Oregon Health Plans

Section 1115 Annual Report

10/1/2023 – 9/30/2024

Demonstration Year (DY): 22 (10/1/2023 – 9/30/2024)

Federal Fiscal Year: 2024

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I. Introduction

A. Letter from the State Medicaid Director

The Oregon Health Authority (OHA) continued to work with our partners in the health care and social services delivery system to make significant progress on implementing the Oregon Health Plan (OHP) waiver across all initiatives.

Health Related Social Needs

The state continued to build the community infrastructure necessary to deliver health-related social needs (HRSN) services. Initial critical investments provided through the Designated State Health Program (DSHP) Health Related Social Needs (HRSN) Infrastructure funds, were distributed during this period via the Community Capacity Building Funds (CCBF) Grant Program (OHA's terminology for the state's HRSN Infrastructure funding, authorized under STC 9.3 "HRSN Infrastructure"). OHA and coordinated care organizations (CCOs) awarded a combined $37 million to 161 community organizations across the state to help support the delivery of HRSN benefits in this period. These investments will support social service providers and organizations to develop what they need to be able to participate in the Medicaid delivery system.

In honoring the government-to-government relationship with the Nine Federally Recognized Tribes of Oregon, an additional $11.9 million of CCBF funding has been set aside for the Nine Tribes.

In addition, OHA laid the groundwork to begin delivering HRSN services to qualifying members. OHA engaged with housing partners across the state to inform and develop technical components of the service descriptions, including specifying activities, limits, units, duration, and collected data to determine the fee schedule for housing and nutrition services. OHA developed comprehensive approaches to overseeing and monitoring HRSN service delivery via contracts with key partners and administrative rules. The state continued to build the technical solutions necessary to collect data on and oversee the delivery of HRSN services via community information exchange. This intensive planning will help to support a more successful launch of additional HRSN housing benefits in November 2024 and nutrition benefits in January 2025.

Finally, the state began its phased roll out of HRSN housing benefits through the launch of home modification devices and outreach and engagement services in March 2024.

Continuous Eligibility

During the reporting period, OHA implemented and maintained Continuous Eligibility policy, allowing most medical assistance recipients to receive an ensured continuous enrollment period of 24 months, or, for children, through the end of the month of the child's sixth birthday, whichever produces a longer enrollment period.

Youth with Special Health Care Needs (YSCHN)

The state continued to define and plan for the benefits expansion for youth with special health care needs (YSHCN), including by building the technical solutions necessary to support this expansion and developing supporting administrative rules and contracts with implementing partners (e.g., CCOs).

Re-entry Demonstration

Since the approval of the state's Re-entry demonstration initiative on July 2, 2024, the state has undertaken several coordinated planning measures to support launch in 2026. Planning measures include initiating readiness assessments, developing operational guides and contracts, and planning for the release of authorized capacity building funding to qualifying entities.

OHA looks forward to a continued partnership with CMS.

Emma Sandoe, State Medicaid Director

B. Demonstration description

On September 28, 2022, the Centers for Medicare & Medicaid Services (CMS) approved Oregon's renewed 1115 Demonstration waiver, effective October 1, 2022 to September 30, 2027. This most recent approval builds on the successes of Oregon's previous 1115 waivers and included significant eligibility expansion authority, as well as new benefits for individuals who have health-related social needs (HRSNs) and are experiencing life transitions. This most recent approval advances the work conducted under the state's prior waivers, including those approved in 2012 and 2017, to provide care through the state's CCOs and to provide integrated, whole-person care to members. Collectively, these reforms are expected to further OHA's goal to eliminate health inequities by 2030 through connecting underserved populations with effective health care and supports.

Voluminous and complex changes are included in the waiver, impacting many populations and creating new opportunities to provide coordinated care. Children who are enrolled in Medicaid any time prior to their sixth birthday will remain enrolled until age six. People over age six will automatically remain enrolled for two years (instead of one). These eligibility changes help members remain covered longer and be less likely to lose coverage due to administrative issues.

The approved waiver also includes some benefit changes for youth. All federally required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children and youth to age 21 will be available. Additionally, for youth with special health care needs, eligibility criteria will allow access to expanded benefits, including EPSDT, until age 26.

Additionally, the waiver includes significant and nationally innovative service expansions for select populations. Beginning in 2024, Oregon will provide HRSN benefits (such as housing and nutrition services) to people who have a demonstrated clinical and social need. This includes individuals who:

- Are at risk of becoming homeless
- Are experiencing low food security
- Have a clinically appropriate need for a home modification device

Under the new waiver, eligible OHP members will get increased care and social supports, which will support members upstream, and ultimately prevent more costly care including emergency and urgent services. OHA is committed to working collaboratively with partners to design a benefit and implementation approach that expands health care access, quality and improves the lifelong health of everyone in Oregon.

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II. Title

Oregon Health Plan (OHP)

Section 1115 Annual Report

Reporting period: 10/1/2023 – 9/30/2024

Demonstration Year (DY): 22 (10/1/2023 – 9/30/2024)

Federal Fiscal Year: 2024

III. Overview of the current quarter

This reporting period included continued and extensive operational planning to support the successful launch of waiver initiatives, including engaging with key partners in the health care and social services delivery system. This work is further detailed throughout the report but has informed critical aspects of successful launch of all HRSN benefits including collaborative processes of developing service description and fee schedules.

Initial critical financial resources were distributed during this period via the CCBF Grant Program. OHA and CCOs awarded a combined $37 million in infrastructure funding to organizations supporting the delivery of HRSN services and supports. These investments will support social service providers and organizations to develop what they need to be able to participate in the Medicaid delivery system. An additional $11.9 million of CCBF funding has been set aside for the Nine Federally Recognized Tribes of Oregon. The grant program will begin again in 2025 to further resource identified gaps in the HRSN delivery system across the state.

Additional highlights include:

- Began rolling out HRSN services and preparing contracts, administrative rules and related requirements to enable launch of additional housing services on 11/1/24 and select nutrition services on 1/1/25.
- Refined definitions of community information exchange (CIE) and closed loop referrals to support HRSN Guidance Document and an implementation plan to support HRSN Service Providers with adoption and use of CIE while increasing requirements for CIE use over time.
- Further development of the benefits expansion for YSHCN implementation January 2025.

- Convened internal systems teams including with the Oregon Eligibility (ONE) Information Exchange, Medicaid Management Information System (MMIS), and Mainframe groups to map out technological pathways to coverage and care.
- Re-entry planning measures, to support launch in 2026, including initiating readiness assessments, developing operational guides and contracts, and planning for the release of authorized capacity building funding to qualifying entities.

A. Enrollment progress

1. Oregon Health Plan eligibility

After an extended public health emergency (PHE) unwinding period, the final group of post-PHE renewals was triggered in September 2024 which will conclude Oregon's unwinding effort for all but approximately 3,800 individuals. Due to robust renewal outreach efforts, renewal reminder notices, more flexible renewal response timelines, and implementation of a temporary adult program to maintain eligibility for those who would ultimately transition to the new Basic Health Program, Oregon has experienced very low attrition rates as we exit the PHE unwinding period.

On July 1, 2024, Oregon implemented a Basic Health Program for adults ages 19 through 64 with income between 138 and 200 percent of the federal poverty level. While the Basic Health Program is not Medicaid-funded, it has helped to minimize the number of individuals who are losing coverage due to being over-income, and it has helped individuals to maintain uninterrupted access to consistent and coordinated care and avoid coverage gaps, like being uninsured.

Title XIX enrollment is seeing steady enrollment increases, particularly for traditional Medicaid categories for those over age 64 or who are blind or disabled. This could be attributed partly to general population age demographics as well as some rebound from enrollment declines that were evident during the PHE.

2. Coordinated care organization enrollment

Continuous eligibility policies and extensions to the public health unwinding period, in addition to expansions of eligibility such as the Basic Health Plan, have maintained steady CCO enrollment with a slight decline. On average enrollment across all CCOs decreased by 1.1%, although Eastern Oregon Coordinated Care Organization, the only CCO serving rural eastern Oregon, saw an increase by 1%. While Pacific Source saw declines in enrollment in three regions, the Columbia Gorge increased by 0.5%. The steepest decline in enrollment occurred with Trillium Health Plan by -5.8%.

Some CCOs continue to experience enrollment exceeding their 2024 contract capacities. Oregon Administrative Rule 410-141-3805 (Mandatory MCE Enrollment Exceptions) was updated to permit OHA to increase a CCO's enrollment in cases of unforeseen events or legislative changes that impact the number of eligible members in a region. Eastern Oregon CCO and Pacific Source have had their enrollment maximums increased above capacity for 2024. New enrollment limits have been established for 2025.

Implementation of the Basic Health Plan presented several challenges to enrollment. BHP members are required to enroll into CCOs, however MMIS configuration created fee-for-service gaps for new enrollees which required both manual and systemic intervention to ensure members were CCO enrolled as of date of eligibility. Other members failed to enroll into plans due to system errors, exemptions placed on member cases preventing enrollment, and case composition issues.

CCO Services, Enrollment and Eligibility Units, and Business Services teams continue to coordinate efforts to ensure all eligible members enroll into CCOs timely through either manual or systemic intervention, communicating with CCOs when rare retroactive enrollment occurs.

B. Benefits

Health Evidence Review Commission (HERC):
Each HERC meeting provided an opportunity to discuss issues related to the coverage of health services and the medical necessity criteria to be reflected in the Prioritized List of Health Services. Complete agendas, materials, minutes and meeting recordings for each meeting are available here.

Pharmacy & Therapeutics (P&T) Committee: The Pharmacy and Therapeutics (P&T) Committee is an 11-member advisory committee of physicians, pharmacists and consumer representatives. The Committee performs drug use reviews and advises the OHA on which prescription drugs should be included on any preferred drug list (PDL) established by OHA. The P&T Committee met several times during the reporting period to develop new or revised prior authorization criteria for priority drugs. The committee also met to recommend key changes to the preferred drug list for a select number of drugs. Additional information on the Committee is available here.

