conversations with patients about sensitive topics, and they demonstrated better ability to provide open-ended questions. The top barriers (from open-ended responses) included time; practice; old habits; challenges of virtual/telephonic visits; and leadership or system barriers (like leadership focus on data-driven results rather than trauma-informed practice, Medicaid reimbursement requiring identified goals/interventions at the onset of treatment, and the medical model's focus on risk over autonomy).

B. Lower cost

Two-percent test data (reporting on an annual basis)

Reported separately in an Appendix

C. Better care and Better health (ANNUAL)

Quality Pool

As the COVID-19 pandemic hit, Oregon's health care delivery system strained and adapted. In-person care was severely disrupted. Although telehealth services were rapidly deployed to fill some gaps, some care simply could not be delivered remotely.

In response to the COVID-19 pandemic, expectations for the CCO quality incentive program were revised. Early on, under the 2020 CCO contract, OHA intended to withhold 4.25% of each CCO's monthly capitation revenue – totaling approximately $17 million per month across all CCOs – to fund the 2020 quality pool. (In 2021, the funding mechanism for the quality pool returned to a bonus rather than a withhold.) Starting in April 2020, the withhold was suspended so that funds could be infused into the health care delivery system to meet immediate needs to maintain capacity and access to care. The funds withheld from January through March 2020 were maintained for payments under the quality incentive program.

The benchmarks required to qualify for incentives, which had been set in September 2019, were suspended. In July 2020, the Metrics and Scoring Committee voted to make **all of the 2020 incentive measures reporting only**. CCOs qualified for incentives by simply reporting measures.

Even before the pandemic struck, changes in the CCO quality incentive program were underway for 2020. In 2019, the Metrics and Scoring Committee made substantial revisions to the 2020 set of incentivized measures, retiring 10 measures, and adding four measures to the CCO quality incentive program.

In addition, **2020 marked the beginning of the "CCO 2.0" contract period**. Some CCOs did not continue, and other CCOs began to serve Oregon Health Plan members in some areas of the state.

OHA continues its commitment to the strategic goal of eliminating health inequities by 2030. Events in 2020, including COVID harming disadvantaged communities, underscore the importance of ongoing work to improve health equity.
OHA supports the quality improvement efforts of CCOs in various ways:

- During the demonstration year, OHA provided every CCO a summarized monthly metrics dashboard with information that can be parsed at the member level to better understand service use. Because this dashboard is updated monthly with claims-based metric information, CCOs and OHA are able to work together throughout the year to validate measure results. Any discrepancies in reporting can be quickly identified and corrected with smaller lag times. In addition, CCOs can use the ongoing data to target quality improvement efforts. At the conclusion of every measurement year, OHA offers a month-long validation period. During this phase of the program, CCOs can ask for clarification about the rules or calculations for any metric and provide additional documentation for the measures as appropriate.
- The CCO Metrics Technical Advisory Group (TAG) typically meets on a bimonthly cycle to identify, discuss, and resolve metric questions and challenges at the operational level. In 2020, some of these meetings were canceled as part of OHA's effort to reduce CCOs' time commitments not directly tied to COVID response; OHA provided email updates to the Metrics TAG to maintain communication lines between meetings. The Metrics TAG meetings are coordinated with the OHA Transformation Center, which provides practical support directly to CCOs and clinics. For example, technical assistance was offered to help CCOs improve performance on metrics including Diabetes HbA1c Poor Control, Oral Evaluation for Adults with Diabetes, and Emergency Department Visits Among Members Experiencing Mental Illness. Resources from earlier technical assistance, such as childhood immunizations, also remain available to CCOs through recorded webinars and other resources. In addition, OHA supports Innovator Agents to serve as liaisons between CCOs and OHA. The Transformation Center and Innovator Agents help remove communication barriers and ensure OHA remains in touch with each CCO's community.

Areas for improvement include:

- **Assessments for children in DHS custody**: This measure has been an important driver of quality improvements in care and outcomes for some of the most vulnerable Oregonians. For the first time since 2014, performance on this measure declined in 2020. The dental assessments component of the measure was a particular obstacle to performance during the pandemic. At the same time, however, process improvements were completed, as OHA and the Oregon Department of Human Services worked with CCOs to enhance the accuracy and timeliness of notifications to CCOs about children in DHS custody. Based on pilot findings, revised reports now have been rolled out to all CCOs and are expected to support improved coordination going forward.
- **Diabetes care: HbA1c poor control**: This measure, using EHR data, examines the percentage of adult CCO members who have diabetes and whose blood sugars are poorly controlled. Poor control is defined by results on a blood test performed by a laboratory, and a missing test result also is counted as poor control. Because the measure reports poor control, a lower score indicates better performance. Performance on this measure dramatically worsened in 2020.
- **Diabetes care: HbA1c testing**: This measure, using claims data, examines the percentage of adult CCO members who have diabetes and received at least one HbA1c blood sugar test. Like the poor control

measure, this process measure worsened significantly in 2020. Declines occurred among all household language groups, with the largest declines among CCO members in households speaking Spanish and Chinese languages.

