Oregon Health Plan

Section 1115 Quarterly Report

10/1/2019 – 12/31/2019
Demonstration Year (DY): 18 (7/1/2019 – 6/30/2020)
Demonstration Quarter (DQ): 2/2020
Federal Fiscal Quarter (FQ): 1/2020

Oregon Health Authority

Oregon HEALTH PLAN

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I. Introduction

A. Letter from the State Medicaid Director

During this quarter Coordinated Care Organizations (CCOs) began a new 5-year contract. The goals and deliverables of the contract reflect the collaborative work of OHA, CCOs, tribes, and other stakeholders to optimize the design of our managed care system.

As we began this new contract period OHA communicated with CCOs through Innovator Agents, operations collaborative meetings, Transformation Center convenings, and by issuing a variety of other sub-regulatory guidance to ensure CCOs understand how to meet the new requirements. CCOs have communicated challenges with some requirements, but OHA has been able to address those challenges through increased dialogue between CCOs and OHA, as well as by facilitating peer learning with other CCOs.

As Oregon began to respond to the Covid-19 pandemic, OHA began discussions with CCOs about the appropriateness of planned metrics and deliverables during this unprecedented time. The fundamental structure of CCOs and deliverables remain intact during the initial period of our Covid-19 response, although we acknowledge that some metrics may take longer to report.

OHA has made clear to CCOs that we intend to adhere to as many elements of our system design as possible, while making sure emerging member needs are met, and that CCOs and their provider networks remain fiscally solvent.

Lori Coyner, 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 Quarterly Report
Reporting period: 1/1/2020 – 3/31/2020
Demonstration Year (DY): 18– Quarter 3
Demonstration Quarter (DQ): 3/2020
Federal Fiscal Quarter (FQ): 2/2020

III. Overview of the current quarter

A. Enrollment progress

This section refers to Appendix A (Enrollment Reports), and the narrative should include information about each of the tables to connect the tables to the report's content and make them easier to read and understand.

1. Oregon Health Plan eligibility

During this reporting period, Oregon is rolling out staff training in preparation for the launch of the new integrated eligibility system as well as a new statewide business model. This caused a reduction of available staff resources at the same time as Federal Marketplace open enrollment, both of which contributed to a backlog of applications and renewals at the beginning of 2020. However, since then, the backlog has continued to decrease week-after-week, thus lending, in part, to the slight monthly increases in the numbers of Title XIX enrollees as referenced in Appendix A.

2. Coordinated care organization enrollment

No significant changes in enrollment occurred during this reporting period.

B. Benefits

The P&T Committee:

Developed new or revised Prior Authorization (PA) criteria for the following drugs: insulin pens; biologics for autoimmune conditions; narcolepsy agents; orphan drugs; and short and long-acting opioids.

The committee also recommended changes to the preferred drug list (PDL): make azathioprine and tacrolimus preferred; make all forms of insulin lispro – except Admelog – preferred; add class for glucagon agents and make GlucaGen, Baqsimi and glucagon emergency kit preferred and Gvoke non-preferred; make lefamulin non-preferred; make secukinumab preferred; and to make armodafinil and modafinil preferred.

The Health Evidence Review Commission:

The January 1, 2020 prioritized list went into effect on January 1, 2020. Errata were published on 2/4/20 and 3/23/2020. These, along with interim modifications approved 3/12/2020 by the Health Evidence Review Commission, were reported in the Notification of Interim Changes for the March 13, 2020 Prioritized List.

C. Access to care (ANNUAL)

D. Quality of care (ANNUAL)

E. Complaints, grievances, and hearings

1. CCO and FFS complaints and grievances

The first quarter of 2020 brings a change in CCOs. Some CCOs are no longer contracting with OHA, and some CCOs have expanded coverage into other areas. The information provided is a compilation of data from the current 15 coordinated care organizations (CCO) and fee-for-service (FFS) data. This quarterly reporting period covers Jan 1, 2020 through Mar 31, 2020.

Trends

	Apr – Jun 2019	Jul – Sep 2019	Oct – Dec 2019	Jan – Mar 2020
Total complaints received	6,875	6776	5954	4233
Total average enrollment	1,131,954	1,203,531	1,183,310	1,050,851
Rate per 1,000 members	6.07	5.63	5.03	4.03

Barriers

The Access to Care category continues to receive the highest number of complaints, however the data shows a decrease of 34% from the previous quarter. The Interaction with Provider/Plan category shows a decrease of 21% this quarter, over the previous quarter and Quality of Care issues decreased by 45%. FFS data shows the highest number of complaints are in the Quality of Service category, with Access to Care the next highest category.

Interventions

CCOs –Some CCOs are reporting in new areas for this first quarter. CCOs report the focus continues to be on ensuring all expressions of dissatisfaction are recorded as complaints. Some CCOs report they have established committees and taskforces specifically to address provider capacity within their networks. CCOs report they are continuing work to reduce issues, which can cause delays in scheduling and misinformation for the member. CCOs report that Peer Review committees are showing improvements in provider services which helps to reduce numbers of complaints. Some CCOs are continuing to report staff is being added internally as well at sub-contractor offices. Rural area CCOs are continuing to report issues with bringing on more providers, which has increased complaints in some areas. NEMT continues to be an issue with several CCOs and report they are continuing to work bi-weekly and monthly with NEMT providers to improve transportation services. Some CCOs say increases or decreases in complaints may be caused by the current crisis caused by Covid-19.