C. Access to care (ANNUAL)

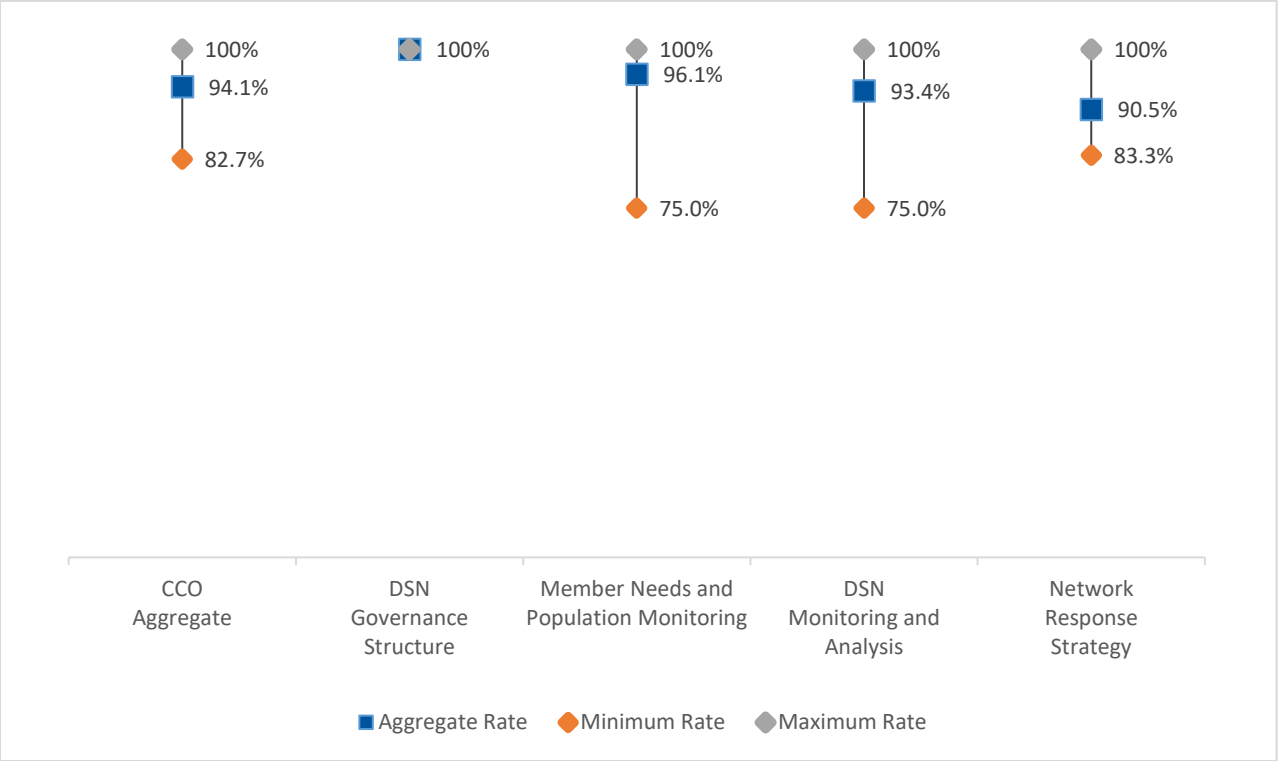
Federal and State regulations governing Medicaid services require each managed care contractor to maintain a network of appropriate health care providers to ensure all services covered under the State plan are available and accessible to members in a timely manner. The State of Oregon, Oregon Health Authority (OHA) contracts with 16 coordinated care organizations (CCOs) to deliver managed care services for Oregon Health Plan (OHP) members. Each contractor must demonstrate the capacity to serve its current and expected membership within its service area and submit documentation to the State Medicaid authority.

To meet oversight requirements, OHA contracted with Health Services Advisory Group, Inc. (HSAG) to conduct an evaluation of the CCOs' delivery system networks (DSNs) to assess network adequacy and compliance with Oregon's standards for access to care. HSAG conducted the DSN Evaluation in alignment with guidance outlined in the Centers for Medicare & Medicaid Services' (CMS) network access and adequacy toolkit and the CMS External Quality Review (EQR) Protocols released in February 2023.

DSN Provider Narrative Review

Based on HSAG's review of the *DSN Provider Narrative Template* submissions, compliance with the State and federal requirements for maintaining and monitoring the adequacy and assurance of the provider network demonstrated opportunities for improvement across all CCOs. HSAG reviewed CCO submissions across 26 total elements representing four domains—i.e., *DSN Governance Structure*, *Member Needs and Population Management*, *DSN Monitoring and Analysis*, and *Network Response Strategy*. Figure 0-1 displays the CCO aggregate compliance rates by *DSN Provider Narrative Template* domain as well as an aggregate compliance rate across domains. Results are given as a range of compliance rates including minimum (i.e., lowest CCO rate), maximum (i.e., highest CCO rate), and aggregate (i.e., CCO average) rates. The CCO aggregate category is a measure of the overall compliance rate across all domains.

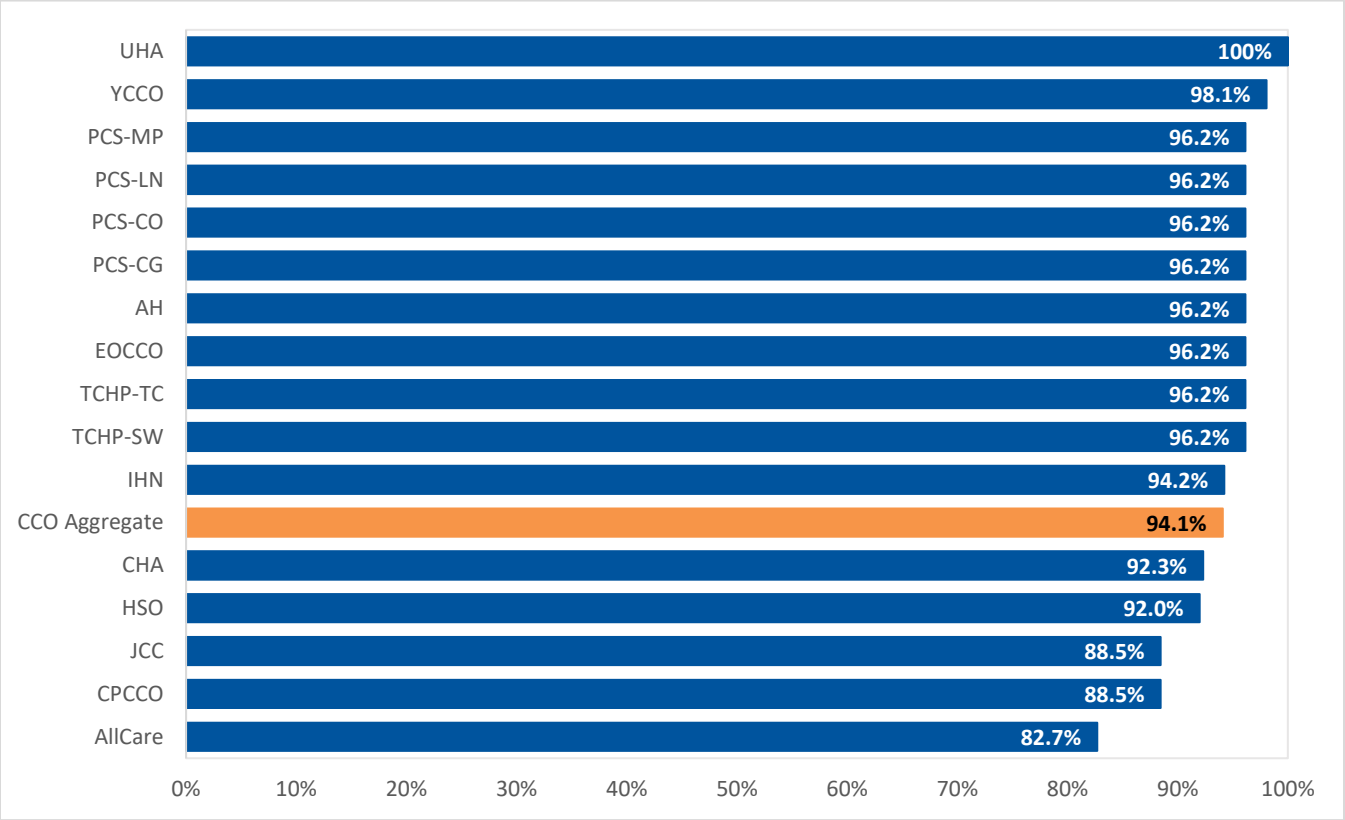
Figure 0-1—Statewide DSN Provider Narrative Template Results



Statewide, the CCOs exhibited compliance with 94.1 percent of the elements across all *DSN Provider Narrative Template* domains, with individual domain CCO aggregate compliance ranging from 90.5 percent (i.e., *Network Response Strategy*) to 100 percent (i.e., *DSN Governance Structure*). Overall, these results suggest a high level of compliance with State reporting requirements for most CCOs, with room for improvement for the CCOs at the lower end of compliance rates.

Figure 0-2 displays each CCO's overall DSN Provider Narrative compliance score relative to the CCOs' aggregate score. All CCO compliance scores are ranked from highest to lowest, including the overall CCO aggregate score, within the domain.

Figure 0-2—Overall DSN Provider Narrative Template Results by CCO



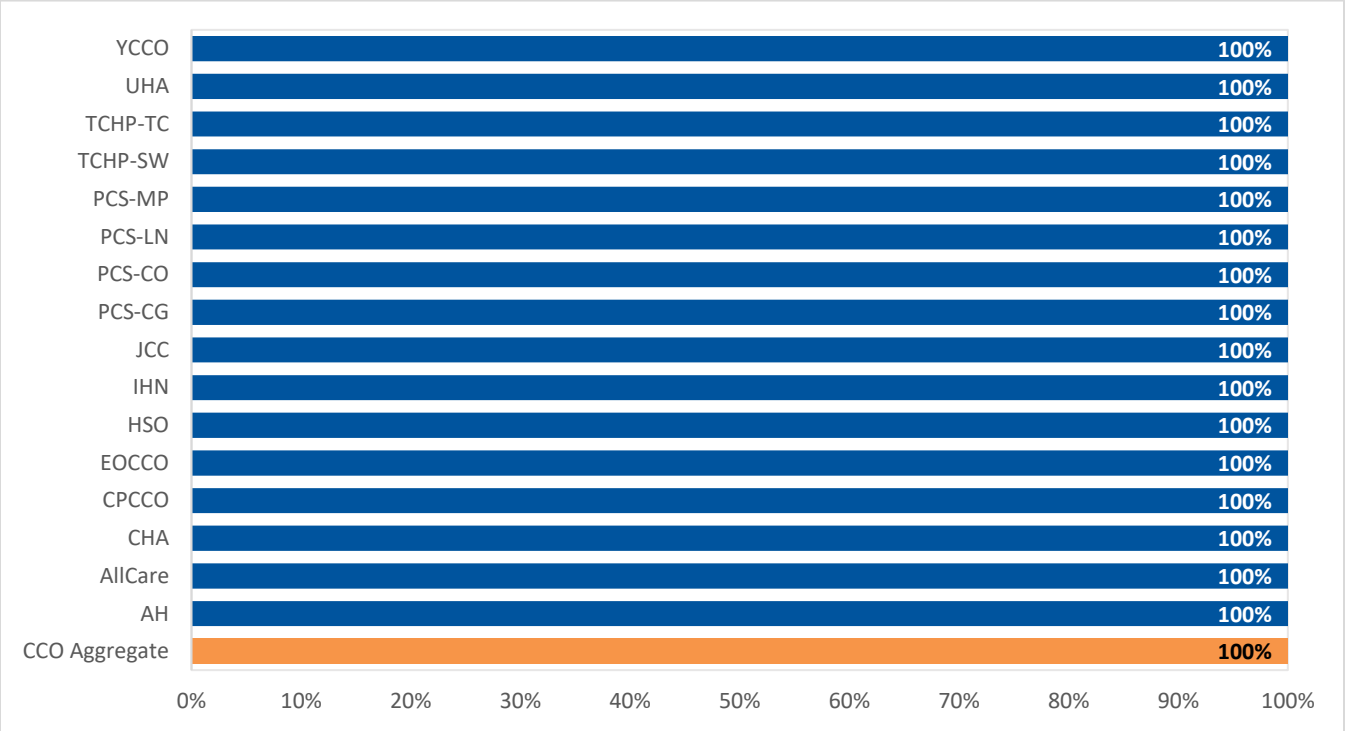
The CCOs showed a smaller range and higher overall compliance scores than in prior years' DSN Provider Narrative Reviews. CCO-specific compliance scores ranged from 82.7 percent (AllCare) to 100 percent (UHA). Of the 11 CCOs with compliance scores equal to or above the CCO aggregate, all exhibited an overall high level of compliance (i.e., 90 percent or greater). Of the five CCOs performing below the CCO aggregate score, only three (AllCare, CPCCO, and JCC) exhibited less than 90 percent compliance. Individual CCO results and conclusions are located in the CCO-specific appendices of this report.

Domain-Specific Findings

DSN Governance Structure

The *DSN Governance Structure* domain evaluates the CCO's operational infrastructure responsible for oversight and monitoring of the adequacy of its DSN. Elements within the domain identify the organizational departments and committees and their roles and responsibilities related to maintaining the CCO's provider networks; the CCO's policies, procedures, and processes for overseeing subcontractors' delegated network-related managed care functions; and an assessment of the information systems used to collect, store, validate, calculate, and report network provider data and metrics. Figure 0-5 shows the individual CCO compliance scores for elements in the *DSN Governance Structure* domain. All CCO compliance scores are ranked from highest to lowest, including the overall CCO aggregate score, within the domain.