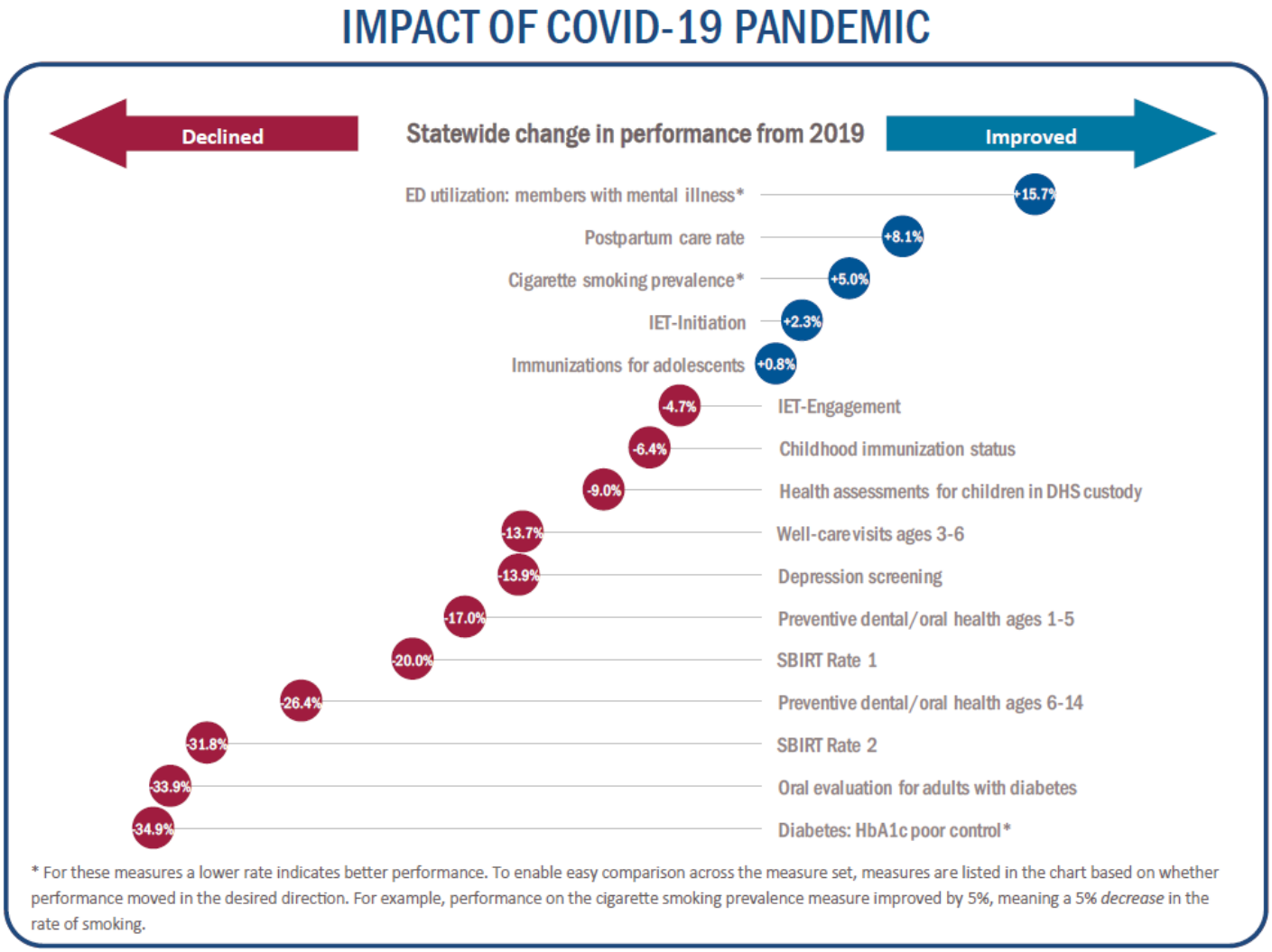
- **Preventive dental services (ages 1-5)**: As routine dental care was suspended or avoided in 2020, the percentage of young children who received a preventive dental service during the year declined significantly. Only one CCO made improvements on this measure in 2020. Performance dropped among all household language groups.
- **Well-child visits (ages 3-6)**: With severe disruptions in routine care, the percentage of children who received at least one primary care well-care visit declined. Only one CCO made improvements on this measure in 2020. Performance dropped among all household language groups.

Areas of strength include:

- **Cigarette smoking prevalence**: Performance on this measure continued to improve in 2020, with the statewide smoking rate among CCO members declining again. The majority of CCOs reported at least some improvement in 2020.

- **Immunizations for adolescents**: Although performance on this measure fell short of the original benchmark, the statewide rate increased slightly from 2019, with the majority of CCOs reporting improved performance. When broken out by household language, most groups improved, but there were declines for CCO members in households speaking English and Russian.

- **Initiation and engagement of alcohol or other drug treatment**: Statewide performance improved for initiation, which is the proportion of members who begin treatment within 14 days of an initial diagnosis of alcohol or other drug dependence. The majority of CCOs improved between 2019 and 2020. When broken out by language, however, there were declines in performance for CCO members in households speaking Spanish and (with a larger decline) Vietnamese. In addition, the rate of timely engagement in services fell between 2019 and 2020.



2020 Quality Pool Distribution

The Oregon Health Authority established the quality pool process to drive improvement through incentive payments to coordinated care organizations (CCOs). This is the eighth year of the quality incentive program, and normally, each CCO is paid for reaching benchmarks or making improvements on incentive measures. Because of the pandemic, ordinary processes were changed for 2020.

Under the original 2020 CCO contract, OHA was to withhold approximately 4.25 percent of each CCO's monthly 2020 capitation revenue to fund the quality pool. These funds were scheduled to be paid out in June 2021. However, due to the health care disruption occurring during the COVID-19 pandemic and the need for increased cash flow to address critical needs, OHA suspended the 2020 withhold starting in April 2020. This resulted in approximately $17 million or more per month to help CCOs address critical needs that could not wait for later funding. Such areas of need include, but are not limited to, hospital access (urban and rural), operation of residential facilities, expanded telehealth services, and laboratory and diagnostic testing, as well as support for local public health agencies, primary care providers, behavioral health providers, transportation services and social service agencies. CCOs had to provide information to OHA on plans for spending these

funds. The funds withheld from January to March 2020 were maintained for the quality pool, and all of those funds were disbursed to CCOs by June 30, 2021.