Fee-For-Service –Client Services data shows a decrease from the previous quarter for Fee for Service member complaints and complaints from members enrolled in a CCO. The number of complaints from members who were on Fee for Service coverage during the quarter was 89. An additional 2557 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 445 calls regarding complaints about Dental Care Organizations. There were 833 informational calls 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	Apr– Jun 2019	Jul – Sep 2019	Oct – Dec 2019	Jan – Mar 2020
Access to care	3,127	2687	2370	1566
Client billing issues	600	586	604	293
Consumer rights	202	248	175	277
Interaction with provider or plan	1,958	2161	1863	1464
Quality of care	514	660	719	397
Quality of service	456	434	223	223
Other	18	0	0	13
Grand Total	6875	6776	5954	4233

Related data

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

2. CCO and FFS appeals and hearings

Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs during the 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. For the Jan – Mar 2020 quarter CCOs report that the highest number of NOABDs were issued for specialty care related denials. Pharmacy was the next highest and Diagnostics was the third highest. Some 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)	**Apr – Jun 2019**	**Jul – Sep 2019**	**Oct – Dec 2019**	**Jan – Mar 2020**
a) Denial or limited authorization of a requested service.	36,276	33,609	33,906	25,964
b) Single PHP service area, denial to obtain services outside the PHP panel	132	149	325	326
c) Termination, suspension, or reduction of previously authorized covered services	149	143	138	267
d) Failure to act within the timeframes provided in § 438.408(b)	41	26	8	47
e) Failure to provide services in a timely manner, as defined by the State	263	234	49	111
f) Denial of payment, at the time of any action affecting the claim.	18,986	19,823	19,581	41,912
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	55,847	53,984	54,007	68,627

Number per 1000 members	47	45	46	72

CCO Appeals

The table below shows the number of appeals the CCOs received during the quarter. There was a 26% decrease in the number appeals over the previous quarter. CCOs reported the highest number of appeals this quarter were related to Pharmacy. Outpatient care appeals were the next highest and specialty care was the third highest. 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 site visits, 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	Apr – Jun 2019	Jul – Sep 2019	Oct – Dec 2019	Jan – Mar 2020
a) Denial or limited authorization of a requested service.	1,358	1,236	1,273	811
b) Single PHP service area, denial to obtain services outside the PHP panel.	2	17	3	4
c) Termination, suspension, or reduction of previously authorized covered services.	2	11	12	6
d) Failure to act within the timeframes provided in § 438.408(b).	1	1	3	4
e) Failure to provide services in a timely manner, as defined by the State.	0	0	0	0
f) Denial of payment, at the time of any action affecting the claim.	387	355	303	353
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	1,750	1,620	1,594	1178
Number per 1000 members	1.95	1.35	1.35	1.23
Number overturned at plan level	573	495	537	379
Appeal decisions pending	12	8	8	9
Overturn rate at plan level	32.74%	30.56%	33.69%	32.17%

CCO and FFS Contested Case Hearings

The following information is a compilation of data from 15 coordinated care organizations (CCO), 6 dental care organizations (DCO) and fee-for-service (FFS). FFS members may be enrolled with a DCO for dental coverage.

The Oregon Health Authority (OHA) received 296 hearing requests related to the denial of medical, dental and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 270 were from CCO-enrolled members and 26 were from FFS members.

During the third quarter, 305 cases were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. In every quarter there is an overlap of processed cases with those received. For instance, cases resolved in January of 2020 may be cases OHA received as far back as August and September of 2019.

OHA dismissed 236 cases that were determined not hearable cases. Of the not-hearable cases, 208 were forwarded to the member's respective CCO to process as an appeal. Per Oregon Administrative Rule, Oregon Health Plan (OHP) members must exhaust their appeal rights at the CCO level and receive notice of appeal resolution (NOAR) before they can request a contested case hearing at the state level. Hearing requests received by OHA prior to the appeal being exhausted are dismissed as not hearable with a letter to the member explaining their appeal rights through the CCO and their hearing rights after receiving an NOAR.

Of the 58 cases that were determined to be hearable, 16 were approved prior to hearing. Members withdrew from 22 cases after an informal conference with an OHA hearing representative and 20 cases went to hearing, where an administrative law judge upheld the OHA or CCO decision in 14 cases and dismissed 6 cases for the members failure to appear.

4 cases were dismissed due to a member requesting a hearing after the allowed time frames without good cause for the late request.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	16	5%
Client withdrew request after pre-hearing conference	22	7%
Dismissed by OHA as not hearable	236	77%
Decision affirmed*	14	5%
Client failed to appear*	6	2%
Dismissed as non-timely	4	1%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	0	0%

Set Aside	0	0%
Total	305	

* Resolution after an administrative hearing.

Related data

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

F. CCO activities

1. New plans

As reported in previous quarterly reports, OHA awarded 15 CCO contracts under a new procurement. 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 1/1/2020.

2. Provider networks

There were no significant provider network changes during this reporting period.

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 the majority 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 six Dental Only (DCO) contracts where capitation rates are developed separately.

Starting January 1, 2020, OHA entered a new five-year contracting cycle with CCOs. The start of the contract included a member transition period, and it was expected that risk would shift in the program. Because the shifts in risk were not reasonably predictable prior to the original publication of 2020 capitation rates, state law allows for and OHA will prepare a retroactive rate adjustment covering all of 2020. OHA is working closely with CCOs on the retroactive rate process to adjust for risk changes due to membership. OHA is also monitoring the COVID-19 pandemic closely and working with CCOs in a partnership in preparing and maintaining our healthcare system.

OHA meets with CCOs regularly to review financial and rate-related matters. During Quarter 1 2020, OHA met with the CCOs to discuss; 1) the transition to a new financial reporting standard and NAIC submission, 2) the CY2021 rate development process, and 3) the CY2020 retroactive rates.

In the next quarter, OHA expects to start the 2021 rate process and finalize the 2020 retroactive rate adjustment work.