Figure 0-3—DSN Governance Structure Compliance Scores by CCO

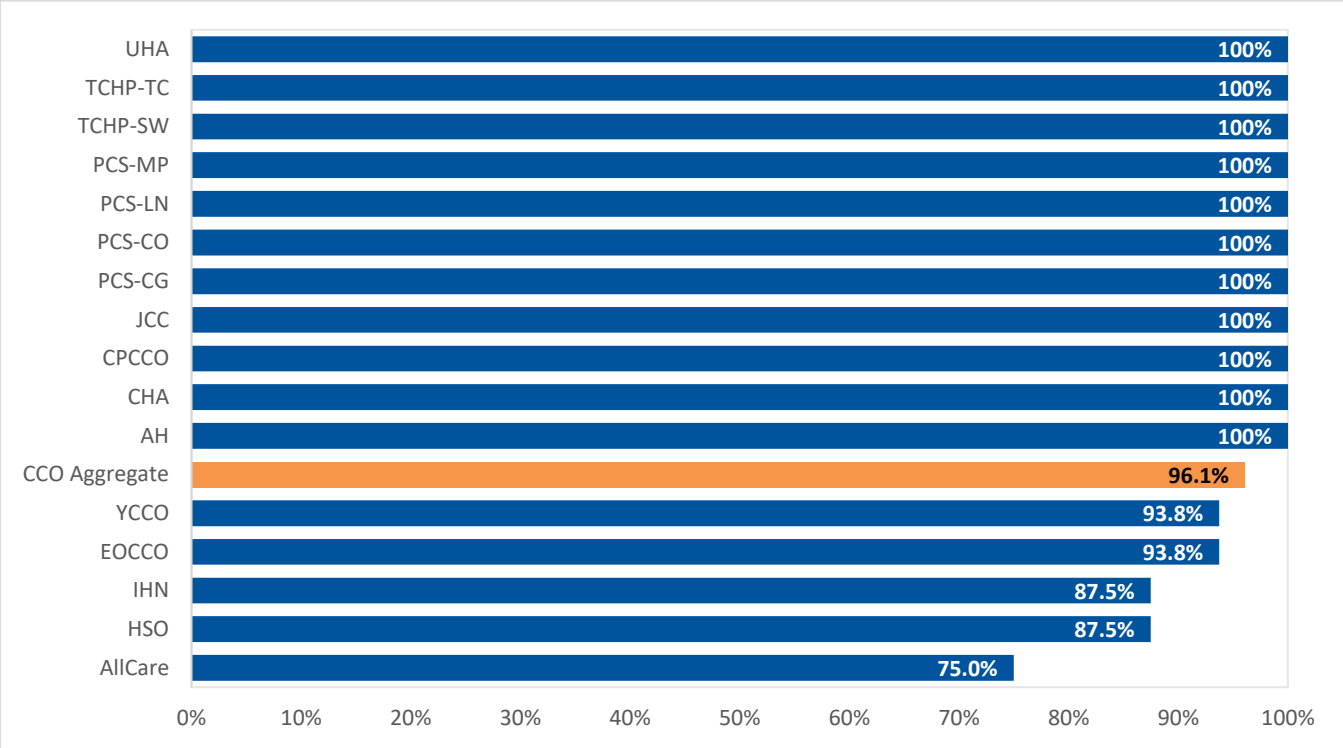


All CCOs achieved 100 percent compliance with *DSN Governance Structure* domain elements. Most CCOs attested to having made no substantive changes to governance structures or subcontractual relationships since 2023.

Member Needs and Population Management

The *Member Needs and Population Management* domain evaluates the CCO's approach to monitoring its provider network relative to the characteristics and needs of its membership. Elements within the domain are designed to collect information on the CCO's membership in terms of physical and mental disabilities and special health care needs (SHCN), linguistic and cultural needs, grievances, workforce readiness to provide culturally and linguistically appropriate services, and Medicaid and full-benefit/dual-eligible (FBDE) enrollment and trends for utilization of services. Figure 0-4 shows the individual CCO compliance scores for elements in the *Member Needs and Population Management* domain. All CCO compliance scores are ranked from highest to lowest, including the overall CCO aggregate score, within the domain.

Figure 0-4—Member Needs and Population Management Compliance Scores by CCO



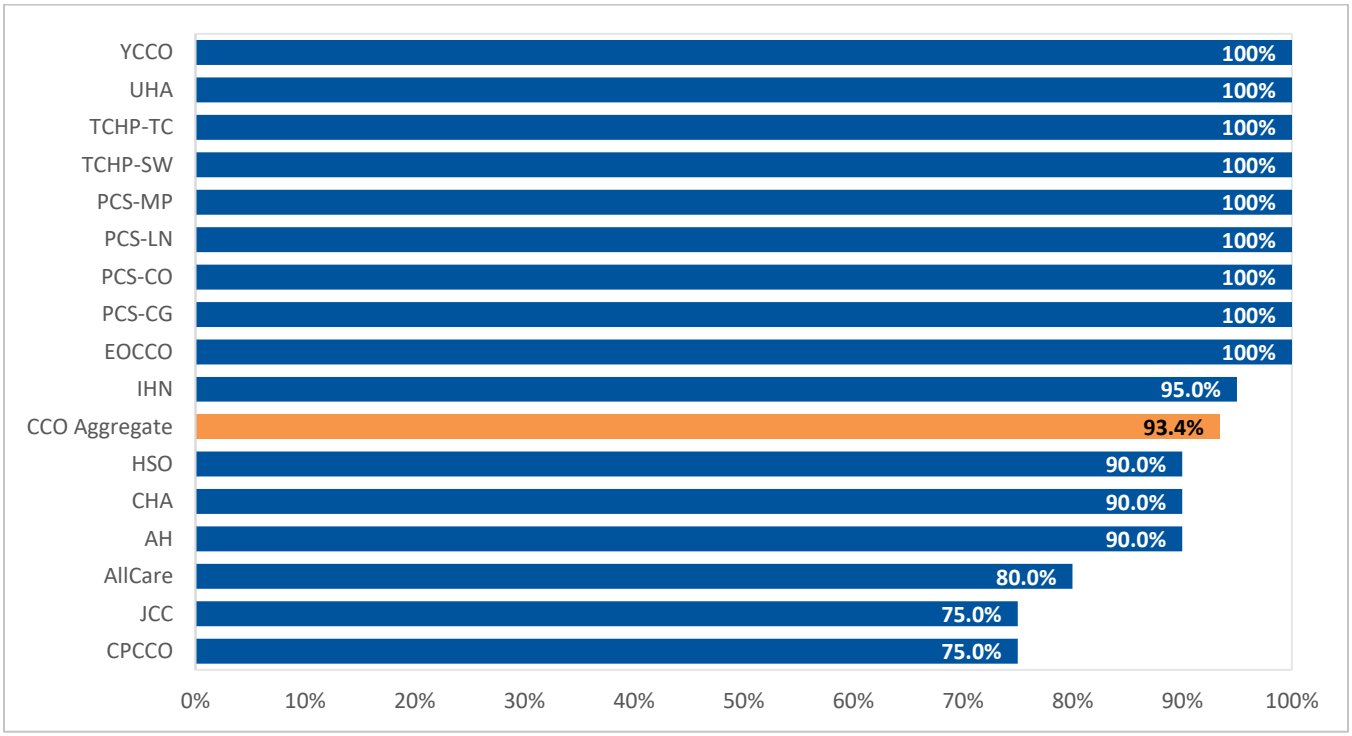
Eleven CCOs achieved 100 percent compliance with *Member Needs and Population Management* domain elements, and the CCO aggregate compliance score was over 95 percent, suggesting high overall compliance within the domain. Additional observations include the following:

- Most CCOs reported implementation or planned implementation of frequently updated dashboards rather than periodic manual reporting for monitoring member needs and conducting population management.
- Findings of noncompliance and CCOs with scores below the CCO aggregate were typically related to operational practices of monitoring and reporting on individual members (e.g., case management for members with disabilities) rather than member populations, or only assessing OHA-determined CCO performance metrics (e.g., preventive screening rates) rather than the actual needs or utilization patterns of the member population.

DSN Monitoring and Analysis

The *DSN Monitoring and Analysis* domain evaluates the CCO's processes for monitoring and analyzing the adequacy of its provider network, including the collection, calculation, and reporting of network performance measures. Elements within the domain identify the network performance measures used by the CCO and the data sources, measure specifications, and reporting mechanisms in place. This domain also includes a review of the CCO's most recent network monitoring results. Figure 0-5 shows the individual CCO compliance scores for elements in the *DSN Monitoring and Analysis* domain. All CCO compliance scores are ranked from highest to lowest, including the overall CCO aggregate score, within the domain.

Figure 0-5—DSN Monitoring and Analysis Compliance Scores by CCO



Nine CCOs achieved 100 percent compliance with *DSN Monitoring and Analysis* domain elements. The CCO aggregate score was 93.4 percent, and of the six CCOs scoring below the aggregate, three still achieved 90 percent compliance, suggesting high overall compliance with the domain. Additional observations include the following:

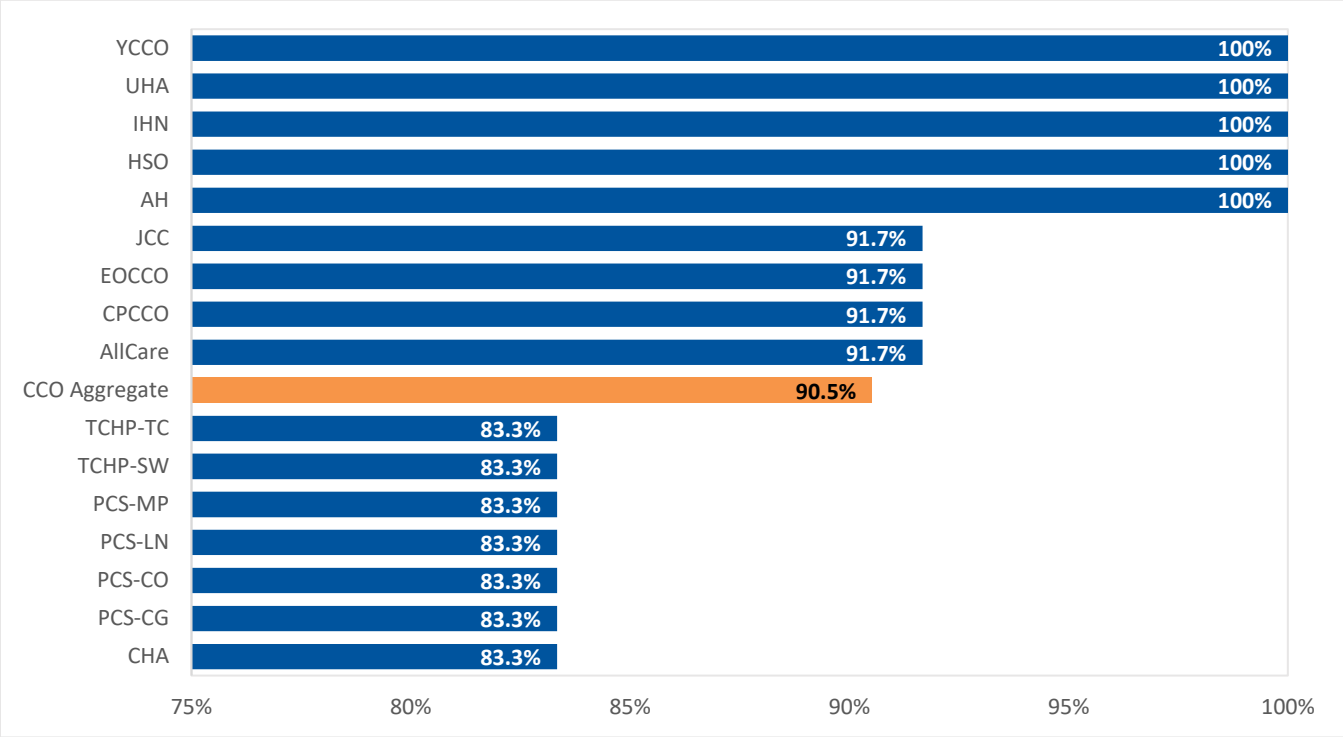
- All CCOs were compliant with OHA's 2024 provider monitoring requirements by provider types, tiers, and urbanicities. Implementation of these standards was essential to the CCOs' overall compliance with OHA's quantitative network adequacy requirements.
- Several CCOs identified the expansion of traditional health worker (THW) providers as critical to their monitoring of and network capacity for the provision of culturally and linguistically appropriate care. These CCOs allocated funding toward the training, recruitment, retention, and expansion of their THW provider network.
- Most deficiencies in this domain were related to collecting required data in ways that were not methodologically robust and/or being unable to demonstrate consideration of the data to support network adequacy monitoring and decision making.
- The least compliant CCO aggregate compliance scores for individual elements were wait time to appointment availability (84.4 percent), use of telehealth modalities (78.1 percent), and the availability of physical accessibility accommodations (81.3 percent).