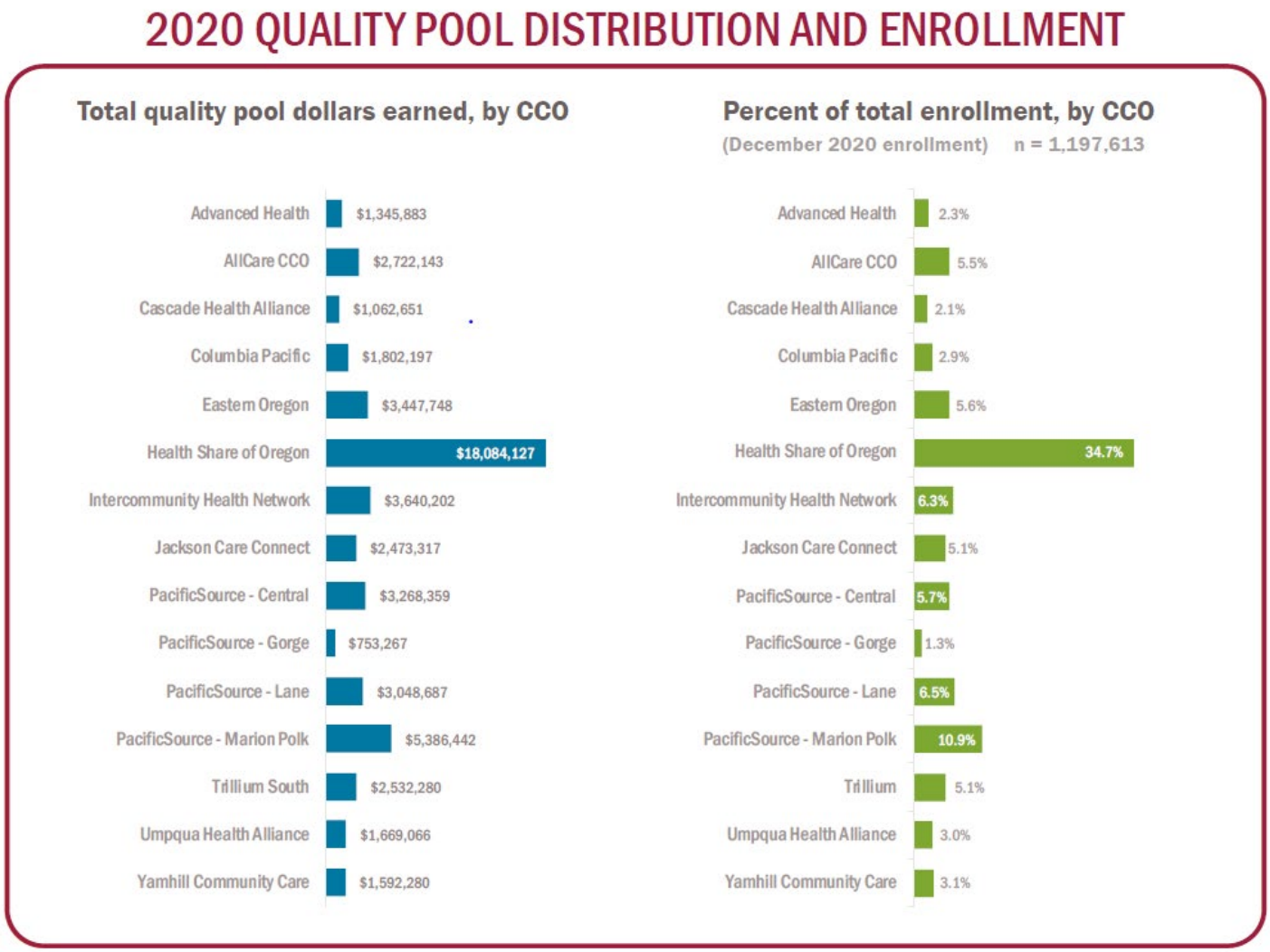
Quality Pool: Phase One Distribution
Due to the COVID-19 pandemic, 2020 data cannot be meaningfully used to assess quality improvement. For this reason, the Metrics and Scoring Committee adjusted the benchmark expectation of each measure in the incentive program to reporting-only, meaning that **2020 quality pool payments are based solely on whether CCOs reported their data to OHA as stipulated in OHA program documentation.**

Challenge Pool: Phase Two Distribution
The challenge pool contains all funds remaining after the phase one distribution of quality pool funds. For 2020, with phase one distribution based on reporting-only, all CCOs earned 100% of their quality pool funds in phase one. Therefore, no funds were allocated to the challenge pool.

2020 QUALITY POOL DISTRIBUTION

CCO	# Measures reported (of 13 possible)*	Total payment earned	Total % quality pool funds earned
Advanced Health	13	$ 1,345,883	100%
AllCare Health Plan	13	$ 2,722,143	100%
Cascade Health Alliance	13	$ 1,062,651	100%
Columbia Pacific	13	$ 1,802,197	100%
Eastern Oregon	13	$ 3,447,748	100%
Health Share of Oregon	13	$ 18,084,127	100%
Intercommunity Health Network	13	$ 3,640,202	100%
Jackson Care Connect	13	$ 2,473,317	100%
PacificSource - Central Oregon	13	$ 3,268,359	100%
PacificSource - Gorge	13	$ 753,267	100%
PacificSource - Lane	13	$ 3,048,687	100%
PacificSource - Marion Polk	13	$ 5,386,442	100%
Trillium South	13	$ 2,532,282	100%
Umpqua Health Alliance	13	$ 1,669,066	100%
Yamhill Community Care	13	$ 1,592,280	100%
Total		$ 52,828,651	

* Quality pool distribution is based on number of measures met and CCO size (number of members). See page X for CCO enrollment.



Oregon proposes replacing the metrics table with a semi-annual submission of our public facing metrics report. Report would be similar to the report found at the following link: https://www.oregon.gov/oha/analytics/Documents/LegislativeReport_Q2-Q3_2016.pdf.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately

2. State reported enrollment table

Enrollment	April/2021	May/2021	June/2021

Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,148,102	1,154,133	1,158,768
Title XXI funded State Plan	105,572	107,573	109,649
Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A

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 XIX**	PLM children FPL > 170%	4	41	0.00%	75.00%
		Pregnant women FPL > 170%	N/A	N/A	N/A	N/A
	Title XXI	SCHIP FPL > 170%	58,021	492,673	5.53%	-0.58%
Optional	**Title XIX**	PLM women FPL 133-170%	2	18	0.00%	-100.00%
	Title XXI	SCHIP FPL < 170%	151,157	1,228,838	6.58%	7.24%
Mandatory	**Title XIX**	Other OHP Plus	194,174	1,984,232	2.18%	8.52%
		MAGI adults/children	984,085	10,029,592	1.97%	8.25%
		MAGI pregnant women	21,533	111,631	6.07%	-0.10%
		QUARTER TOTALS	1,408,976			
** Due to retroactive eligibility changes, the numbers should be considered preliminary*						

OHP eligible and managed care enrollment

		Coordinated Care				Dental Care	Mental Health
OHP eligible*		**CCOA****	**CCOB****	**CCOE****	**CCOG****	**DCO**	**MHO**
July	1,048,316	986,297	2,448	288	11,677	50,249	N/A

August	1,063,279	999,087	2,536	268	12,075	52,481	N/A
September	1,074,394	1,008,772	2,412	214	12,193	53,406	N/A
October	1,086,884	1,019,972	2,291	221	12,221	54,877	N/A
November	1,104,604	1,035,056	2655	245	12,655	57,106	N/A
December	1,123,679	1,051,877	2392	223	13,220	58,728	N/A
January	1,136,061	1,061,283	2,092	243	13,688	60,889	N/A
February	1,146,155	1,070,515	2,098	245	14,022	61,429	N/A
March	1,159,280	1,083,160	2,095	197	14,478	61,724	N/A
April	1,168,381	1,092,640	2,402	198	14,415	62,100	N/A
May	1,180,707	1,104,157	2,766	194	14,209	62,893	N/A
June	1,187,362	1,110,469	2,251	195	14,303	62,954	N/A
Annual average	1,123,259	1,051,940	2,370	228	13,263	58,236	
	Average percentage	93.65%	0.21%	0.02%	1.18%	5.18%	

** 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: Physical, dental, and mental health; CCOB: Physical and mental health; CCOE: Mental health only; and CCOG: Mental and dental health*

B. Complaints and grievances

Report will be attached separately that will provide a summary of statewide complaints and grievances reported by the CCOs for the relevant quarter. A report will not be attached if there is no activity during the relevant quarter.