4. Enrollment/disenrollment

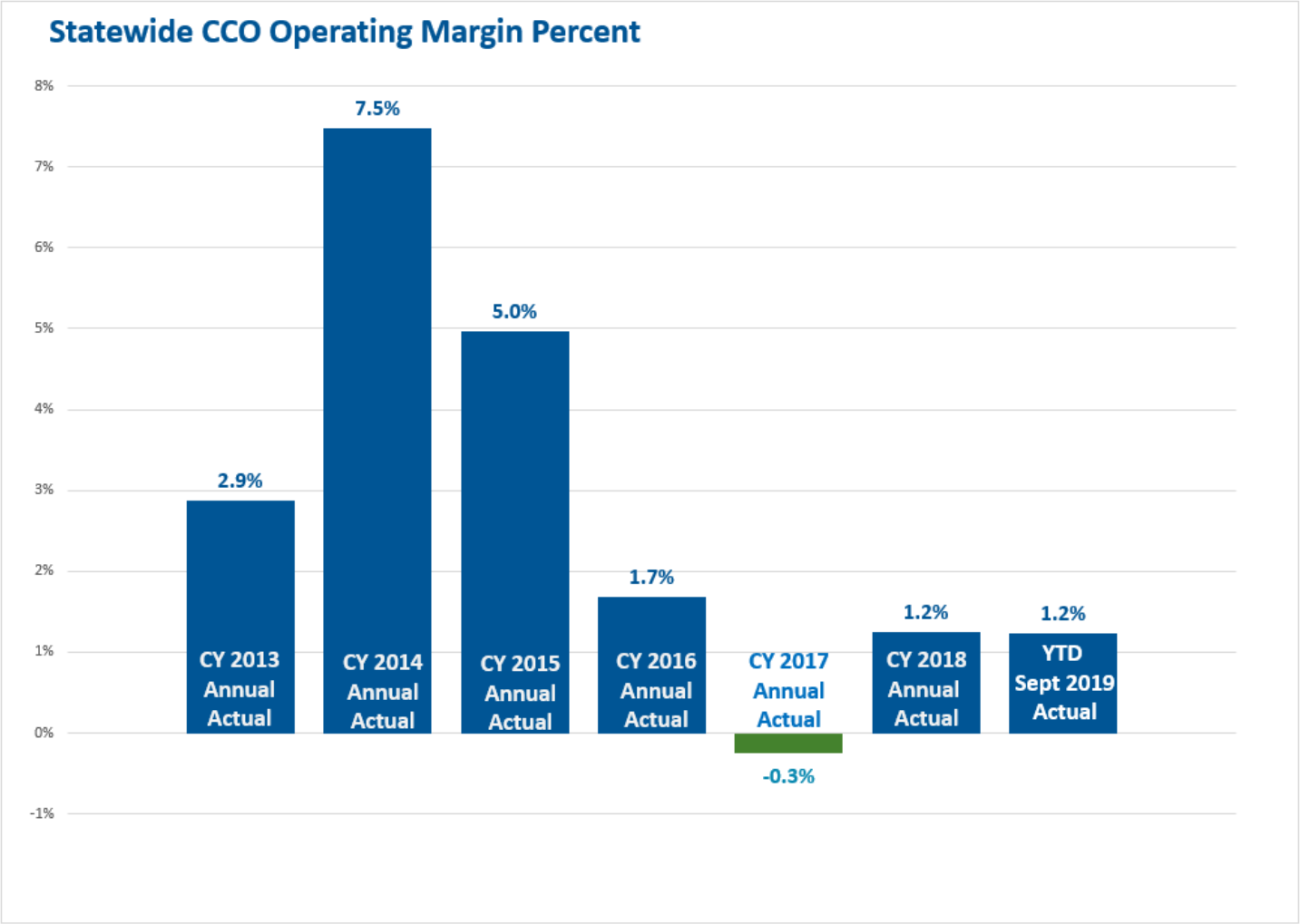
Due to the Covid-19 pandemic, and to fulfill the requirements of the CARES Act, Oregon has discontinued redeterminations and is implementing self-attestation of client information for new applicants.

5. Contract compliance

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

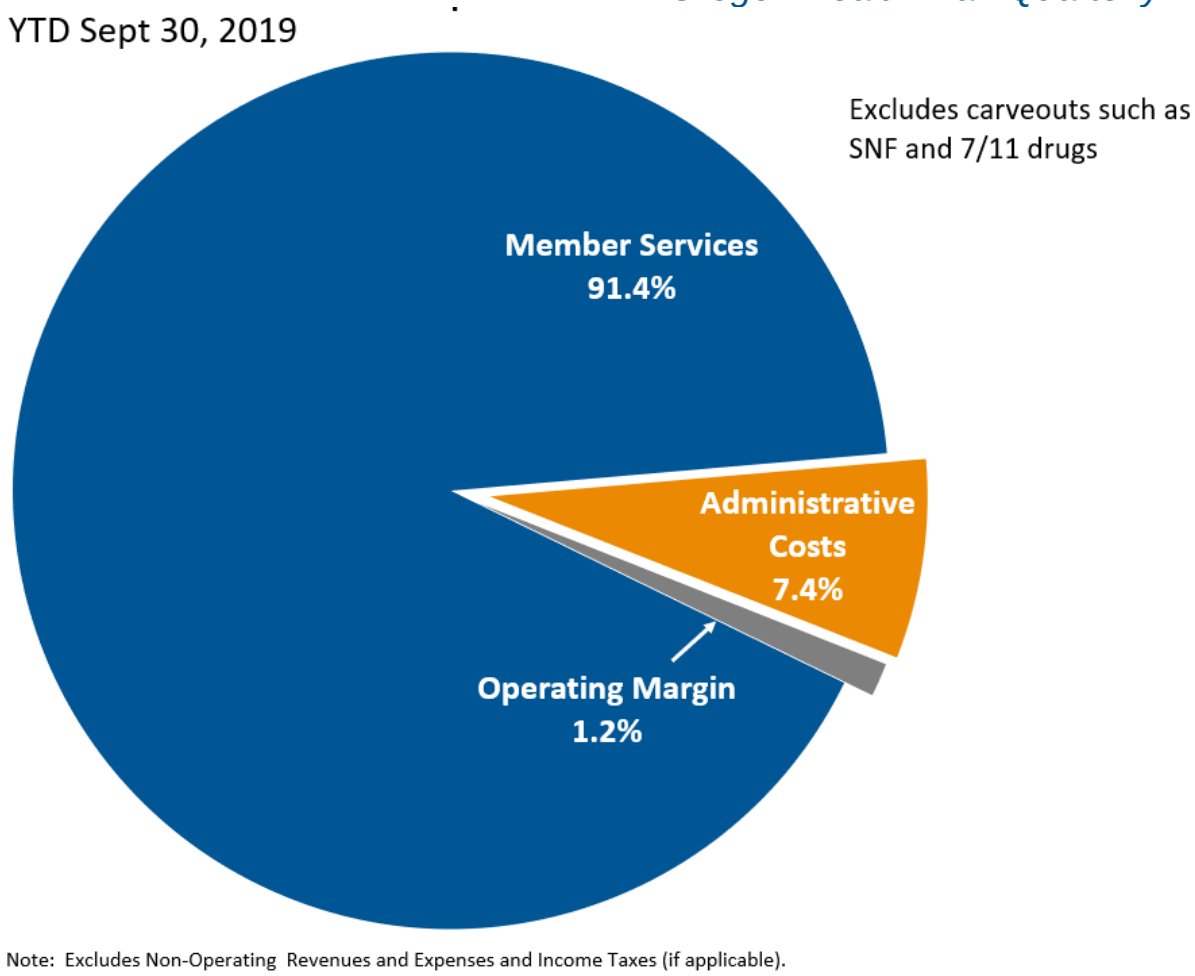
6. Relevant financial performance

For the 9-months ended September 30, 2019, the statewide CCO operating margin was at 1.2% compared to 1.2% for the year ended December 31, 2018. For reference, the capitation rates include a 1% profit margin. CCO operating margins returned to a slightly profitable status after trending downward during 2015-2017 period.