Network Response Strategy

The *Network Response Strategy* domain provides insight into the methodologies used by the CCO to identify barriers affecting network adequacy, implement interventions to resolve barriers, evaluate the efficacy of any interventions, and the actions taken to address any previously identified areas for improvement. Figure 0-6 shows the individual CCO compliance scores for elements in the *Network*

Response Strategy domain. All CCO compliance scores are ranked from highest to lowest, including the overall CCO aggregate score, within the domain.

Figure 0-6—Network Response Strategy Compliance Scores by CCO



Five CCOs achieved 100 percent compliance with *Network Response Strategy* domain elements, and the CCO aggregate score was above 90 percent, indicating an overall moderate to high level of compliance with the domain. Additional observations include the following:

- Similar to previous years, most CCOs identified a network adequacy gap around certified and qualified health care interpreters. Some CCOs described intervention plans that included funding scholarship programs for qualified and certified health care interpreters.
- Many CCOs demonstrated consideration of both their global provider network and region-specific provider networks (both at the county and city level) when assessing network adequacy gaps and planning interventions. These gap assessments were often driven by time and distance assessment and community and provider feedback. Several CCOs also showed proactive identification of potential gaps by cross-referencing multiple analyses, including but not limited to telehealth utilization, service trends by demographics, and out-of-network requests and authorizations.
- Most deficiencies in this domain were related to providing insufficient answers to elements or lack of specific details (i.e., methods, metrics, and timelines) regarding monitoring the efficacy of planned network interventions and anticipated changes to future network capacity needs.

Network Capacity and Adequacy Assessment

Network Capacity

To address provider network capacity, HSAG conducted a review of the CCOs' provider network data files and synthesized the results to understand the provider network infrastructure in place to provide health care services to members. Using CCO data provided by OHA, HSAG aggregated the data and reported three core metrics for PCPs, PCDs, MH providers, and SUD providers—i.e., provider counts, network stability, and provider-to-member ratios. These provider types were selected as key measures of network capacity due to their role in providing front-line health services, which serve the widest array of needs and act as intake points. The results are unweighted, and percentages were calculated based on the number of unique, individual practitioners within each category.

HSAG calculated CCO-specific provider-to-member ratios for all provider types in order to standardize the reporting of provider capacity. The provider-to-member ratio was calculated by dividing the total number of members enrolled in each CCO by the total number of providers within the CCO's network. The number of members enrolled in each CCO was determined by extracting members from the OHA enrollment and eligibility files who were active with the CCO as of March 31, 2024. Since OHA does not currently have specific provider-to-member ratio standards for any provider type, the results below are presented for informational purposes.

Primary Care Providers

Table 0-1 shows the total number of PCPs contracted with each CCO and the ratio of providers to all members. The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of PCPs. Due to how providers were grouped depending on population served, percentages may not total 100 percent.

Table 0-1—Counts, Ratios, and Percentages of PCPs by Quarter

CCO	Q1 2023		Q1 2024		Difference PCP-All	
	PCP-All (N)	Provider-to-Member Ratio	PCP-All (N)	Provider-to-Member Ratio	Number	% Change in Counts
AH	89	1:349	79	1:363	-10	-11.2% ▼
AllCare	352	1:191	355	1:189	3	0.9%
CHA	92	1:329	88	1:314	-4	-4.3%
CPCCO	1,703	1:25	1,661	1:23	-42	-2.5%
EOCCO	1,784	1:45	1,105	1:72	-679	-38.1% ▼
HSO	2,103	1:230	1,990	1:228	-113	-5.4%
IHN	290	1:309	319	1:269	29	10.0% ▲
JCC	1,733	1:43	1,731	1:39	-2	-0.1%

CCO	Q1 2023		Q1 2024		Difference PCP-All		
	PCP-All (N)	Provider-to-Member Ratio	PCP-All (N)	Provider-to-Member Ratio	Number	% Change in Counts	
PCS-CO	248	1:333	240	1:326	-8	-3.2%	
PCS-CG	90	1:227	90	1:204	0	0%	
PCS-LN	402	1:241	353	1:265	-49	-12.2%	▼
PCS-MP	342	1:455	331	1:471	-11	-3.2%	
TCHP-SW	500	1:80	645	1:58	145	29.0%	▲
TCHP-TC	618	1:97	710	1:93	92	14.9%	▲
UHA	150	1:273	116	1:345	-34	-22.7%	▼
YCCO	790	1:48	1,314	1:29	524	66.3%	▲

Overall, eight out of 16 CCOs showed substantial changes in PCP counts between 2023 and 2024. Of these, EOCCO, TCHP-SW, UHA, and YCCO showed more than a 20 percentage point change in contracted PCPs. Additional observations include the following:

- UHA's 22.7 percent decrease can be attributed to the limited available provider pool within the CCO's rural and geographically isolated service region but still represents a potential access concern given that it has the second-highest PCP provider-to-member ratio among all CCOs.
- TCHP-SW's substantial increase in providers is attributed to expanded contracting efforts for both TCHP-SW and TCHP-TC. TCHP-TC's increase (i.e., 14.9 percent) kept pace with the CCO's member population growth, as indicated by its relatively unchanged provider-to-member ratio between 2023 and 2024.
- EOCCO showed a decrease of 38.1 percent of contracted PCPs. This can be attributed to improved data collection and reporting between 2023 and 2024, particularly in regard to excluding providers in other states who were previously included as part of EOCCO's overarching Moda Health network. Taken in context of meeting time and distance access requirements for PCPs, these losses did not necessarily represent an access concern.
- Between 2023 and 2024, YCCO showed a 66.3 percent increase in PCPs (i.e., a gain of 524 providers). This may indicate improved data collection and reporting, an expanded physical health footprint via its subcontractor, a data quality issue, or a combination of the three.
- When taken in the context of provider-to-member ratios, the changes for EOCCO, TCHP-SW, UHA, and YCCO placed them in approximate equivalence with other CCOs of similar membership size and urbanicity. This suggests that these results represent more accurate reporting and/or network alignment of anticipated member needs with available provider pools.

Primary Care Dentists

Table 0-2 shows the total number of PCDs contracted with each CCO and the ratio of providers to all members. The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of PCDs. Due to how providers were grouped depending on population served, percentages may not total 100 percent.

Table 0-2—Counts, Ratios, and Percentages of PCDs by Quarter

CCO	Q1 2023		Q1 2024		Difference PCD-All		
	PCD-All (N)	Provider-to-Member Ratio	PCD-All (N)	Provider-to-Member Ratio	Number	%Change in Counts	
AH	23	1:1,115	22	1:1,303	-1	-4.3%	
AllCare	36	1:1,460	32	1:2,087	-4	-11.1%	▼
CHA	28	1:910	26	1:1,060	-2	-7.1%	
CPCCO	181	1:188	211	1:181	30	16.6%	▲
EOCCO	145	1:465	142	1:559	-3	-2.1%	
HSO	504	1:797	478	1:947	-26	-5.2%	
IHN	139	1:517	129	1:664	-10	-7.2%	
JCC	76	1:760	90	1:745	14	18.4%	▲
PCS-CO	296	1:217	281	1:278	-15	-5.1%	
PCS-CG	296	1:49	281	1:66	-15	-5.1%	
PCS-LN	296	1:259	281	1:332	-15	-5.1%	
PCS-MP	296	1:416	281	1:555	-15	-5.1%	
TCHP-SW	116	1:279	108	1:341	-8	-6.9%	
TCHP-TC	365	1:139	348	1:188	-17	-4.7%	
UHA	29	1:1,113	25	1:1,598	-4	-13.8%	▼
YCCO	54	1:621	55	1:690	1	1.9%	

Overall, the PCD network remained fairly stable or saw moderate decreases. As in previous years, most CCOs partially or fully delegate dental health care services and management to subcontracted dental care organizations. Most of these subcontractors have a statewide presence, leading to relatively stable dental provider networks. Additional observations include the following:

- UHA lost 13.8 percent of its PCD network. This marked the second year UHA demonstrated a decrease in PCDs, having lost 16.3 percent of its network between 2022 and 2023. While UHA's reductions should be taken in the context of the CCO's small available provider pool

(i.e., less than 30 providers in total) the changes still represent a potential access concern given that UHA has the second highest PCD provider-to-member ratio among CCOs.

- AllCare lost 11.1 percent of its PCD network (i.e., four providers), and had the highest provider-to-member ratio for PCDs of any CCO. No reliable data prior to 2023 was available for comparison, but these results suggest an access concern.
- The four CCOs with the highest provider-to-member ratios for PCDs were AH (1:1,303), AllCare (1:2,087), CHA (1:1,060), and UHA (1:1,598). These four CCOs are located in southern Oregon, suggesting a regional access concern for PCDs. No other CCO reached a provider-to-member threshold of 1:1,000 for PCDs.

Mental Health Providers

Table 0-3 shows the total number of MH providers contracted with each CCO and the ratio of providers to all members. The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH providers.

Table 0-3—Counts, Ratios, and Percentages of MH Providers by Quarter

CCO	Q1 2023		Q1 2024		Difference MH-All		
	MH-All (N)	Provider-to-Member Ratio	MH-All (N)	Provider-to-Member Ratio	Number	% Change in Counts	
AH	182	1:144	250	1:115	68	37.4%	▲
AllCare	488	1:125	501	1:134	13	2.7%	
CHA	123	1:194	120	1:230	-3	-2.4%	
CPCCO	1,987	1:16	2,467	1:16	480	24.2%	▲
EOCCO	1,100	1:57	1,246	1:64	146	13.3%	▲
HSO	2,012	1:176	2,964	1:153	952	47.3%	▲
IHN	1,217	1:53	1,265	1:68	48	3.9%	
JCC	2,108	1:27	2,661	1:26	553	26.2%	▲
PCS-CO	3,682	1:19	4,079	1:20	397	10.8%	▲
PCS-CG	3,681	1:5	4,079	1:5	398	10.8%	▲
PCS-LN	3,681	1:22	4,079	1:23	398	10.8%	▲
PCS-MP	3,684	1:35	4,082	1:39	398	10.8%	▲
TCHP-SW	1,660	1:21	1,933	1:20	273	16.4%	▲
TCHP-TC	1,739	1:28	2,519	1:26	780	44.9%	▲
UHA	139	1:227	209	1:192	70	50.4%	▲
YCCO	2,013	1:16	2,292	1:17	279	13.9%	▲

Overall, the MH provider network increased substantially both in comparison to other provider types and in raw numbers. Several factors likely contributed to this growth, including efforts by OHA and the CCOs to distribute targeted behavioral health payments, expanded CCO contracting efforts, and data improvements from OHA and the CCOs. However, caution should be used when interpreting the results, as some CCOs report provider network capacity data at an enterprise level, which may increase the overall number of providers regardless of local availability to Medicaid members. Additional observations include the following:

- Of the 16 CCO networks, 13 showed substantial changes between 2023 and 2024. Of the CCOs with substantial changes, six CCOs showed more than a 20-percentage point change, with three CCOs showing more than a 40 percentage point change.
- Raw counts of additional MH providers among the 15 CCOs that increased their networks ranged from as low as 13 to as high as 952, with a median increase of 397 providers.