C. CCO appeals and hearings

Report will be attached separately that will provide a summary of appeals and hearings for the relevant quarter. A report will not be attached if there is no activity during the relevant quarter.

D. Neutrality reports

Budget monitoring spreadsheets

Attached separately. Moving forward, we will submit the following reports for budget neutrality purposes:

- OHP Section 1115 Demonstration (Expenditures)
- OHP Title XXI Allotment

CHIP Statistical Enrollment Data Reports

Form 21E | OR | 2021 | Quarter 3

Conception to birth:

1. What is the unduplicated number of children Under Age 0 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	1,594	125	12	4	2	**1,737**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**1,594**	**125**	**12**	**4**	**2**	**1,737**

2. What is the unduplicated number of new enrollees Under Age 0 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	455	36	4	0	0	**495**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**455**	**36**	**4**	**0**	**0**	**495**

3. What is the unduplicated number of disenrollees Under Age 0 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	543	37	7	1	0	**588**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**543**	**37**	**7**	**1**	**0**	**588**

4. What is the number of member-months of enrollment for children Under Age 0 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	3,772	305	22	12	6	**4,117**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**3,772**	**305**	**22**	**12**	**6**	**4,117**

5. What is the average number of months of enrollment for children Under Age 0 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.4	2.4	1.8	3.0	3.0	**2.37**
B. Managed Care Arrangements	0	0	0	0	0	**0.00**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**2.37**	**2.44**	**1.83**	**3.00**	**3.00**	**2.37**

Values will not appear until source data is provided

6. What is the number of children Under Age 0 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	1,116	93	6	3	2	**1,220**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**1,116**	**93**	**6**	**3**	**2**	**1,220**

Birth through age 12 months:

1. What is the unduplicated number of children between the ages of 0 and 1 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	20	30	25	0	**75**
B. Managed Care Arrangements	0	106	334	239	0	**679**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**126**	**364**	**264**	**0**	**754**

2. What is the unduplicated number of new enrollees between the ages of 0 and 1 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	16	22	18	0	**56**
B. Managed Care Arrangements	0	34	100	78	0	**212**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**50**	**122**	**96**	**0**	**268**

3. What is the unduplicated number of disenrollees between the ages of 0 and 1 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	4	6	7	0	**17**
B. Managed Care Arrangements	0	10	15	18	0	**43**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**14**	**21**	**25**	**0**	**60**

4. What is the number of member-months of enrollment for children between the ages of 0 and 1 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	37	47	39	0	**123**
B. Managed Care Arrangements	0	290	900	645	0	**1,835**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**327**	**947**	**684**	**0**	**1,958**

5. What is the average number of months of enrollment for children between the ages of 0 and 1 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	1.9	1.6	1.6	0	**1.64**
B. Managed Care Arrangements	0	2.7	2.7	2.7	0	**2.70**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**0.00**	**2.60**	**2.60**	**2.59**	**0.00**	**2.60**

Values will not appear until source data is provided

6. What is the number of children between the ages of 0 and 1 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	17	26	20	0	**63**
B. Managed Care Arrangements	0	100	324	227	0	**651**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**117**	**350**	**247**	**0**	**714**

Age 1 year through age 5 years:

1. What is the unduplicated number of children between the ages of 1 and 5 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	1,177	398	445	0	**2,020**
B. Managed Care Arrangements	0	18,415	6,191	4,327	0	**28,933**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**19,592**	**6,589**	**4,772**	**0**	**30,953**

2. What is the unduplicated number of new enrollees between the ages of 1 and 5 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	340	105	70	0	**515**
B. Managed Care Arrangements	0	5,024	1,058	715	0	**6,797**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**5,364**	**1,163**	**785**	**0**	**7,312**

3. What is the unduplicated number of disenrollees between the ages of 1 and 5 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	112	27	32	0	**171**
B. Managed Care Arrangements	0	2,046	403	217	0	**2,666**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**2,158**	**430**	**249**	**0**	**2,837**

4. What is the number of member-months of enrollment for children between the ages of 1 and 5 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	3,085	1,040	1,213	0	**5,338**
B. Managed Care Arrangements	0	49,297	17,362	12,233	0	**78,892**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**52,382**	**18,402**	**13,446**	**0**	**84,230**

5. What is the average number of months of enrollment for children between the ages of 1 and 5 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	2.6	2.6	2.7	0	**2.64**
B. Managed Care Arrangements	0	2.7	2.8	2.8	0	**2.73**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**0.00**	**2.67**	**2.79**	**2.82**	**0.00**	**2.72**

Values will not appear until source data is provided

6. What is the number of children between the ages of 1 and 5 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	1,115	379	418	0	**1,912**
B. Managed Care Arrangements	0	17,078	5,912	4,178	0	**27,168**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**18,193**	**6,291**	**4,596**	**0**	**29,080**

Age 6 years through age 12 years:

1. What is the unduplicated number of children between the ages of 6 and 12 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	1,593	606	576	0	**2,775**
B. Managed Care Arrangements	0	27,074	10,044	6,770	0	**43,888**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**28,667**	**10,650**	**7,346**	**0**	**46,663**

2. What is the unduplicated number of new enrollees between the ages of 6 and 12 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	440	107	94	0	**641**
B. Managed Care Arrangements	0	5,810	1,186	826	0	**7,822**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**6,250**	**1,293**	**920**	**0**	**8,463**

3. What is the unduplicated number of disenrollees between the ages of 6 and 12 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	151	49	50	0	**250**
B. Managed Care Arrangements	0	2,616	513	279	0	**3,408**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**2,767**	**562**	**329**	**0**	**3,658**

4. What is the number of member-months of enrollment for children between the ages of 6 and 12 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	4,184	1,656	1,565	0	**7,405**
B. Managed Care Arrangements	0	74,724	28,945	19,481	0	**123,150**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**78,908**	**30,601**	**21,046**	**0**	**130,555**

5. What is the average number of months of enrollment for children between the ages of 6 and 12 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	2.6	2.7	2.7	0	**2.67**
B. Managed Care Arrangements	0	2.8	2.9	2.9	0	**2.81**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**0.00**	**2.75**	**2.87**	**2.86**	**0.00**	**2.80**

Values will not appear until source data is provided

6. What is the number of children between the ages of 6 and 12 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	1,479	570	536	0	**2,585**
B. Managed Care Arrangements	0	25,297	9,712	6,556	0	**41,565**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**26,776**	**10,282**	**7,092**	**0**	**44,150**

Age 13 years through age 18 years:

1. What is the unduplicated number of children between the ages of 13 and 18 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	1,313	523	446	0	**2,282**
B. Managed Care Arrangements	0	20,336	8,471	5,866	0	**34,673**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**21,649**	**8,994**	**6,312**	**0**	**36,955**

2. What is the unduplicated number of new enrollees between the ages of 13 and 18 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	355	90	74	0	**519**
B. Managed Care Arrangements	0	3,947	837	620	0	**5,404**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**4,302**	**927**	**694**	**0**	**5,923**

3. What is the unduplicated number of disenrollees between the ages of 13 and 18 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	134	50	41	0	**225**
B. Managed Care Arrangements	0	1,699	387	244	0	**2,330**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**1,833**	**437**	**285**	**0**	**2,555**

4. What is the number of member-months of enrollment for children between the ages of 13 and 18 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	3,462	1,412	1,195	0	**6,069**
B. Managed Care Arrangements	0	56,473	24,512	16,955	0	**97,940**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**59,935**	**25,924**	**18,150**	**0**	**104,009**

5. What is the average number of months of enrollment for children between the ages of 13 and 18 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	2.6	2.7	2.7	0	**2.66**
B. Managed Care Arrangements	0	2.8	2.9	2.9	0	**2.82**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**0.00**	**2.77**	**2.88**	**2.88**	**0.00**	**2.81**

Values will not appear until source data is provided

6. What is the number of children between the ages of 13 and 18 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	1,229	489	415	0	**2,133**
B. Managed Care Arrangements	0	19,203	8,225	5,699	0	**33,127**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**20,432**	**8,714**	**6,114**	**0**	**35,260**

Add any notes here to accompany the form submission:

Form 21E | OR | 2021 | Quarter 3

CHIP Statistical Enrollment Data Reports

Form 64.21E | OR | 2021 | Quarter 3

Birth through age 12 months:

1. What is the unduplicated number of children between the ages of 0 and 1 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service						**0**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

2. What is the unduplicated number of new enrollees between the ages of 0 and 1 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service						**0**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

3. What is the unduplicated number of disenrollees between the ages of 0 and 1 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service						**0**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

4. What is the number of member-months of enrollment for children between the ages of 0 and 1 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service						**0**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

5. What is the average number of months of enrollment for children between the ages of 0 and 1 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	0	0	0	0	**0.00**
B. Managed Care Arrangements	0	0	0	0	0	**0.00**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Values will not appear until source data is provided

6. What is the number of children between the ages of 0 and 1 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service						**0**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

Age 1 year through age 5 years:

1. What is the unduplicated number of children between the ages of 1 and 5 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service						**0**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

2. What is the unduplicated number of new enrollees between the ages of 1 and 5 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service						0
B. Managed Care Arrangements						0
C. Primary Care Case Management						0
Totals:	0	0	0	0	0	0

3. What is the unduplicated number of disenrollees between the ages of 1 and 5 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service						0
B. Managed Care Arrangements						0
C. Primary Care Case Management						0
Totals:	0	0	0	0	0	0

4. What is the number of member-months of enrollment for children between the ages of 1 and 5 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service						**0**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

5. What is the average number of months of enrollment for children between the ages of 1 and 5 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	0	0	0	0	**0.00**
B. Managed Care Arrangements	0	0	0	0	0	**0.00**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Values will not appear until source data is provided

6. What is the number of children between the ages of 1 and 5 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service						**0**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

Age 6 years through age 12 years:

1. What is the unduplicated number of children between the ages of 6 and 12 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	28,320					**28,320**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**28,320**	**0**	**0**	**0**	**0**	**28,320**

2. What is the unduplicated number of new enrollees between the ages of 6 and 12 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	5,913					**5,913**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**5,913**	**0**	**0**	**0**	**0**	**5,913**

3. What is the unduplicated number of disenrollees between the ages of 6 and 12 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	4,167					**4,167**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**4,167**	**0**	**0**	**0**	**0**	**4,167**

4. What is the number of member-months of enrollment for children between the ages of 6 and 12 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	74,282					**74,282**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**74,282**	**0**	**0**	**0**	**0**	**74,282**

5. What is the average number of months of enrollment for children between the ages of 6 and 12 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.6	0	0	0	0	**2.62**
B. Managed Care Arrangements	0	0	0	0	0	**0.00**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**2.62**	**0.00**	**0.00**	**0.00**	**0.00**	**2.62**

Values will not appear until source data is provided

6. What is the number of children between the ages of 6 and 12 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	25,129					**25,129**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**25,129**	**0**	**0**	**0**	**0**	**25,129**

Age 13 years through age 18 years:

1. What is the unduplicated number of children between the ages of 13 and 18 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	22,491					**22,491**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**22,491**	**0**	**0**	**0**	**0**	**22,491**

2. What is the unduplicated number of new enrollees between the ages of 13 and 18 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	3,691					**3,691**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**3,691**	**0**	**0**	**0**	**0**	**3,691**

3. What is the unduplicated number of disenrollees between the ages of 13 and 18 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	3,280					**3,280**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**3,280**	**0**	**0**	**0**	**0**	**3,280**

4. What is the number of member-months of enrollment for children between the ages of 13 and 18 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	60,090					**60,090**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**60,090**	**0**	**0**	**0**	**0**	**60,090**

5. What is the average number of months of enrollment for children between the ages of 13 and 18 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.7	0	0	0	0	**2.67**
B. Managed Care Arrangements	0	0	0	0	0	**0.00**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**2.67**	**0.00**	**0.00**	**0.00**	**0.00**	**2.67**

Values will not appear until source data is provided

6. What is the number of children between the ages of 13 and 18 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	20,000					**20,000**
B. Managed Care Arrangements						**0**
C. Primary Care Case Management						**0**
Totals:	**20,000**	**0**	**0**	**0**	**0**	**20,000**

Add any notes here to accompany the form submission:

Form 64.21E | OR | 2021 | Quarter 3

CHIP Statistical Enrollment Data Reports

Form 64.EC | OR | 2021 | Quarter 3

Birth through age 12 months:

1. What is the unduplicated number of children between the ages of 0 and 1 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	1,071	0	0	0	0	**1,071**
B. Managed Care Arrangements	19,945	0	0	0	0	**19,945**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**21,016**	**0**	**0**	**0**	**0**	**21,016**

2. What is the unduplicated number of new enrollees between the ages of 0 and 1 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	674	0	0	0	0	**674**
B. Managed Care Arrangements	5,154	0	0	0	0	**5,154**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**5,828**	**0**	**0**	**0**	**0**	**5,828**

3. What is the unduplicated number of disenrollees between the ages of 0 and 1 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	32	0	0	0	0	**32**
B. Managed Care Arrangements	473	0	0	0	0	**473**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**505**	**0**	**0**	**0**	**0**	**505**