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. For the 9-months ended September 30, 2019, the MSR for all CCOs in aggregate was 91.4%. Administrative Services accounted for 7.4% of total CCO revenue, leaving 1.2% as operating margin.

For the 9-months ended September 30, 2019, 13 out of the 15 CCOs met or exceeded the 85% target for MSR, a key indicator for MLR (Seven of the CCOs had MSRs above 90%). Two CCOs reported MSR below 85%, Umpqua Health Alliance at 83.3% and Cascade Health Alliance 84.4%.



As of September 30, 2019, all CCOs met their net worth requirement. Net Assets of the CCOs ranged from a low of $230 per member (Willamette Valley Community Health, LLC and Health Share of Oregon) to a high of $1,288 per member (Intercommunity Health Network), averaging $475 per member for the state.

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

For this reporting quarter, one CCO continues to be on a Corrective Action Plan (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:* April 14, 2020. Given recent changes in the CCO's NEMT vendors, OHA will continue the CAP through October 2020.

• *Action sought:* Development and implementation of a plan for correcting the issues identified by OHA; submission of weekly reports to OHA for a period of at least six (6) months.

• *Progress during current quarter:* HSO's reports for January-March 2020 show that the previous quarter's modest gains in driver no-show rates, late pick-up for rides, call wait times, and call abandonment have been erased and that the net performance on each of these metrics is worse than in the previous quarter. The metric for driver no-shows had both its best and worst scores since the CAP began. Only the metric for member grievances shows continuous improvement; HSO exceeded this target for each month in the quarter.

Major factors affecting HSO's performance in this quarter are: (1) On February 1, HSO entered into a contract with a new vendor for NEMT services; (2) on March 1, HSO deployed new ride management software for its NEMT provider network; and (3) starting in March, HSO's members and NEMT provider network began to experience the effects of the COVID-19 national emergency.

8. One-percent withhold

During this quarter of 2019, MAP analyzed encounter data received for completeness and accuracy for the subject months of June 2019 through August 2019. All CCOs except for two met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

Due to the public health crisis and our commitment to working with the CCOs to ensure they can continue to focus on servicing our members we did not recommend a withhold for August 2019 subject month.

9. Other significant activities

The Covid-19 pandemic has had a significant impact on CCOs and their provider networks. During this reporting period OHA began a review of contract deliverables that may need to be adjusted to reflect the utilization and emerging needs of members. OHA also began exploring strategies to ensure a maximum amount of resources are available to members, and to ensure that CCOs can support their provider networks during a period of low utilization.

CCOs have been cooperative and understanding of the need to change some previously agreed upon deliverables and metrics. OHA will continue to work closely with CCOs to ensure the integrity of our coordinated care system, and ultimately access to quality care for members of the Oregon Health Plan.

G. Health Information Technology

Medicaid Electronic Health Record (EHR) Incentive Program

Through the Medicaid EHR Incentive Programs (also known as the Promoting Interoperability Programs), eligible Oregon providers and hospitals can receive federally-funded financial incentives for adopting, implementing, upgrading, or meaningfully using certified electronic health records technology (CEHRT). Since the Medicaid EHR Incentive Program's inception in 2011, 3,843 Oregon providers and 60 hospitals have received over $207 million in federal incentive payments (as of March 31, 2020). Between January and March 2020, 227 Oregon providers received $1.9 million in Medicaid EHR incentive payments. The program sunsets at the end of 2021.

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, and health plans.

The HIT Commons Governance Board meets bi-monthly and supports two ongoing initiatives, Emergency Department Information Exchange (EDie) and Prescription Drug Monitoring Program (PDMP) Integration. Additionally, the Board has approved support through the HIT Commons for adoption and spread activities in support of the Oregon Provider Directory and directed staff to begin exploration and conceptual development of a statewide social determinants of health (SDoH) "Community Information Exchange" effort (see below for more information).

EDie/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 and critical information to ED physicians, such as: security alerts, care guidelines entered by the patient primary care home, and contact information for case managers.

PreManage is a companion software tool to EDie. PreManage 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, Coordinated Care Organizations (CCOs), providers, and care coordinators. EDie and PreManage are in use statewide and adoption for PreManage continues to grow.

Oregon continues to work towards improving and enhancing EDie/PreManage for users. Highlights included:

- A 2020 Technical Assistance calendar has been created, with a three-part series held. The series supported basic, intermediate, and advanced use of the platform for primary care, behavioral health clinic use and work flows, and technical work flows.
- 66% of Oregon's hospitals are receiving PDMP data (see below) within their EDie alert.
- 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.
- PreManage began to roll out to Skilled Nursing Facilities (SNFs) across Oregon in 2019. more than half of Oregon's SNFs are live. SNFs are also now contributing admission and discharge encounter information into the platform to further support transitions of care and care coordination.
- Oregon created specific cohorts and informationals for Collective (Edie/PreManage) users in support of COVID-19 response.
- HIT Commons and OHA formed a small working team comprised of two CCOs, two large health systems, and Collective. This group meets weekly and is organizing COVID-19 response efforts for those using the platform.

- Housing Management Information System (HMIS) data will start populating for a pilot to identify homeless individuals who need additional supports during the pandemic

Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative

Oregon's Prescription Drug Monitoring Program (PDMP) Integration initiative connects EDie, HIEs, 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 oversees the PDMP Integration work with guidance from the Oregon PDMP Integration Steering Committee and in coordination with OHA's Public Health PDMP program.