Substance Use Disorder Providers

Table 0-4 shows the total number of SUD providers contracted with each CCO and the ratio of providers to all members. The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of SUD providers. Due to how providers were grouped depending on population served, percentages may not total 100 percent.

Table 0-4—Counts, Ratios, and Percentages of SUD Providers by Quarter

CCO	Q1 2023		Q1 2024		Difference SUD-All		
	SUD-All (N)	Provider-to-Member Ratio	SUD-All (N)	Provider-to-Member Ratio	Number	% Change in Counts	
AH	56	1:518	74	1:388	18	32.1%	▲
AllCare	144	1:457	121	1:552	-23	-16.0%	▼
CHA	69	1:396	49	1:563	-20	-29.0%	▼
CPCCO	528	1:72	511	1:75	-17	-3.2%	
EOCCO	292	1:261	409	1:194	117	40.1%	▲
HSO	582	1:755	558	1:811	-24	-4.1%	
IHN	411	1:205	464	1:185	53	12.9%	▲
JCC	534	1:124	536	1:126	2	0.4%	
PCS-CO	550	1:140	578	1:136	28	5.1%	
PCS-CG	550	1:32	578	1:32	28	5.1%	
PCS-LN	550	1:167	578	1:162	28	5.1%	
PCS-MP	550	1:269	578	1:270	28	5.1%	
TCHP-SW	414	1:92	455	1:81	41	9.9%	

CCO	Q1 2023		Q1 2024		Difference SUD-All	
	SUD-All (N)	Provider-to-Member Ratio	SUD-All (N)	Provider-to-Member Ratio	Number	% Change in Counts
TCHP-TC	292	1:189	358	1:183	66	22.6% ▲
UHA	100	1:401	150	1:267	50	50.0% ▲
YCCO	417	1:90	352	1:108	-65	-15.6% ▼

Overall, the SUD provider network showed moderate to substantial changes between 2023 and 2024. Network percentage increases were as high as 50 percent, while the counts of providers gained or lost were typically below 70 percent. These changes continue the trend from 2023 of a gradual increase to the size of the overall SUD provider network. Additional observations include the following:

- Seven of the eight CCOs showing moderate changes in counts reported providers at a network level (i.e., a combined pool) rather than restricting counts to those available within respective service regions, including for regions or CCOs separated by hundreds of miles. These CCOs included CPCCO, JCC, PCS-CO, PCS-CG, PCS-LN, and PCS-MP. This type of reporting may obfuscate potentially substantial changes in the local SUD provider network.
- Most CCOs maintained an approximately equivalent provider-to-member ratio for SUD providers between 2023 and 2024. The outlier to this observation was CHA, which lost 20 providers (i.e., 29 percent of its network), raising its provider-to-member ratio from 1:396 to 1:563. This gave CHA the second-highest provider-to-member ratio among all CCOs. This result should be interpreted with caution due to CHA's small provider pool, which would be expected to exhibit larger shifts in provider-to-member ratios than larger networks. However, it does represent a potential access concern.
- The four highest provider-to-member ratios were HSO (1:811), CHA (1:563), AllCare (1:552), and AH (1:388). All other CCOs maintained a ratio below 1:300. This may indicate a relative or real access concern for the top four CCOs.

Network Availability and Accessibility Analysis

Network Availability and Accessibility results are based on the Q1 2024 Quarterly DSN Provider Capacity data supplied by CCOs to OHA. This section provides key aggregate findings from the data; a summary of CCO-specific results is available in the appendices.

OHA assessed the availability of the CCOs' network providers by assessing the percentage of PCPs, PCDs, MH providers, and SUD providers who were active, accepting new Medicaid patients, and located within a CCO's service areas. These service categories were selected as key measures of the adequacy of accessibility to front-line health services, which serve the widest array of needs and

act as intake points and facilitators to more specialized care. They also constitute the non-facility provider types within OHA's Tier 1 provider grouping.

Table 0-5 through Table 0-8 also display the overall percentage of providers who speak a non-English language. While the CCOs are required to provide qualified health care interpreter services (typically via a vendor service), assessing the number of providers within a network who speak a non-English language contributes to an understanding of how each CCO evaluates and adjusts its ability to provide services in a linguistically accessible and culturally responsive manner. It should be noted that language data for all providers are self-reported, and may not fully represent a provider's fluency or health literacy with a non-English language.

For PCPs, HSAG also evaluated the percentage of a PCP's total capacity available for assignment as of Q1 2024. The measure of "PCP capacity" indicates the difference between a PCP's maximum patient panel assignment and its actual number of assigned patients. For example, if a PCP can accept 100 patients and has 40 assigned to them, their PCP capacity is 60 percent. In the table below, PCP capacity represents this overall measure averaged across all contracted PCPs.

Primary Care Providers

Table 0-5 shows the results for PCPs stratified by CCO.

Table 0-5—Availability and Accessibility of PCPs by CCO

CCO	Count	Availability				Accessibility
		Active	Within Service Region	Accepting New Patients	PCP Capacity	Non-English Speaking
AH	78	96.2%	100%	100%	60.3%	34.6%
AllCare	363	95.3%	98.6%	38.3%	88.7%	33.9%
CHA	88	98.9%	100%	70.5%	93.2%	18.2%
CPCCO	1,661	98.4%	8.1%	58.3%	97.2%	17.5%
EOCCO	823	94.7%	29.5%	94.3%	100%	1.6%
HSO	2,095	98.3%	82.4%	68.6%	80.8%	14.0%
IHN	319	98.8%	76.8%	98.1%	0%	9.7%
JCC	1,731	98.0%	10.6%	59.3%	92.7%	17.6%
PCS-CO	240	99.2%	99.2%	75.0%	88.3%	16.7%
PCS-CG	90	98.9%	97.8%	85.6%	90.0%	27.8%
PCS-LN	352	99.2%	99.4%	53.4%	68.8%	18.2%
PCS-MP	330	99.4%	99.4%	27.6%	84.9%	16.4%
TCHP-SW	646	94.7%	59.7%	98.6%	98.0%	17.2%
TCHP-TC	711	92.0%	90.4%	93.3%	92.0%	15.3%
UHA	115	99.1%	75.7%	58.3%	88.7%	16.5%

CCO	Count	Availability				Accessibility
		Active	Within Service Region	Accepting New Patients	PCP Capacity	Non-English Speaking
YCCO	1,307	98.9%	98.2%	75.7%	49.1%	8.4%

Active Status

For all CCOs, approximately 92 percent to 99 percent of all PCPs were considered active status, indicating a high degree of compliance with the State's expectations and definitions for active Medicaid participation.

Within Service Region

Nine CCOs reported that more than 90 percent of their contracted PCPs were practicing within their service regions. Six CCOs had less than 80 percent of contracted PCPs practicing within their service regions. While it is not necessarily a concern that contracted providers are located outside of a service region, nor is it always within a CCO's control where providers are available for contracting, it is a potential concern when such providers are included in data that may be relied upon as part of network monitoring (e.g., included in provider-to-member ratios, overall active status or new patient acceptance status). Plans that rely heavily on providers located outside of their service areas should take steps to ensure that members do not have additional barriers to accessing quality care.

EOCCO reported 29.5 percent of its PCPs located within its service region, which was higher than reported in 2023 (i.e., 18.3 percent) despite reducing PCP counts by 652 providers in the same time frame. Review of the capacity data indicate that the CCO had removed all PCPs from states besides Oregon and those adjacent to the CCO's service region (i.e., Washington and Idaho) since the 2023 DSN Evaluation. This change indicates an improvement in data quality and reporting. However, PCP counts within the service region were still low, and EOCCO should ensure members do not face additional or unnecessary barriers to accessing care.

The low percentages of providers operating in CPCCO's and JCC's service regions (8.1 percent and 10.6 percent, respectively) indicate that at least 90 percent of providers available to members were located outside of the service region, representing a substantial access concern. These results were similar to those identified to both CCOs since at least the 2021 DSN Evaluation, raising concerns about ongoing and significant access issues, which to HSAG's present knowledge neither the CCOs nor their parent group CareOregon have substantively addressed within their DSN reporting or other communications.

Accepting New Patients and PCP Capacity

The percentages of PCPs accepting new patients varied markedly between CCOs, with rates of acceptance ranging from 27.6 percent (i.e., PCS-MP) to 100 percent (i.e., AH). However, most CCOs maintained relatively stable percentages of new patient acceptance between CY 2023 and CY 2024,

with the exceptions of PCS-MP (62.9 percent to 27.6 percent, respectively) and UHA (35.3 percent to 58.3 percent, respectively).

Some CCOs reported simultaneously high percentages of PCPs accepting new patients and low PCP capacity or vice-versa, likely representing data quality or definition issues, and indicating a need for additional collaboration between OHA and the CCOs to ensure full data alignment.

Accessibility

Twelve CCOs reported that at least 15 percent of all contracted PCPs could speak a non-English language, suggesting relatively high overall rates of multilingual PCPs. In the context of PCP availability within service regions and the inclusion of large numbers of providers out of the service region, it is possible that the percentages of locally available PCPs speaking a non-English language could be substantially different from what is presented in the aggregate (e.g., CPCCO's in-region PCPs may speak a non-English language at a much higher or lower rate than presented in the data above).

EOCCO acknowledged its network language gap (i.e., 1.6 percent of PCPs reporting more than one language) within its DSN Provider Narrative submission, citing efforts to both collect better provider-attested data and conduct workforce enhancement.

Primary Care Dentists

Table 0-6 shows the results for PCDs stratified by CCO.

Table 0-6—Availability and Accessibility of PCDs by CCO

CCO	Count	Availability			Accessibility
		Active	Within Service Region	Accepting New Patients	Non-English Speaking
AH	22	100%	72.7%	100%	18.2%
AllCare	34	97.1%	100%	88.2%	32.4%
CHA	26	100%	53.9%	84.6%	3.9%
CPCCO	211	99.5%	14.2%	97.6%	18.0%
EOCCO	142	96.5%	76.8%	78.9%	12.7%
HSO	482	96.2%	95.4%	76.6%	26.3%
IHN	129	85.3%	76.7%	93.0%	20.9%
JCC	90	97.8%	63.3%	81.1%	32.2%
PCS-CO	281	98.9%	23.5%	74.4%	21.4%
PCS-CG	281	98.9%	6.8%	74.4%	21.4%
PCS-LN	281	98.9%	26.0%	74.4%	21.4%
PCS-MP	281	98.9%	39.2%	74.4%	21.4%

CCO	Count	Availability			Accessibility
		Active	Within Service Region	Accepting New Patients	Non-English Speaking
TCHP-SW	108	97.2%	64.8%	85.2%	23.2%
TCHP-TC	348	94.8%	97.7%	68.4%	35.3%
UHA	25	100%	96.0%	100%	4.0%
YCCO	55	98.2%	40.0%	94.6%	32.7%

Most CCOs subcontract with one or more of four statewide dental subcontractors to manage PCD networks and provide direct dental services. Dental subcontractors operate branded practices and also contract with individual practice PCDs. These factors make it somewhat difficult to assess PCD availability and accessibility for individual CCOs. Overall, PCD availability and accessibility results were similar to previous years.