4. What is the number of member-months of enrollment for children between the ages of 0 and 1 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	1,961	0	0	0	0	**1,961**
B. Managed Care Arrangements	55,599	0	0	0	0	**55,599**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**57,560**	**0**	**0**	**0**	**0**	**57,560**

5. What is the average number of months of enrollment for children between the ages of 0 and 1 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	1.8	0	0	0	0	**1.83**
B. Managed Care Arrangements	2.8	0	0	0	0	**2.79**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**2.74**	**0.00**	**0.00**	**0.00**	**0.00**	**2.74**

Values will not appear until source data is provided

6. What is the number of children between the ages of 0 and 1 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	1,049	0	0	0	0	**1,049**
B. Managed Care Arrangements	19,675	0	0	0	0	**19,675**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**20,724**	**0**	**0**	**0**	**0**	**20,724**

Age 1 year through age 5 years:

1. What is the unduplicated number of children between the ages of 1 and 5 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	5,142	0	0	0	0	**5,142**
B. Managed Care Arrangements	91,150	0	0	0	0	**91,150**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**96,292**	**0**	**0**	**0**	**0**	**96,292**

2. What is the unduplicated number of new enrollees between the ages of 1 and 5 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	438	0	0	0	0	**438**
B. Managed Care Arrangements	8,575	0	0	0	0	**8,575**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**9,013**	**0**	**0**	**0**	**0**	**9,013**

3. What is the unduplicated number of disenrollees between the ages of 1 and 5 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	454	0	0	0	0	**454**
B. Managed Care Arrangements	6,243	0	0	0	0	**6,243**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**6,697**	**0**	**0**	**0**	**0**	**6,697**

4. What is the number of member-months of enrollment for children between the ages of 1 and 5 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	14,356	0	0	0	0	**14,356**
B. Managed Care Arrangements	263,865	0	0	0	0	**263,865**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**278,221**	**0**	**0**	**0**	**0**	**278,221**

5. What is the average number of months of enrollment for children between the ages of 1 and 5 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.8	0	0	0	0	**2.79**
B. Managed Care Arrangements	2.9	0	0	0	0	**2.89**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**2.89**	**0.00**	**0.00**	**0.00**	**0.00**	**2.89**

Values will not appear until source data is provided

6. What is the number of children between the ages of 1 and 5 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	4,811	0	0	0	0	**4,811**
B. Managed Care Arrangements	87,035	0	0	0	0	**87,035**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**91,846**	**0**	**0**	**0**	**0**	**91,846**

Age 6 years through age 12 years:

1. What is the unduplicated number of children between the ages of 6 and 12 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	8,767	0	0	0	0	**8,767**
B. Managed Care Arrangements	102,394	0	0	0	0	**102,394**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**111,161**	**0**	**0**	**0**	**0**	**111,161**

2. What is the unduplicated number of new enrollees between the ages of 6 and 12 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	627	0	0	0	0	**627**
B. Managed Care Arrangements	11,099	0	0	0	0	**11,099**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**11,726**	**0**	**0**	**0**	**0**	**11,726**

3. What is the unduplicated number of disenrollees between the ages of 6 and 12 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	620	0	0	0	0	**620**
B. Managed Care Arrangements	7,351	0	0	0	0	**7,351**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**7,971**	**0**	**0**	**0**	**0**	**7,971**

4. What is the number of member-months of enrollment for children between the ages of 6 and 12 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	24,774	0	0	0	0	**24,774**
B. Managed Care Arrangements	293,749	0	0	0	0	**293,749**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**318,523**	**0**	**0**	**0**	**0**	**318,523**

5. What is the average number of months of enrollment for children between the ages of 6 and 12 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.8	0	0	0	0	**2.83**
B. Managed Care Arrangements	2.9	0	0	0	0	**2.87**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**2.87**	**0.00**	**0.00**	**0.00**	**0.00**	**2.87**

Values will not appear until source data is provided

6. What is the number of children between the ages of 6 and 12 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	8,288	0	0	0	0	**8,288**
B. Managed Care Arrangements	97,080	0	0	0	0	**97,080**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**105,368**	**0**	**0**	**0**	**0**	**105,368**

Age 13 years through age 18 years:

1. What is the unduplicated number of children between the ages of 13 and 18 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	8,689	0	0	0	0	**8,689**
B. Managed Care Arrangements	81,775	0	0	0	0	**81,775**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**90,464**	**0**	**0**	**0**	**0**	**90,464**

2. What is the unduplicated number of new enrollees between the ages of 13 and 18 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	560	0	0	0	0	**560**
B. Managed Care Arrangements	7,488	0	0	0	0	**7,488**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**8,048**	**0**	**0**	**0**	**0**	**8,048**

3. What is the unduplicated number of disenrollees between the ages of 13 and 18 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	454	0	0	0	0	**454**
B. Managed Care Arrangements	4,929	0	0	0	0	**4,929**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**5,383**	**0**	**0**	**0**	**0**	**5,383**

4. What is the number of member-months of enrollment for children between the ages of 13 and 18 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	24,868	0	0	0	0	**24,868**
B. Managed Care Arrangements	236,010	0	0	0	0	**236,010**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**260,878**	**0**	**0**	**0**	**0**	**260,878**

5. What is the average number of months of enrollment for children between the ages of 13 and 18 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.9	0	0	0	0	**2.86**
B. Managed Care Arrangements	2.9	0	0	0	0	**2.89**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**2.88**	**0.00**	**0.00**	**0.00**	**0.00**	**2.88**

Values will not appear until source data is provided

6. What is the number of children between the ages of 13 and 18 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	8,340	0	0	0	0	**8,340**
B. Managed Care Arrangements	78,240	0	0	0	0	**78,240**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**86,580**	**0**	**0**	**0**	**0**	**86,580**

Age 19 years through age 20 years:

1. What is the unduplicated number of children between the ages of 19 and 20 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	5,140	0	0	0	0	**5,140**
B. Managed Care Arrangements	35,322	0	0	0	0	**35,322**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**40,462**	**0**	**0**	**0**	**0**	**40,462**

2. What is the unduplicated number of new enrollees between the ages of 19 and 20 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	457	0	0	0	0	**457**
B. Managed Care Arrangements	4,316	0	0	0	0	**4,316**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**4,773**	**0**	**0**	**0**	**0**	**4,773**

3. What is the unduplicated number of disenrollees between the ages of 19 and 20 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	151	0	0	0	0	**151**
B. Managed Care Arrangements	1,131	0	0	0	0	**1,131**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**1,282**	**0**	**0**	**0**	**0**	**1,282**