PDMP Integration capabilities went live in summer of 2017 and the statewide subscription funding officially launched through the HIT Commons in Spring 2018. As of the March 31st PDMP Integration report:

- 20,507 (this number cannot be deduplicated and may reflect duplicate prescriber counts) prescribers across 165 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), 7 retail pharmacy chains (across 368 sites) and 1 rural pharmacy are also live.
- Interstate data sharing is established with PDMPs in Idaho, Kansas, Nevada, Texas, North Dakota, and Washington (WA for web portal only). Alaska, Wyoming and California are in progress.

Oregon Provider Directory (OPD)

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

The OPD will benefit CCOs by supporting care coordination/HIE, administrative efficiencies, and serve as a resource for heath analytics in the following ways:

- Having one place to go for accurate and complete provider data
- Reducing burden on providers and staff time spent on data maintenance activities
- Enabling better care coordination for patients and ability to meet certain meaningful use objectives by supplying complete information on providers and how to contact them
- Improving the ability to calculate quality metrics that require detailed provider and practice information

The Oregon Provider Directory went live in September 2019 in a soft launch to a small set of users in Central Oregon. Soft launch users include a CCO, health system, independent practice association, dental care organization, and a federally qualified health center. In mid-March, soft launch activities and engagement were paused to allow organizations to focus on COVID-19. During the pause, OHA analyzed additional uses where the OPD can be leveraged as a statewide resource. OHA is partnering with HIT Commons to develop use case testing in soft launch and to assist with deployment planning for later phases of adoption.

Clinical Quality Metrics Registry (CQMR)

Oregon's CQMR collects, aggregates, and provides clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting. The CQMR went live in early 2019 for Medicaid EHR Incentive Program/Promoting Interoperability electronic clinical quality measure (eCQM) reporting and the option for reporting eCQMs to CMS for the Merit-based Incentive Payment System (MIPS) and Comprehensive Primary Care Plus (CPC+). The CQMR went live in January 2020 to collect t eCQMs and some state-specific measures for the CCO incentive measure program. New dashboards for users to review and validate QRDA 1 (patient-level eCQM) files went live in March.

During the initial implementation and user acceptance testing sessions, OHA engaged with stakeholders through a subject matter expert workgroup and other outreach. In March 2020, OHA launched a new CQMR user group. In addition, ongoing technical assistance is offered through a contract with Oregon Health & Science University (OHSU), to help clinics prepare for patient-level eCQM reporting.

Behavioral Health and HIT

The Behavioral Health HIT Workgroup was formed in August 2018 under the direction of HITOC to review the draft Behavioral Health HIT Scan and provide recommendations and priorities. The BH HIT Workgroup met again in February 2020 to provide input to the OHA on how to prioritize strategies for maximizing SAMHSA Block Grant funds. OHA received approval for the $250,000 in November 2019 through the SAMHSA Block Grant application to support behavioral health providers working with patients with substance use disorders. The funds are specifically for providing technical assistance on the adoption and use of electronic health records (EHR) and health information exchange (HIE) tools.

The strategies identified as priorities by the BH HIT Workgroup included development of provider toolkits and trainings to support providers with privacy and security rules governing health information exchange, as well as guidance on EHR adoption. Additionally, another priority included the planning of a behavioral health peer learning collaboration where providers can share lessons learned and best practices related to EHRs and HIE tools with their peers. OHA is currently working on plans to utilize the block grant funds to deliver these priority strategies summer/fall 2020.

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.

Highlights from HITOC's February 2020 meeting includes:

- A presentation by Oregon's public health division sharing their State Health Improvement Plan efforts and priorities for their work

- An update from the Health IT Commons on the Community Information Exchange efforts and roadmap development in Oregon to support referrals for SDOH needs

The work to update the Strategic Plan was planned for 2020. Due to COVID-19 we anticipate this work will extend into 2021.

CCO Health IT Advisory Group (HITAG)

HITAG met in January 2020. The group received an update on community information exchange efforts in Oregon; reviewed the role and scope of HITOC and the upcoming Strategic Plan Update; and heard a presentation on the 2019 Health IT Report to HITOC.

H. Metrics development

Kindergarten Readiness

As a reminder, this developmental work comprises a four-part, multi-year measurement strategy:

1) Adopt two metrics for the 2020 CCO incentive measure set (for inclusion in 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 the 2021 or 2022 CCO incentive measure set).

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

Social Emotional Health Developmental Measure

During this same quarter, OHA 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. The workgroup developing the second component of the strategy (a CCO-level measure to improve the social-emotional health of young children) held monthly working sessions. The team reviewed the 673 responses to the stakeholder survey it fielded in the last quarter.

Given disruption of the pandemic, the team altered its work plan (for example, consultation with stakeholders and pilot testing will need to occur at a later date). During the pandemic, the team is therefore creating draft high level specifications (based upon feedback from the survey stakeholder strategy session held in the last quarter). Stakeholders will be engaged at a later date to review the specifications. The goal remains having a measure ready for implementation in 2022.

Follow-up to Developmental Screening Measure Development

OHA's partner, OPIP, is leading development of this measure. During this quarter OPIP continued work on draft metric, building on pre-pandemic pilot work with various clinics with various EHRs across the state. Pilot findings demonstrate sensitivity and specificity to improvement efforts, face validity to pilot primary care sites.

SDOH/Health-related Social Needs Measure

In this quarter members were recruited for participation on the public workgroup which will consider and develop recommendations back to the Metrics & Scoring and Health Plan Quality Metrics Committees. Over fifty applications were received. The final Workgroup roster includes fifteen workgroup members; in addition, representatives from the National Center for Quality Assurance will serve as national, non-voting advisors to the Workgroup.

The Workgroup initially planned to begin meeting on April 1. However, given the pandemic, the Workgroup's meeting was paused. OHA is Implementing 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.

Therefore, the full Workgroup will not convene until October 2020, and will have fewer, more targeted meetings. A smaller Extended Planning Team will meet (virtually) in the interim and create 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 Center for Quality Assurance.

The full Workgroup will review the options prepared by the Extended Planning Team and finalize a recommendation for the Metrics & Scoring Committee, to be presented in early 2021.