Active Status

For all CCOs, except for IHN, 95 percent or higher of all PCDs were considered active status, indicating a high degree of compliance with the State's expectations and definitions for active Medicaid participation.

Within Service Region

Ten CCOs reported less than 75 percent of PCDs operating within their service areas, suggesting a potential access and/or data issue. Similar to PCPs, however, it was more likely that the CCOs were reporting all providers within a network without limiting reported provider pools to those within or adjacent to their service regions. For example, PCS reported PCDs collectively, resulting in in-region rates ranging from 6.8 percent to 39.2 percent between the four CCOs.

Accepting New Patients

The CCOs showed a relatively wide range of patient acceptance rates, even between the CCOs that typically report data globally and that contract with the same dental care networks. However, individual CCO new patient acceptance rates were generally consistent across years, suggesting persistent local variations in either PCD panel capacity or CCO data definitions and reporting.

Accessibility

Eleven CCOs reported that at least 20 percent of all contracted PCDs could speak a non-English language, suggesting relatively high overall rates of multilingual PCDs. Similar to PCPs, it is possible that the percentages of locally available PCPs speaking a non-English language could be substantially different from what is presented in the aggregate.

CHA and UHA were outliers for PCDs speaking a non-English language (i.e., 3.9 percent and 4.0 percent, respectively). However, this result should be interpreted with caution, as both CCOs had

less than 30 contracted providers. This increases both the likelihood and impact of any minor variations, and the apparent lack of multilingual providers may be situational.

Mental Health Providers

Table 0-7 shows the results for MH providers stratified by CCO.

Table 0-7—Availability and Accessibility of MH Providers by CCO

CCO	Count	Availability			Accessibility
		Active	Within Service Region	Accepting New Patients	Non-English Speaking
AH	248	94.4%	60.1%	100%	11.3%
AllCare	471	90.2%	96.2%	89.4%	8.9%
CHA	118	94.1%	87.3%	100%	8.5%
CPCCO	2,224	86.5%	7.6%	0.2%	3.8%
EOCCO	1,177	74.9%	33.0%	0.1%	0.1%
HSO	2,646	88.2%	80.4%	7.0%	4.4%
IHN	1,093	84.3%	37.9%	98.2%	4.3%
JCC	2,456	86.1%	22.4%	0.1%	2.9%
PCS-CO	3,796	92.9%	19.8%	85.7%	6.5%
PCS-CG	3,796	92.9%	2.7%	85.7%	6.5%
PCS-LN	3,796	92.9%	32.9%	85.8%	6.5%
PCS-MP	3,799	92.9%	16.5%	85.7%	6.5%
TCHP-SW	1,835	77.8%	69.5%	100%	3.3%
TCHP-TC	2,279	83.3%	94.0%	99.0%	3.6%
UHA	197	92.4%	71.1%	93.4%	1.0%
YCCO	2,053	80.4%	74.8%	98.3%	1.6%

Active Status

Eight CCOs showed 90 percent or higher of all MH providers had an active status. This indicates that half of all CCOs had a high degree of compliance with the State's expectations and definitions for active Medicaid participation for those CCOs.

Eight CCOs showed between 74.9 percent and 88.2 percent active status (i.e., had not submitted any claims in the previous two years), indicating that half of all CCOs had a low to moderate degree of compliance with State expectations. This suggests that these CCOs may have inaccurate provider network information or may have standing contracts with providers who are not actively engaged in providing services to Medicaid members.

Within Service Region

With the exceptions of AllCare and TCHP-TC, all CCOs reported less than 90 percent of MH providers practiced within their service regions, with 12 CCOs reporting that less than 75 percent practiced within their service regions and eight CCOs reporting less than 50 percent. While this should be taken in the context that all CCOs met state-established time and distance access standards, the low percentage of MH providers operating within service region raised substantial access concerns that should be monitored by OHA and all CCOs to ensure adequate availability of providers for all member populations. OHA and the CCOs should collaborate to ensure that data collection, monitoring, and reporting are performed transparently, robustly, and consistently.

Accepting New Patients

In a similar result to 2023, 12 CCOs reported at least 85 percent of MH providers were accepting new patients, with three CCOs reporting 100 percent acceptance. Three CCOs reported less than 1 percent acceptance rates, and one CCO reported 7 percent acceptance. These results may indicate data quality issues, such as "blanket" statuses associated with walk-in availability at behavioral health facilities rather than new patient acceptance rates for establishing regular care. These potential issues have persisted as a year-over-year pattern more closely associated with behavioral health providers than physical or oral health providers.

Accessibility

All but one CCO (i.e., AH) reported less than 10 percent of MH providers spoke a non-English language. This consistently low percentage across the CCOs and review years suggests that there is a statewide language accessibility barrier for mental health services.

Substance Use Disorder Providers

Table 0-8 shows the results for SUD providers stratified by CCO.

Table 0-8—Availability and Accessibility of SUD Providers by CCO

CCO	Count	Availability			Accessibility
		Active	Within Service Region	Accepting New Patients	Non-English Speaking[1]
AH	74	91.9%	48.7%	100%	1.4%
AllCare	126	92.9%	87.3%	93.7%	17.5%
CHA	49	93.9%	67.4%	100%	6.1%
CPCCO	511	90.2%	6.5%	0.6%	2.5%
EOCCO	412	73.5%	30.6%	0%	NR
HSO	559	90.7%	65.4%	3.6%	3.9%
IHN	464	78.2%	38.2%	99.4%	NR
JCC	536	91.4%	17.7%	0.6%	2.8%
PCS-CO	579	88.3%	17.8%	96.9%	3.6%

CCO	Count	Availability			Accessibility
		Active	Within Service Region	Accepting New Patients	Non-English Speaking[1]
PCS-CG	579	88.3%	1.2%	96.9%	3.6%
PCS-LN	579	88.3%	33.7%	96.9%	3.6%
PCS-MP	579	88.3%	25.9%	96.9%	3.6%
TCHP-SW	455	71.2%	51.0%	100%	0.4%
TCHP-TC	360	74.4%	93.1%	100%	2.2%
UHA	148	74.3%	33.1%	100%	NR
YCCO	349	79.7%	86.5%	99.4%	0.3%

[1] NR (Not Reported) indicates data elements that were not reported by OHA.

Active Status

Six CCOs showed 90 percent or higher of all SUD providers had an active status, indicating a high degree of compliance with the State's expectations and definitions for active Medicaid participation for those CCOs.

Ten CCOs showed between 71.2 percent and 88.3 percent active status, indicating a low to moderate degree of compliance with State expectations. This suggests that these CCOs may have inaccurate provider network information or have contracted with providers who are not engaged in providing services to Medicaid members.

Within Service Region

With the exception of TCHP-TC, all CCOs reported less than 90 percent of SUD providers practiced within their service regions. Eleven CCOs reported that less than 50 percent of contracted providers practiced within their service regions. Similar to MH provider results, this raised significant access concerns that should be monitored by OHA and all CCOs to ensure adequate availability of providers for all member populations.

Accepting New Patients

Results for accepting new patients were nearly identical to the 2023 results for all CCOs. The large number of CCOs reporting either 100 percent or less than 1 percent acceptance suggests either ongoing data issues with "blanket" statuses or a provider availability gap.

Accessibility

All but two CCOs (i.e., AllCare with 17.5 percent, and CHA with 6.1 percent) either did not report data or reported that less than 5 percent of contracted SUD providers spoke a non-English language. This consistently low percentage across the CCOs and review years suggests that there is a statewide language accessibility barrier for SUD services.

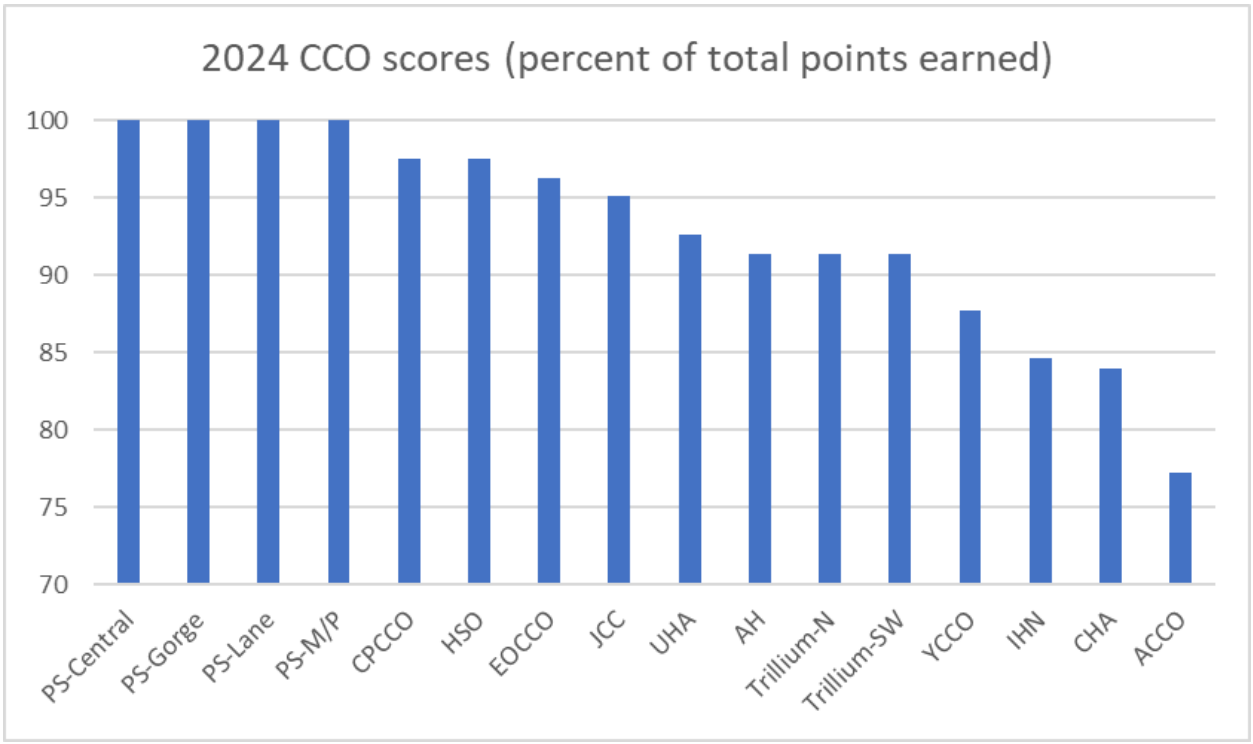
D. Quality of care (ANNUAL)

Transformation Quality Strategy (TQS)
In this reporting period, OHA shared the TQS guidance document and templates with CCOs. The guidance is updated annually to reflect any policy direction changes in the OHA quality strategy and TQS component areas as well as subject matter feedback from each CCO's prior year's TQS assessment. The TQS template and CCO TQS submissions are available on OHA's TQS webpage.

In addition, OHA provided technical assistance (webinars, peer sharing and office hours) and written assessments for each CCO's TQS during this reporting period. The TQS assessments include pre-defined assessment components and scoring determined by whether each project was: fully relevant, fully detailed, and feasible (3 points); somewhat relevant, somewhat to very limited detail and feasibility (2 points); or very limited relevance, very limited to not detailed and feasible (1 point).

2024 TQS scoring results summary
The average CCO score increased from 2023 to 2024 by 2.5 percentage points, even with increased REALD requirement.