4. What is the number of member-months of enrollment for children between the ages of 19 and 20 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	14,472	0	0	0	0	**14,472**
B. Managed Care Arrangements	102,369	0	0	0	0	**102,369**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**116,841**	**0**	**0**	**0**	**0**	**116,841**

5. What is the average number of months of enrollment for children between the ages of 19 and 20 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.8	0	0	0	0	**2.82**
B. Managed Care Arrangements	2.9	0	0	0	0	**2.90**
C. Primary Care Case Management	0	0	0	0	0	**0.00**
Totals:	**2.89**	**0.00**	**0.00**	**0.00**	**0.00**	**2.89**

Values will not appear until source data is provided

6. What is the number of children between the ages of 19 and 20 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	5,041	0	0	0	0	**5,041**
B. Managed Care Arrangements	34,617	0	0	0	0	**34,617**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**39,658**	**0**	**0**	**0**	**0**	**39,658**

Add any notes here to accompany the form submission:

Form 64.EC | OR | 2021 | Quarter 3

CHIP Statistical Enrollment Data Reports

Form GRE | OR | 2021 | Quarter 3

Conception through age 18 years:

1. What is the number of enrollees by gender?

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
1. Female			**0**			**0**
2. Male			**0**			**0**
3. Unspecified Gender			**0**			**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

2. What is the number of enrollees by race?

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
1. White			**0**			**0**
2. Black or African American			**0**			**0**
3. American Indian or Alaska Native			**0**			**0**
4. Asian Indian			**0**			**0**
5. Chinese			**0**			**0**
6. Filipino			**0**			**0**
7. Japanese			**0**			**0**
8. Korean			**0**			**0**
9. Vietnamese			**0**			**0**
10. Other Asian			**0**			**0**
11. Asian Unknown			**0**			**0**
12. Native Hawaiian			**0**			**0**

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
13. Guamanian or Chamorro			**0**			**0**
14. Samoan			**0**			**0**
15. Other Pacific Islander			**0**			**0**
16. Native Hawaiian or Other Pacific Islander Unknown			**0**			**0**
17. Some other race			**0**			**0**
18. Two or more races (regardless of ethnicity)			**0**			**0**
19. Unspecified Race			**0**			**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

3. What is the number of enrollees by ethnicity?

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
1. Not of Hispanic, Latino/a, or Spanish origin			**0**			**0**
2. Mexican, Mexican American, Chicano/a			**0**			**0**
3. Puerto Rican			**0**			**0**
4. Cuban			**0**			**0**
5. Another Hispanic, Latino, or Spanish Origin			**0**			**0**
6. Hispanic or Latino Unknown			**0**			**0**
7. Unspecified Ethnicity			**0**			**0**
Totals:	**0**	**0**	**0**	**0**	**0**	**0**

Add any notes here to accompany the form submission:

Form GRE | OR | 2021 | Quarter 3

CY 2021 Q2	Advanced Health	AllCare	Cascade Health	Columbia Pacific	Eastern Oregon
ACCESS - "A"					
TOTAL:	35	12	9	26	51
PENDING:	0	0	0	0	0
RESOLVED:	35	12	9	26	51
INTERACTION WITH PROVIDER OR PLAN - "IP"					
TOTAL:	41	26	13	34	82
PENDING:	0	0	0	0	0
RESOLVED:	41	26	13	34	82
CONSUMER RIGHTS - "CR"					
TOTAL:	15	3	4	2	9
PENDING:	0	0	0	0	0
RESOLVED:	15	3	4	2	9
Quality-of-Care - "QC"					
TOTAL:	9	9	2	12	12
PENDING:	0	0	0	0	0
RESOLVED:	9	9	2	12	12
QUALITY OF SERVICE - "QS"					
TOTAL:	2	6	1	1	7
PENDING:	0	0	0	0	0
RESOLVED:	2	6	1	1	7
CLIENT BILLING ISSUES - "CB"					
TOTAL:	11	2	0	9	18
PENDING:	0	0	0	0	0
RESOLVED:	11	2	0	9	18
OTHER	0	0	0	0	0
PENDING:	0	0	0	0	0
GRAND TOTAL	113	58	29	84	179
Enrollment Numbers: as of 06/30/2021	25,130	55,490	22,546	28,296	62,756
Per 1000 members:	4.50	1.05	1.29	2.97	2.85

Health Share	IHN	Jackson Care	PCSC CG	PCSC CO	PCSC Lane	PCSC MP	Trillium Lane	Trillium TriCo
687	45	34	4	61	98	140	30	54
61	2	0	0	0	1	0	0	0
626	43	34	4	61	97	140	30	54
555	106	40	7	44	126	105	42	20
33	0	0	0	0	0	2	9	0
522	106	40	7	44	126	103	33	20
116	20	8	3	17	51	26	13	2
9	0	0	0	0	0	0	1	0
107	20	8	3	17	51	26	12	2
292	27	14	0	9	41	41	6	0
24	0	0	0	0	1	3	0	0
268	27	14	0	9	40	38	6	0
62	38	7	3	12	39	21	5	0
1	0	0	0	0	0	0	1	0
61	38	7	3	12	39	21	4	0
81	9	8	1	7	15	4	36	14
0	0	0	0	0	0	0	6	0
81	9	8	1	7	15	4	30	14
0	0	0	0	0	0	0	0	0
128	2	0	0	0	2	5	17	0
1793	245	111	18	150	370	337	132	90
388,973	69,833	52,710	14,891	64,615	76,021	123,454	35,723	15,023
4.61	3.51	2.11	1.21	2.32	4.87	2.73	3.70	5.99

Umpqua	Yamhill County	FFS	Totals
3	19	16	1324
0	0	0	64
3	19	16	1260
13	23	4	1281
0	1	0	45
13	22	4	1236
10	1	1	301
0	0	0	10
10	1	1	291
2	8	14	498
0	0	0	28
2	8	14	470
5	3	1	213
0	0	0	2
5	3	1	211
3	2	58	278
0	0	0	6
3	2	58	272
0	0	0	0
0	1	0	155
36	56	94	3895
33,333	31,034	289,625	1,389,453
1.08	1.80	0.32	2.80