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, based on the prevalence and issue of obesity among Oregonians. 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 measure is Part One of a two-part measure. Part One addresses obesity prevention and reducing the prevalence of obesity through evidence-based multisector interventions. Part Two, an outcome measure including BMI measurement and interventions completed, is still in development and will be completed for rollout at a later date. The measure aligns with CCO 2.0 goals because it direction attention to interventions outside of the doctor's office while building stronger relationships with community partners.

Part One of the measure (multisector interventions) utilizes an attestation model with a point system across five areas. The areas are based on Oregon's Health Evidence Review Commission (HERC) evidence-review guidance document on obesity. The five areas are:

- Coverage and promotion to adult and pediatric intensive supports

- Root cause analysis and actions plans
- Community engagement
- Multisector interventions
- Foundational criteria

During the period of January 1 to March 31, 2020, the workgroup for Part One, Multisector Interventions, met with OHA metrics committees to present results of the pilot test conducted during the last quarter of 2019. Ten of fifteen CCOs participated in this pilot project.

Committee presentation on results of the pilot project and final measure overview and technical specifications. Workgroup would like the committee to consider including the measure in the 2021 incentive measure set.

- January 17, 2020: Metrics and Scoring Committee

During the period of January 1 to March 31, 2020, the workgroup for Part Two (documentation and assessment of BMI) did not meet as a workgroup.

Health Equity Measurement Workgroup (Developmental 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 Health Equity Measurement Workgroup convened in October 2018.

The proposed 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. The measure is titled: Meaningful Language Access for Culturally Responsive and Quality Health Care.

The workgroup has met continuously since October 2018 to develop the measure for inclusion in the CCO incentive measure set. Included in the efforts of the workgroup is the CCO 2.0 contract requirement to report the total number of interpreters and type of interpreter services provided per quarter. The reporting requirement was effective January 1, 2020 with the first reporting expected in April 2020. The contract requirement is separate from the proposed incentive measure.

During the period of January 1 to March 31, 2020, the workgroup met with OHA metrics committees to present results of the pilot test conducted during the last quarter of 2019. Nine of fifteen CCOs participated in this pilot project.

Committee presentation on results of the pilot project and final measure overview and technical specifications. Workgroup would like the committee to consider including the measure in the 2021 incentive measure set.

- January 17, 2020: Metrics and Scoring Committee
- February 13, 2020: Health Plan Quality Metrics Committee

I. Budget neutrality

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

Reports are attached separately as Appendix D – Neutrality Reports.

J. Legislative activities

There are no legislative activities to report for this quarter.

K. Litigation status

Family Care v. OHA

A CCO, FamilyCare, has filed a lawsuit making the following claims against OHA and its current and former Directors. Some of the trial court's decisions have been taken up on immediate appeal, and the trial court action has been stayed pending the outcome of those appeals. There was no significant activity during the reporting period.

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 hospital to support the Oregon Health Plan. The Oregon Tax Court ruled against the Hospital on the issue of the assessment, in May of 2019. The Hospital appealed to the Oregon Supreme Court but later dismissed the appeal and an appellate judgment dismissing the appeal was issued December 27, 2019. A proposed order from the administrative law judge is expected to be issued by early July.

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. There was no significant activity during the reporting period.

L. Public forums

Medicaid Advisory Committee

The Medicaid Advisory Committee met two during this reporting period. There was no public comment in each committee meeting.

Metrics and Scoring Committee

Recordings, meeting minutes, and copies of written public testimony are available on the Committee webpage, here: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metric-Scoring-Committee-Archives.aspx

January 7, 2020

Public testimony at the meeting:

- Samantha Shepherd of CCO Oregon provided testimony on the new preventive dental incentive measure, raising concerns about whether and when services provided in primary care settings are counted in the measure. Ms. Shepherd also circulated a written version of her testimony, which is included in the packet of the February meeting.
- Oregon's Health Equity Committee (a sub-committee of the Oregon Health Policy Board) provided written testimony in support of the health equity measure being presented to the Metrics & Scoring Committee.

February 21, 2020

Public testimony at the meeting:

- A letter from CCO Oregon (written testimony supporting spoken testimony at the January meeting).
- A letter from the Medicaid Advisory Committee in support of the developmental health equity measure.
- A letter from the Health Equity Committee in support of the developmental health equity measures.
- A letter from Felicity Ratway.
- A letter from Joelle Morgan.
- A letter from an anonymous Medicaid member.
- A letter from the Oregon Medical Association in support of the developmental obesity measure.
- A letter from the Public Health Advisory Board in support of the obesity and equity developmental measures.
- Bob Dannenhoffer spoke to MSC on behalf of Public Health Advisory Board (PHAB) endorsing the proposed obesity and health equity metrics and encouraging future innovation.
- Felicity Ratway, Jillian Weiser, Janice Van Domelen, and Stick Crosby gave public comment by phone, advocating for better interpreter services for Oregon patients, and/or testifying about patients' difficulties accessing care due to inadequate translation services.

March 20, 2020

Several pieces of written testimony were submitted and can be found online in the meeting listing:

- Dr. William J. Koenig, Yamhill County in relation to the developmental obesity measure.
- Pacific Source CCO, in relation to continuous enrollment criteria
- Thomas Potter of Eugene Pediatrics, regarding COVID-19 and metrics impact.
- Children's Health Alliance, regarding COVID-19 and metrics impact.

Julie Harris (Children's Health Alliance) spoke about concerns regarding the impact of COVID-19 response on the 2020 CCO Incentive Program (this supplemented written testimony from the Children's Health Alliance).

Health Plan Quality Metrics Committee

January 9, 2020

No public comment by phone, in the room or written.

February 13, 2020

Written testimony submitted by:

- OHA Public Health Advisory Board in support of Obesity Multisector Interventions metric
- OHA Health Equity Committee in support of Meaningful Language Access for Culturally Responsive and Quality Health Care measure
- AllCare CCO in support of Meaningful Language Access for Culturally Responsive and Quality Health Care measure
- OHA Medicaid Advisory Committee in support of Meaningful Language Access for Culturally Responsive and Quality Health Care measure
- Oregon Council on Health Care Interpreters chair Erin Neff-Minyard in support of Meaningful Language Access for Culturally Responsive and Quality Health Care measure

Public testimony by phone:

The following people gave public comment by phone, advocating for better interpreter services for Oregon patients, and/or testifying about their difficulties accessing care due to inadequate translation services: Stick Crosby, Eileen Marma, Velma Foust, John Curtis, Erin Neff-Minyard, Don Bruland.