- Range (81 points possible) = 63–81 (77–100%)
    - Average = 75 points (92.9%)
- Prior year (2023) range = 75–97% (average 90%)
- Scores from 2023 to 2024: 12 CCOs improved, three stayed even, one decreased



2024 TQS scores by component and CCO

	AH	ACCO	CHA	CPCCO	EOCCO	HSO	IHN	JCC	PS-Central	PS-Gorge	PS-Lane	PS-M/P	Trillium-N	Trillium-SW	UHA	YCCO	Avg CCO
BHI	9	9	7	9	8	8	8	7	9	9	9	9	9	9	9	9	8.56
CLAS Standards	9	5.5	9	9	9	9	6	9	9	9	9	9	9	9	8	9	8.53
Health Equity: Cultural Responsiveness	9	6	9	9	9	9	7.5	9	9	9	9	9	9	9	8	9	8.66
OHI	7	7	8	9	9	9	7	9	9	9	9	9	6	6	9	5	7.94
PCPCH Enrollment	9	9	9	8	9	9	9	9	9	9	9	9	9	9	9	9	8.94
PCPCH Tiers	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9.00
SPMI	9	8	7	9	9	9	9	9	9	9	9	9	9	9	9	9	8.81
SHCN FBDE	5	5	5	9	8	9	5	9	9	9	9	9	7	7	7	4	7.25
SHCN Non-duals	8	4	5	8	8	8	8	7	9	9	9	9	7	7	7	8	7.56
TOTAL SCORE	74	62.5	68	79	78	79	68.5	77	81	81	81	81	74	74	75	71	75.3
Percent of total possible	91.4%	77.2%	84.0%	97.5%	96.3%	97.5%	84.6%	95.1%	100.0%	100.0%	100.0%	100.0%	91.4%	91.4%	92.6%	87.7%	92.9%
Prior year %	82.9%	89.6%	84.2%	94.9%	95.9%	91.5%	75.2%	90.0%	97.4%	97.4%	97.4%	96.6%	89.3%	91.0%	91.0%	82.3%	90.4%

Statewide Performance Improvement Project (PIP)

In the time period for this annual report, the CCOs continued work on two distinct areas for statewide PIPs: 1) the integration statewide PIP, referred to as *Mental Health Service Access Monitoring,* and 2) substance use disorder PIP. For each of these PIPs the CCOs were involved in different stages of quality improvement efforts, described below .

Mental Health Service Access Monitoring

The development of the *Mental Health Service Access Monitoring* PIP (the integration statewide PIP) occurred collaboratively between OHA, community, partners and CCOs from March 2021 through August 2021. During the time period for this annual report, CCOs completed work for remeasurement year 2 (calendar year 2023) and embarked on work for remeasurement year 3 (calendar year 2024). In July 2024, CCOs submitted annual external quality review (EQR) validation reports for the calendar year 2023 work on the integration statewide PIP.

Aim Statement: Do targeted interventions increase the percentage of targeted members who receive outpatient MH services during the measurement year?

PIP Population: Members 2 years of age and older with receipt of any diagnosis of mental illness (not restricted to primary) in the mental illness (MI)-diagnosis code set in the 24-month identification window.

Numerator Description	Total number of members from the denominator with at least one outpatient MH service meeting the criteria during the measurement period
Denominator Description	Total number of eligible members with a MH service need meeting the criteria in the 24-month identification window

Measurement: The percentage of members with a mental health service need who received mental health services.

For the purpose of the PIP, a MH service need is defined by the occurrence of any of the following conditions within a 24-month identification window including the 12 months of each annual measurement period and the 12 months prior to each annual measurement period:

- Receipt of any MH service encounter meeting the service criteria for the numerator description included below under *Performance Indicator.*
- Any diagnosis of mental illness (not restricted to primary) in the mental illness (MI)-diagnosis code set.
- Receipt of any psychotropic medication listed in the Psychotropic-National Drug Code (NDC) code set.

Measurement Period	Date Range
Baseline	January 1, 2021, through December 31, 2021
Remeasurement 1	January 1, 2022, through December 31, 2022
Remeasurement 2	January 1, 2023, through December 31, 2023
Remeasurement 3	January 1, 2024, through December 31, 2024

Interventions:
Interventions across CCOs varied and included increasing mental health workforce capacity, providing workforce training, developing campaigns to decrease stigma associated with receiving mental health services, and implementing technological solutions such as care coordination platforms and the development of data exchange processes to increase data accuracy. Several CCOs increased funding and/or increased outreach and engagement to expand access for members. Many expanded telehealth providers and/or utilization of telehealth amongst existing provider networks. Additionally, OHA worked to expand the BH workforce through several policy levers including loan repayment, qualified direct payment (QDP) initiatives to support improvement in network adequacy.

Results:

CCO	Baseline (2021)	Remeasure 1 (2022)	Remeasure 2 (2023)	Improvement Trend
Advanced Health	55.3%	57.3%	59.6%	Significant improvement in both remeasurement years
AllCare Health	49.4%	51.2%	54.3%	Significant improvement in both remeasurement years
Cascade Health Alliance	59.6%	58.9%	63.5%	Significant improvement in remeasurement 2
Columbia Pacific CCO	54.9%	55.5%	58.4%	Significant improvement in remeasurement 2
Eastern Oregon CCO	58.5%	56.1%	61.1%	Significant improvement in remeasurement 2
Health Share of Oregon	57.7%	58.5%	60.3%	Significant improvement in both remeasurement years
Intercommunity Health Network	57.6%	56.3%	58.1%	Non-significant improvement in remeasurement 2

CCO	Baseline (2021)	Remeasure 1 (2022)	Remeasure 2 (2023)	Improvement Trend
Jackson Care Connect	58.8%	58.5%	61.7%	Significant improvement in remeasurement 2
PacificSource Community Solutions–Central Oregon	63.4%	63.2%	64.8%	Significant improvement in remeasurement 2
PacificSource Community Solutions–Columbia Gorge	55.7%	55.3%	59.2%	Significant improvement in remeasurement 2
PacificSource Community Solutions–Lane	64.5%	63.4%	66.9%	Significant improvement in remeasurement 2
PacificSource Community Solutions–Marion	57.97%	56.8%	58.6%	Non-significant improvement in remeasurement 2
Trillium Community Health Plan – Tri County	61.1%	52.1%	55.1%	Decrease from baseline
Trillium Community Health Plan – Southwest	58.9%	58.4%	59.1%	Non-significant improvement in remeasurement 2
Umpqua Health Alliance	60.2%	62.0%	63.8%	Significant improvement in both remeasurement years
Yamhill Community Care Organization	58.3%	58.3%	61.3%	Significant improvement in remeasurement 2
TOTAL-Statewide	58.4%	58.3%	60.7%	Significant improvement in remeasurement 2

Extracted from External Quality Review (EQR) Report:

The validation findings demonstrate strong performance across all CCOs for Validation Rating 1, adhering to acceptable methodology for all phases of the *Mental Health Service Access Monitoring* PIP through Remeasurement 2, with all 16 CCOs receiving a *High Confidence* level. There was increased variation in performance among the CCOs for Validation Rating 2, achieving significant improvement. Most (12 of 16) CCOs received a *High Confidence* level for Validation Rating 2 by reporting performance indicator results that demonstrated statistically significant improvement over baseline at Remeasurement 2. Three of the remaining CCOs (IHN, PCS-MP, and TCHP-SW) received a *Moderate Confidence* level for Validation Rating 2; for these three CCOs' PIPs, the Remeasurement 2 indicator results demonstrated improvement over baseline performance, but the improvement was not statistically significant. One other remaining CCO (TCHP-TC) received a *No Confidence* level for Validation Rating 2 because the CCO's reported Remeasurement 2 indicator results demonstrated a decline in performance from baseline.

Initiation Engagement and Treatment (IET)

In April 2021, CMS approved Oregon's SUD 1115 waiver with the inclusion of a SUD statewide PIP. The SUD statewide PIP topic design work began in March 2022 through July 2022. Access to care for OUD/SUD services and Initiation, Engagement, and Treatment (IET) was selected as the SUD statewide PIP topic. During the time period for this annual report, CCOs completed work for remeasurement year 1 (calendar year 2023) and embarked on work for remeasurement year 2 (calendar year 2024). In July 2024, CCOs submitted annual external quality review (EQR) validation reports for the calendar year 2023 work on the SUD statewide PIP.

Aim Statement: Do targeted interventions increase the percentage of targeted members who initiate and receive SUD treatment?

PIP Population: Members 13 years of age or older with a newly identified SUD episode.

Measurement: OHA aligns with the NCQA HEDIS specifications for the *IET* measure indicators to support performance and quality improvement efforts with CMS Medicaid Adult Core set.

Interventions: Interventions across CCOs varied and included improving primary care provider notification of diagnostic episodes for their patients, implementing behavioral health workforce development initiatives, enhancing care coordination for members with SUD diagnoses, and providing provider trainings around SUD treatment. The majority of CCOs included efforts to build new pathways for treatment initiation and engagement, including adding peer specialists and navigators to different settings, increasing prescribing of MOUD and AUD medications, promoting referrals to School-based Health Centers, and utilizing telehealth and app services.

Results:

Indicator 1: Initiation Rates		
CCO	**Baseline (2022)**	**Remeasurement 1 (2023)**
Advanced Health	34.1%	37.2%
AllCare Health	35.1%	37.7%
Cascade Health Alliance	45.0%	46.7%
Columbia Pacific CCO	40.2%	37.2%
Eastern Oregon CCO	37.8%	37.1%
Health Share of Oregon	42.5%	45.7%
Intercommunity Health Network	39.6%	37.8%
Jackson Care Connect	39.7%	42.1%
PacificSource Community Solutions–Central Oregon	39.7%	42.1%
PacificSource Community Solutions–Columbia Gorge	41.6%	39.4%
PacificSource Community Solutions–Lane	43.8%	41.5%
PacificSource Community Solutions–Marion Polk	40.8%	41.3%

Indicator 1: Initiation Rates		
CCO	**Baseline (2022)**	**Remeasurement 1 (2023)**
Trillium Community Health Plan – Tri County	40.9%	45.7%
Trillium Community Health Plan – Southwest	42.4%	42.5%
Umpqua Health Alliance	39.9%	39.3%
Yamhill Community Care Organization	41.3%	42.0%
TOTAL-Statewide	40.9%	42.2%

Indicator 2: Engagement Rates		
CCO	**Baseline (2022)**	**Remeasurement 1 (2023)**
Advanced Health	11.8%	11.9%
AllCare Health	13.7%	14.9%
Cascade Health Alliance	23.5%	22.7%
Columbia Pacific CCO	13.9%	14.1%
Eastern Oregon CCO	14.7%	14.1%
Health Share of Oregon	15.3%	17.2%
Intercommunity Health Network	19.7%	18.8%
Jackson Care Connect	14.5%	15.1%
PacificSource Community Solutions–Central Oregon	16.7%	16.9%
PacificSource Community Solutions– Columbia Gorge	15.1%	14.7%
PacificSource Community Solutions–Lane	17.9%	17.1%
PacificSource Community Solutions–Marion	18.2%	19.3%
Trillium Community Health Plan – Tri County	15.3%	17.8%
Trillium Community Health Plan – Southwest	16.5%	16.4%
Umpqua Health Alliance	16.5%	14.9%
Yamhill Community Care Organization	16.6%	15.7%
TOTAL-Statewide	16.2%	16.8%

Extracted from External Quality Review (EQR) validation report:
For the Remeasurement 1 period, CY 2023, three CCOs' (AllCare, HSO, and TCHP-TC) PIP indicator results demonstrated a statistically significant improvement from baseline to Remeasurement 1 for Indicator 1 (Rate of SUD Treatment Initiation). The remaining 13 CCOs' PIP indicator results demonstrated either improvement from baseline to Remeasurement 1 that was not

statistically significant or no improvement in SUD treatment initiation rates from baseline to Remeasurement 1. For Indicator 2 (Rate of SUD Treatment Engagement), one CCO's (HSO) PIP indicator results demonstrated a statistically significant improvement from baseline to Remeasurement 1 for Indicator 2 (Rate of SUD treatment engagement). The remaining 15 CCOs' PIP indicator results demonstrated either improvement from baseline to Remeasurement 1 that was not statistically significant or no improvement in SUD treatment engagement from baseline to Remeasurement 1.