Hearing Outcome Types Completed Quarter 4, 2021

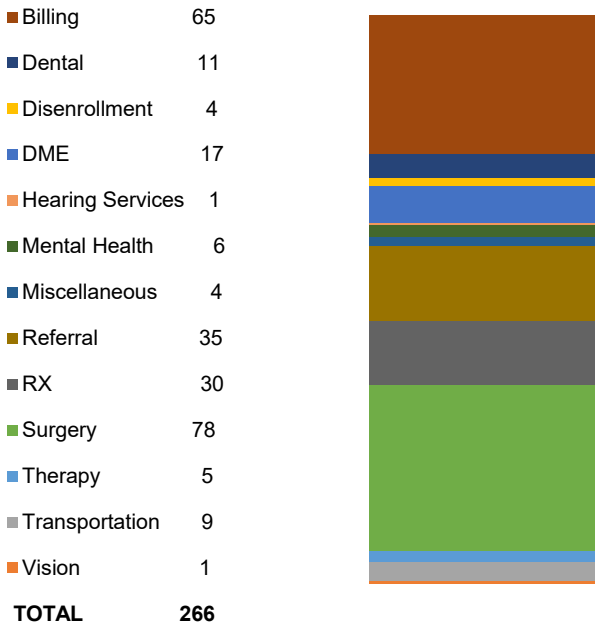
PlanName	Affirmed	Client Failed to Appear	Clients Withdrew Hearing Request	Decisions Overturned by OHA (FFS)	Decisions Overturned by Plan	Dismissed as Not Hearable	Dismissed as Not Hearable - No Appeal	Dismissed as Not Timely	Reversed	Set Aside
ADVANCED HEALTH			2				1			
ALLCARE HEALTH PLAN, INC.	2		2				2			
CASCADE HEALTH ALLIANCE	1	1								
COLUMBIA PACIFIC CCO, LLC							10	0		
EASTERN OREGON CCO, LLC	3	1			4					
HEALTH SHARE of Oregon	7	1	7		5	2	36	0	1	1
INTERCOMMUNITY HEALTH NETWORK	1	2	3				3			
JACKSON CARE CONNECT	1				1	1	6			
PACIFICSOURCE COMM. SOLUTIONS - Central	4	2	8			1	16			1
PACIFICSOURCE COMM. SOLUTIONS - Gorge					1	1		0		
PACIFICSOURCE COMM. SOLUTIONS - Lane	9	2	2		2	3	11			
PACIFICSOURCE COMM. SOLUTIONS - Marion Polk	6	1	3		4		5			
TRILLIUM COMM. HEALTH PLAN							1			
TRILLIUM COMM. HEALTH PLAN - Tri-County	1		1			3	5			
UMPQUA HEALTH ALLIANCE			1				9			
YAMHILL CO CARE ORGANIZATION	2						9			
ADVANTAGE DENTAL										
CAPITOL DENTAL CARE INC										
CARE OREGON DENTAL										
FAMILY DENTAL CARE										
MANAGED DENTAL CARE OF OR										
ODS COMMUNITY HEALTH INC										
FFS	5	1	7	6		5				
Total	**42**	**11**	**36**	**6**	**17**	**16**	**114**	**0**	**1**	**2**

Data Source: DSS
Data Extraction Date: 09/03/2021
Data Analyst: Rosey Ball

Hearing Requests Received
4/1/2021-6/30/2021
by CCO, DCO and FFS

Plan Name	Total Hearing Requests Received	Avg. Plan Enrollment *	Per 1000 Members
ADVANCED HEALTH	2	25,754	0.08
ALLCARE HEALTH PLAN, INC.	5	57, 777	0.09
CASCADE HEALTH ALLIANCE	2	23,660	0.08
COLUMBIA PACIFIC CCO, LLC	13	32,926	0.39
EASTERN OREGON CCO, LLC	3	65,277	0.05
HEALTH SHARE of OREGON	72	397,872	0.18
INTERCOMMUNITY HEALTH NETWORK	9	73,134	0.12
JACKSON CARE CONNECT	11	58,994	0.19
PACIFICSOURCE COMM. SOLUTIONS - Central	30	65,902	0.46
PACIFICSOURCE COMM. SOLUTIONS - Gorge	0	15,416	0.00
PACIFICSOURCE COMM. SOLUTIONS - Lane	35	78,541	0.45
PACIFICSOURCE COMM. SOLUTIONS – Mar/Polk	28	126,472	0.22
TRILLIUM COMM. HEALTH PLAN	11	37,305	0.29
TRILLIUM COMM. HEALTH PLAN – Tri-County	2	20,084	0.05
UMPQUA HEALTH ALLIANCE, DCIPA	12	34,034	0.35
YAMHILL CO CARE ORGANIZATION	10	32,927	0.30
ADVANTAGE DENTAL		24,892	0.00
CAPITOL DENTAL CARE INC		18,205	0.00
FAMILY DENTAL CARE		4,164	0.00
MANAGED DENTAL CARE OF OR		4,091	0.00
ODS COMMUNITY HEALTH INC		16,284	0.00
FFS	21	267,219	0.07
Total	**266**	**1,480,930**	**0.18**

Hearing Requests Received
4/1/2021-6/30/2021
by Issue



Data Source: DSS
Data Extraction Date: 09/03/2021
Data Analyst: Rosey Ball
*** Avg. Plan Enrollment based on average of Preliminary Member Months for April, May, June 2021**

	State Fiscal Year 2021 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care	1,406,598,957	831,594,233	1,034,652,934	466,949,617	3,253,016,404		6,992,812,144
	Total Fee For Service (for equivalent CCO services)	104,993,719	41,164,046	47,184,346		203,815,109		397,157,220
	Incentive Payment Pool						-	-
								-
	Total Capitation	1,511,592,676	872,758,280	1,081,837,280	466,949,617	3,456,831,513	-	7,389,969,365
	Services Outside of Capitation + Subject to Evaluation							
	Babies First						152,370	152,370
	Adult Residential Mental Health Services						36,142,533	36,142,533
	Cost-sharing for Medicare skilled nursing facility care						1,301,411	1,301,411
	Young Adults in Transition Mental Health Residential						5,420,759	5,420,759
	Targeted Case Management						11,221,128	11,221,128
	Federally Qualified Health Center and Rural Health Center Wrap						272,655,703	272,655,703
	Hospital Transformation Performance Program						-	-
	Total Global Expenditures						**326,893,904**	**7,716,863,269**
	Total Caseload							**13,657,714**
	Global Budget PMPM							**565**
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service	6,945,415	10,130,266	44,250,143	46,459	58,523,649	-	119,895,931
	Long Term Care						1,691,877,557	1,691,877,557
	School Based Health Services						20,484,213	20,484,213
	Behavioral Rehabilitative Services (BRS)						2,156,294	2,156,294
	Personal Care 20 Client Employed Provider	-	6,037	727,148	1,018,064	41,328	-	1,792,577
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011						33,083,664	33,083,664
	Mental Health Habilitative[2]						90,919,831	90,919,831
	Hospital Presumptive Eligibility						3,082,194	3,082,194
	Services Outside of Capitation + NOT Subject to Evaluation	**6,945,415**	**10,136,303**	**44,977,291**	**1,064,522**	**58,564,977**	**1,841,603,753**	**1,963,292,261**

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.