March 12, 2020

Written testimony submitted by:

- Immigrant and Refugee Community Organization (IRCO) in support of Meaningful Language Access for Culturally Responsive and Quality Health Care measure
- Oregon Medical Association in support of Obesity Multisector Interventions metric
- Yamhill County Health Officer, William Koenig DO, in support of Obesity Multisector Interventions metric

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

PCPCH program staff conducted 12 site visits to primary care clinics this quarter. 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 March 30, 2020, 650 clinics were recognized as PCPCHs (two more than the prior quarter). This is approximately three-quarters of all primary care practices in Oregon. Seventy-eight PCPCHs (seven more than the prior quarter) have been designated as 5 STAR, the highest tier in the PCPCH model.

The Oregon Health Authority has proposed revisions to the 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. The revised PCPCH standards were scheduled be implemented in mid-2020, but the implementation has been delayed until early 2021 because of Oregon's response to the COVID-19 pandemic.

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 care management fees and performance-based payments are key components of the CPC+ payment model.

The Oregon CPC+ payers had monthly facilitated meetings to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers:

- Decided to produce additional "Data Bytes" using the Oregon Data Collaborative with possible topics of specialty care, behavioral health and transitions of care, and discussed the inclusion of case studies, particularly to learn how the model of care has changed clinics;
- Discussed ways to support clinics during the pandemic, including telehealth, increased provider communication and flexibility regarding care management requirements; and
- Agreed on the ongoing need for conveners and discussed elements of the next convening contract.

Value-based payment (VBP) innovations and technical assistance
The Transformation Center convened a VBP Alignment Listening Session with CCO leadership to inform OHA's strategic approach to CCO VBP alignment in service areas with multiple CCOs. The goal of the listening session was to gather CCOs' recommendations for VBP alignment. OHA specifically requested recommendations with the intent of reducing provider reporting burden; reducing administrative costs; and improving quality of care for members.

The center added an "Elements of VBP Contracting" brief and checklist to the VBP online toolkit for CCOs, available on OHA's VBP webpage (https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Contracting-Elements-Brief.pdf).

Staff reviewed all 2020 VBP reporting requirements and developed a plan to delay or pause them, given the CCOs' need to focus activities on COVID-19 response, but maintain the five-year CCO VBP Roadmap targets and longer-term goals.

Primary Care Payment Reform Collaborative
OHA convenes the Primary Care Payment Reform Collaborative, a legislatively required multi-stakeholder advisory group tasked with assisting OHA with the development and implementation of a Primary Care Transformation Initiative. The collaborative's three work groups support work in the following areas: metrics, evaluation, and implementation/technical assistance.

At the January meeting, members received updates on Primary Care First, discussed the annual report to the Legislature and Oregon Health Policy Board, the 2020 workplan and next steps for infrastructure support. OHA staff also presented an update on the Clinical Quality Metrics Registry, describing how it will consolidate reporting for the Medicaid EHR Incentive Program and CCO incentive metrics.

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

Statewide Performance Improvement Project
For calendar year 2020 the statewide performance improvement project (PIP) will be in baseline year. CCOs have completed the statewide PIP design phase submission, as part of the annual external quality review (EQR). Due to report submission and EQRO review, analysis and reporting of the PIP EQR will be in forthcoming Oregon Health Plan Section 1115 Annual Report.

Roadmap to Oral Health

Oregon Health Authority

OHA continued with Oral Health Roadmap activities to improve integration of oral health care with physical and behavioral health. An internal workgroup developed performance indicators to measure oral health integration within Oregon's CCO, ideally beginning with the 2021 contract year.

OHA's statewide dental director has left the agency; we will be recruiting for a replacement in the near future. This will create a temporary challenge in oral health integration efforts.

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

1) **Activities:** Sustainable Relationships for Community Health (SRCH) is a grant funded opportunity for clinical and community partners to address 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, clinical partners and community-based organizations, to determine and build together shared health systems change goals and systems, to be sustained and spread beyond the grant period. The four SRCH teams for 2019-2020 met again in February 2020, for SRCH Institute 2, a two-day, in-person convening. This was the second convening in a three-part series. During SRCH Institute 2, teams revisited the aims and drivers developed in SRCH Institute 1 (October 2019), assessed progress through the plan-do-study-act (PDSA) model, and continued to co-design strategies to build and implement quality improvement processes, such as screening and referral and closed-loop referrals for chronic disease prevention and management. OHA staff and contracted quality improvement specialists provide technical assistance and support to each team during and between SRCH Institutes.

2) **Progress and Findings:** During SRCH Institute 2, each SRCH team co-designed sustainable health systems strategies to improve health outcomes, promote equity and contain costs. For each intervention, teams co-developed shared goals, measurable outcomes, identified and refined PDSAs, and assigned specific actions to partners using a 90-day plan. All SRCH teams learned techniques that are critical to establishing, nurturing and sustaining partnerships to improve health outcomes in their communities.

3) **Trends, Successes, or Issues**: Though much progress was made between Institute 1 and 2, the experience of COVID-19 has slowed the SRCH teams' progress and in some cases halted planned strategies all together. SRCH teams are working with OHA staff to determine timing and feasibility for a virtual SRCH Institute 3. The goals of SRCH Institute 3 will be to ensure sustainability of the partnerships developed through SRCH and to develop a plan for carrying the quality improvement processes forward for chronic disease prevention and management.

Process Improvement (workflow) Technical Assistance

Technical assistance given by QI and Transformation Center technical assistance bank relating to process improvement (workflows). Not a significant amount of work to report but continuous throughout the year across health topics. Additional work out of HSD for simplification of reporting and meeting collaboration

Innovator Agents

Innovator Agents continued to work with Coordinated Care Organizations' (CCO) Community Health Improvement Plans and provided education and support of new rules to Community Advisory Committees as they related to Coordinated Care Organization 2.0. They also informed Community Advisory Committee members on new 2.0 related contract changes.

Additionally, Innovator Agents assisted in navigating relationships and inclusion with the Native American tribes who resides in their prospective CCO regions. Supported CCO engagement with OHA lead staff on 2.0 contractual areas regarding health equity; tribal connections, and health related services.

Two Innovator Agents worked on the closeout of CCOs. One CCO decided not to reapply for the new CCO 2.0 contract, while another CCO did not meet the requirements of their proposal for CCO 2.0. During these transitions, Innovator Agents were involved in making sure Oregon Health Plan members' health and behavioral needs were addressed adequately by bringing concerns to Oregon Health Authority leadership for resolution. Support was provided to members during member choice period (Jan. 1, 2020 – March 21, 2020).

Innovator Agents supported the COVID-19 response and assumed lead positions in Oregon's Health Information Committee.

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.

Staff shared the CCO 2018 expenditure analysis with CCOs. Themes across CCOs include:

- Approximately half of all HRS expenditures from Q1 2018 were confirmed as meeting HRS criteria, while most of the other half were missing required details to confirm whether criteria were met.
- Expenditures confirmed to meet HRS criteria accounted for $0.95 per member per month.
- Three times more was spent on community-benefit initiatives (76%) than on flexible services (24%).
- The three most common categories for confirmed expenditures were programs to improve community or public health (38.8%), training and education for health improvement or management (28.0%), and home and living environment items or improvements.

To improve future use and reporting of HRS, staff updated three existing HRS guidance documents and created two new guidance documents for CCOs focused on community benefit initiatives and addressing the social determinants of health and equity through HRS. They're all available on OHA's webpage (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.

Behavioral health integration

The center provided technical assistance to help fulfill the behavioral health goals of CCO 2.0, including hosting eight webinars in January and February for CCOs and providers covering early childhood mental health, children's system of care and wraparound. In addition, the center supported a comprehensive assessment of variations between requirements in the County Financial Assistance Agreement (CFAA) and CCO contracts. Recommendations were developed regarding possible changes to the CFAA to better align with the CCO contract.

Population health

Community advisory council activities

The center continued to host monthly CAC learning collaborative calls on CAC member recruitment and engagement and other topics, as well as separate monthly calls for CAC coordinators. The center hosted four webinars during this period:

- Two webinars focused on CAC-related CCO 2.0 contract and rule changes;
- One webinar centered on working with Oregon tribes; and
- One webinar focused on youth engagement in committees.

Staff also developed a guidance document about virtual CAC meetings and COVID-19. The CAC annual event is on hold.

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

Based on OHA's review of every CCO's second CHP, OHA requested and received additional information from CCOs. OHA reviewed the additional information to identify CCOs' gaps in CHP development, which will inform future CCO guidance and technical assistance. This will include a CCO CHA/CHP requirement guidance and checklist document and an update to the CHA/CHP development curriculum. The curriculum update will include the changes in CHA/CHP requirements, evolving COVID-19 context, and adjustments for remote training delivery.

CCO incentive metrics technical assistance

The Transformation Center is planning TA to support several of the 2020 CCO incentive metrics.

Adolescent immunizations

The Transformation Center held a webinar for CCO and clinic staff to introduce the metric, review technical specifications and share best practices for increasing HPV immunizations.

Diabetes (HbA1C and a new oral health visit metric)

The Transformation Center held four webinars to support system and clinic efforts to lower rates poor HbA1c control. One webinar was presented by community partners and focused on tailoring nutrition programs for different populations, and three webinars were presented by a local clinical champion. These three webinars focused on a systems approach to improving diabetes care, pharmacists on the diabetes care team, and patient education and engagement. Two sessions had CME credits attached. Across the three clinical webinars, an average of 55 people attended live and 86% of evaluation respondents said the webinar was valuable to their work.

Health aspects of kindergarten readiness (well-child visits and preventive dental visits)

The Transformation Center held a webinar for CCO and clinic staff to introduce the two CCO metrics of kindergarten readiness: well-child visits (ages 3-6) and preventive dental visits (ages 1-5). The center also hosted three webinars focused on increasing well-child visits:

- Reach out and Read program;
- How Washington state increased well child visits; and
- Oregon CCO peer sharing.

The center also contracted with a communications firm to conduct an environmental scan and develop messaging about the value of well-child and preventive dental visits.

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. 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 morbidity and mortality. Thirty-seven clinics across Oregon have signed up to participate so far.

Cross-cutting supports

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee
The Transformation Center coordinated a statewide CCO learning collaborative session that focused on the health aspects of kindergarten readiness, which includes the CCO incentive metrics for increasing well-child and preventive dental visits. The session included background on the metrics and presentations from two CCOs about provider engagement and member outreach. Most evaluation respondents rated the session as valuable for supporting their work.

Transformation and Quality Strategy (TQS) technical assistance
Center staff hosted five webinars and three office hours to support CCOs' development of their annual TQS. Center staff also facilitated a process to design a scoring framework for this year's TQS submissions. CCOs submitted their 2020 TQS in March and center staff will manage the review and feedback process.

B. Lower cost (ANNUAL)

C. Better care and Better health (ANNUAL)

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports
Attached separately as Appendix A.

2. State reported enrollment table

Enrollment	January/2020	February/2020	March/2020
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	958,413	963,428	968,566
Title XXI funded State Plan	91,516	91,778	91,968

Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A
Enrollment current as of	1/31/2020	2/28/2020	3/31/2020

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%	0	0	0	0
		Pregnant women FPL > 170%	0	0	0	0
	Title XXI	SCHIP FPL > 170%	43,399	209,143	3.99%	-15.18%
	Title XXI	SCHIP FPL < 170%	104,119	272,432	1.61%	6.83%
Mandatory	**Title XIX**	Other OHP Plus	159,621	452,916	0.53%	1.83%
		MAGI adults/children	754,654	2,094,484	2.39%	2.61%
		MAGI pregnant women	11,181	25,699	4.52%	-1.82%
		QUARTER TOTALS	1,072,974			
** Due to retroactive eligibility changes, the numbers should be considered preliminary*						

OHP eligible and managed care enrollment

OHP eligible*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
January		898,341	904	340	12,378	43,490	
February		900,622	1,005	341	11,987	43,018	
March		903,822	1,192	325	10,955	41,710	
Quarter average		900,928	1,034	335	11,773	42,739	
	Average percentage						

** 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

Attached separately as Appendix B.

C. CCO appeals and hearings

Attached separately Appendices C & D.

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