The validation findings demonstrate strong performance across all CCOs for Validation Rating 1, adhering to acceptable methodology for all phases of the *Initiation, Engagement and Treatment of Alcohol and Other Drug Use Disorders* PIP through Remeasurement 1, with all 16 CCOs receiving a *High Confidence* level. CCO performance varied for Validation Rating 2, achieving significant improvement. Only one CCO (HSO) received a *High Confidence* level for achieving statistically significant improvement across both performance indicators at Remeasurement 1. Six CCOs (AH, AllCare, JCC, PCS-CO, PCS-MP, and TCHP-TC) received a *Moderate Confidence* level, four CCOs (CHA, CPCCO, TCHP-SW, and YCCO) received a *Low Confidence* level, and the remaining five CCOs (EOCCO, IHN, PCS-CG, PCS-LN, and UHA) received a *No Confidence* level for Validation Rating 2. The Validation Rating 2 confidence level HSAG assigned to each CCO's PIP depended on whether the Remeasurement 1 results for the two performance indicators demonstrated statistically significant improvement, any improvement, or no improvement over baseline results.

Statewide PIP website: https://www.oregon.gov/oha/HPA/DSI/Pages/Performance-Improvement-Project.aspx

E. Complaints, grievances, and hearings

1. CCO and FFS complaints and grievances

CCO and FFS Complaints

The information provided in the charts below is a compilation of data from the current 16 coordinated care organizations (CCO) and fee-for-service (FFS) data. This annual report covers the time period of October 1, 2023 through September 30, 2024.

Trends

	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024	Jul – Sep 2024
Total complaints received	4,543	4,834	4,891	4,843
Total average enrollment	1,539,494	1,605,776	1,583,231	1,415,232
Rate per 1,000 members	2.95	3.01	3.09	3.42

Barriers

The number of complaints CCOs reported from October 1, 2023 to September 30, 2024 shows some fluctuation in numbers of complaints between each quarter of this reporting period. There is a 6.6% increase between the October – December 2023 quarter and the July -September 2024 quarterly reporting. The average number of complaints for the October 1, 2023 through September 30, 2024 period was 4,778 overall for this reporting period. This is a slight increase of .38% over the previous annual reporting period which saw an average number of complaints of 4,760 during the October 1, 2022 through September 30, 2023 annual reporting period.

OHA tracks complaints across several different subcategories. In this reporting period, the Interaction with Provider or Plan category shows an increase of 6% in this annual reporting period as compared to the previous annual reporting period. The Access to Care category shows a slight decrease of 3.6% from the previous annual reporting period. Quality of Care continues to be the third highest category of complaints with an increase of 11.7% from the previous annual reporting period. FFS data shows the highest number of complaints this annual reporting period remains the Quality of Care category and the Quality of Service category received the second highest number of complaints.

For individuals enrolled in fee-for-service, the number of complaints from members who were on Fee for Service coverage during the October 1, 2023 through September 30, 2024 annual reporting period was 587 complaints. This is a 2.8% increase over the previous annual reporting period. During this reporting period, 1,418 records were identified as calls received from members enrolled in CCOs. This is a 21.9% decrease from the previous annual reporting period. These calls were referred to the appropriate CCO.

Interventions

CCOs: For members enrolled in managed care, issues related to non-emergency medical transportation or (NEMT) continue to receive the highest number of complaints followed by issues related to Primary Care Providers. While NEMT complaints have shown an overall decrease over the past few years, CCOs continue to work with their NEMT providers to improve services. CCOs report they are continuing to work with providers to improve access to primary care services. Some CCOs in rural areas continue to work on encouraging a higher rate of provider participation to address the root cause of these issues.

Statewide rolling 12-month Complaints totals

This chart includes the total of all complaints reported statewide by CCOs and FFS.

Complaint category	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024	Jul – Sep 2024
Access to care	1563	1648	1703	1689
Client billing issues	434	438	411	336
Consumer rights	334	349	350	318
Interaction with provider or plan	1407	1589	1583	1732

Complaint category	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024	Jul – Sep 2024
Quality of care	595	612	626	605
Quality of service	210	198	218	163
Other	0	0	0	0
Grand Total	4543	4834	4891	4843

Related data

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

CCO Notices of Adverse Benefit Determinations and Appeals

2. Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs between October 1, 2023 through September 30, 2024. 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. The three highest number of NOABDs issued were in the diagnostics, outpatient and pharmacy categories. CCOs are working directly with providers to reduce the numbers of denials and improve services to members. 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)	**Oct – Dec 2023**	**Jan – Mar 2024**	**Apr – Jun 2024**	**Jul – Sep 2024**
a) Denial or limited authorization of a requested service.	29,559	29,981	31,857	31,233
b) Single PHP service area, denial to obtain services outside the PHP panel	921	1,914	1,987	1,127
c) Termination, suspension, or reduction of previously authorized covered services	57	163	163	109
d) Failure to act within the timeframes provided in § 438.408(b)	11	6	11	5
e) Failure to provide services in a timely manner, as defined by the State	72	146	170	283
f) Denial of payment, at the time of any action affecting the claim.	163,969	206,658	233,448	207,349
g) Denial of a member's request to dispute a financial liability.	0	0	6	5
Total	194,589	238,868	267,642	240,111

Number per 1000 members	139.5	176.9	199.3	184.1

CCO Appeals

The table below shows the number of appeals the CCOs received during the October 1, 2023 through September 30, 2024 quarter. OHA implemented a new process requirement for reporting appeals with the appropriate NOABD identified. Over the past twelve months, the CCOs have been given extensions in meeting reporting deadlines for Appeals due to this change in the reporting requirement. This report includes the past quarters that were not reported. The three highest categories of appeals for this reporting period were Pharmacy, Outpatient and Dental.

CCO Appeals	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024	Jul – Sep 2024
a) Denial or limited authorization of a requested service.	573	963	1098	1323
b) Single PHP service area, denial to obtain services outside the PHP panel.	29	53	54	38
c) Termination, suspension, or reduction of previously authorized covered services.	1	3	3	3
d) Failure to act within the timeframes provided in § 438.408(b).	0	0	0	0
e) Failure to provide services in a timely manner, as defined by the State.	1	0	1	1
f) Denial of payment, at the time of any action affecting the claim.	520	836	887	698
g) Denial of a member's request to dispute a financial liability.	0	0	0	1
Total	1,124	1,855	2,043	2,065
Number per 1000 members	.81	1.3	1.5	1.6
Number overturned at plan level	219	583	804	796
Appeal decisions pending	0	17	34	27
Overturn rate at plan level	19.5%	31.4%	39.4%	38.5%

3. CCO and FFS appeals and hearings
CCO and FFS Contested Case Hearings

The following information is a compilation of data from 16 Coordinated Care Organizations (CCOs), and Fee-for-Service (FFS).

During the fourth quarter (July 1, 2024 to September 30, 2024), the Oregon Health Authority (OHA) received 260 hearing requests related to the denial of medical, dental, and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 328 were from CCO-enrolled members and 230 were from FFS members.

279* cases were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing.

OHA dismissed 141 cases that were determined not hearable cases. Of the not-hearable cases, 120 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 the NOAR. Three cases were dismissed as not hearable because the hearing request was not submitted within the timelines identified in rule.

Of the 138 cases that were determined to be hearable, 31 were approved prior to hearing. Members withdrew from 58 cases after an informal conference with an OHA hearing representative. 37 cases went to hearing, where an administrative law judge upheld the OHA or CCO decision and 9 cases were dismissed for the members failure to appear. I case was dismissed at non-timely, and one case was dismissed because of non-jurisdiction. The administrative law judge reversed the decision stated in the denial notice in one case.

* In every quarter there is an overlap of processed cases with those received. For instance, cases processed and resolved in July of 2024 may be cases OHA received as far back as May or June of 2024.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	31	11%
Client withdrew request after pre-hearing conference	58	21%
Dismissed by OHA as not hearable	141	51%
Decision affirmed*	37	13%
Client failed to appear*	9	3%
Dismissed as non-timely	1	0%
Dismissed because of non-jurisdiction	1	0%
Decision reversed*	1	0%

Outcome Reasons	Count	% of Total
Set Aside	0	0%
Total	279	

* Resolution after an administrative hearing.

Related data

Reports are attached separately as Appendix C – Contested Case Hearings.
For CCOs, refers to CCO logs in Appendix C. Narrative to include trends and interventions.

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 was subject to a Corrective Action Plan (CAP) effective March 5, 2021; the CAP was closed on May 31, 2022.

2. Provider networks
Please see the Network Capacity subsection in the Access to Care section.

3. Rate certifications
The Oregon Health Plan (OHP) is our state Medicaid program. It provides health coverage for low-income Oregonians that include working families, children, pregnant women, single adults, seniors and more. The Oregon Health Authority (OHA) has contracted with a variety of health entities, known as Coordinated Care Organizations or CCOs, to manage and deliver health care for most of these people eligible for Medicaid. OHA pays CCOs to cover these individuals with capitation rates. Capitation rates are a predetermined payment that depends on the individual's OHP eligibility status and is paid to CCOs on a monthly basis dependent on enrollment.

The capitation rates are developed and certified by OHA's contracted actuaries on a yearly basis. The process and methodology used to develop capitation rates are governed by federal and state regulations. CMS requires Oregon's capitation rates be Actuarially Sound and follow applicable Actuarial Standards of Practice, which are developed by the Actuarial Standards Board.

In October 2023, OHA delivered the final CY24 CCO rates package to the Centers for Medicare & Medicaid Services (CMS), which included the Oregon CY24 rate certifications and contract rate

Sheets. These capitation rates are developed and certified by OHA's contracted actuaries on a yearly basis. The process and methodology used to develop capitation rates are governed by federal and state regulations. Subsequent years, such as CY25, are submitted in October of the prior year and follow a similar process.

In preparation for the CY25 Rate Development year OHA sent CCOs their 2023 data to support the rate process and evaluating additional contract and rate changes for the 2025 rate development process, which included the Directed Payment programs and Health Equity incentives to improve the financial model to support current initiatives that promote health equity and supporting OHA's goals of eliminating health inequity by 2030.

OHA has continued their planning efforts around the Health-Related Social Needs (HRSN) services implementation for 2024 and 2025. This includes developing the HRSN fee schedules.

In April 2024, CCOs submitted their completed Exhibit Ls to OHA to begin the CY2025 rate development and data validation process. OHA met with CCOs from May to August 2024 to discuss the CY2025 rate development process. At the end of the process, OHA delivered the final CY22 rate packages to CCOs in early August 2024 and met with each CCO, individually, to discuss their rates and request feedback. The data for their CY2024 rates. The purpose of these data validation meetings was to discuss the CCOs' financial data, the rate setting data, and the encounter data to cross-compare and ensure there is a consensus on the starting point of the base data. The discussions centered around encounter data validation and CY2023 financials.

In addition, to developing the CY2025 rates OHA in collaboration with Mercer simultaneously developed the CY2025 Behavioral Health Program (BHP).

CY2025 CCO capitation rates were submitted to CMS October 3, 2024 and are posted on our website: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/OHP-Rates.aspx

OHA continues to monitor the COVID-19 pandemic closely and working with CCOs in a partnership in maintaining our healthcare system.

Corrective Action Plans: Rates & Financial:

There are no issues with any CCO contract compliance that warranted a corrective action plan during this reporting period.

4. Enrollment/disenrollment

All significant updates are reported in other sections.

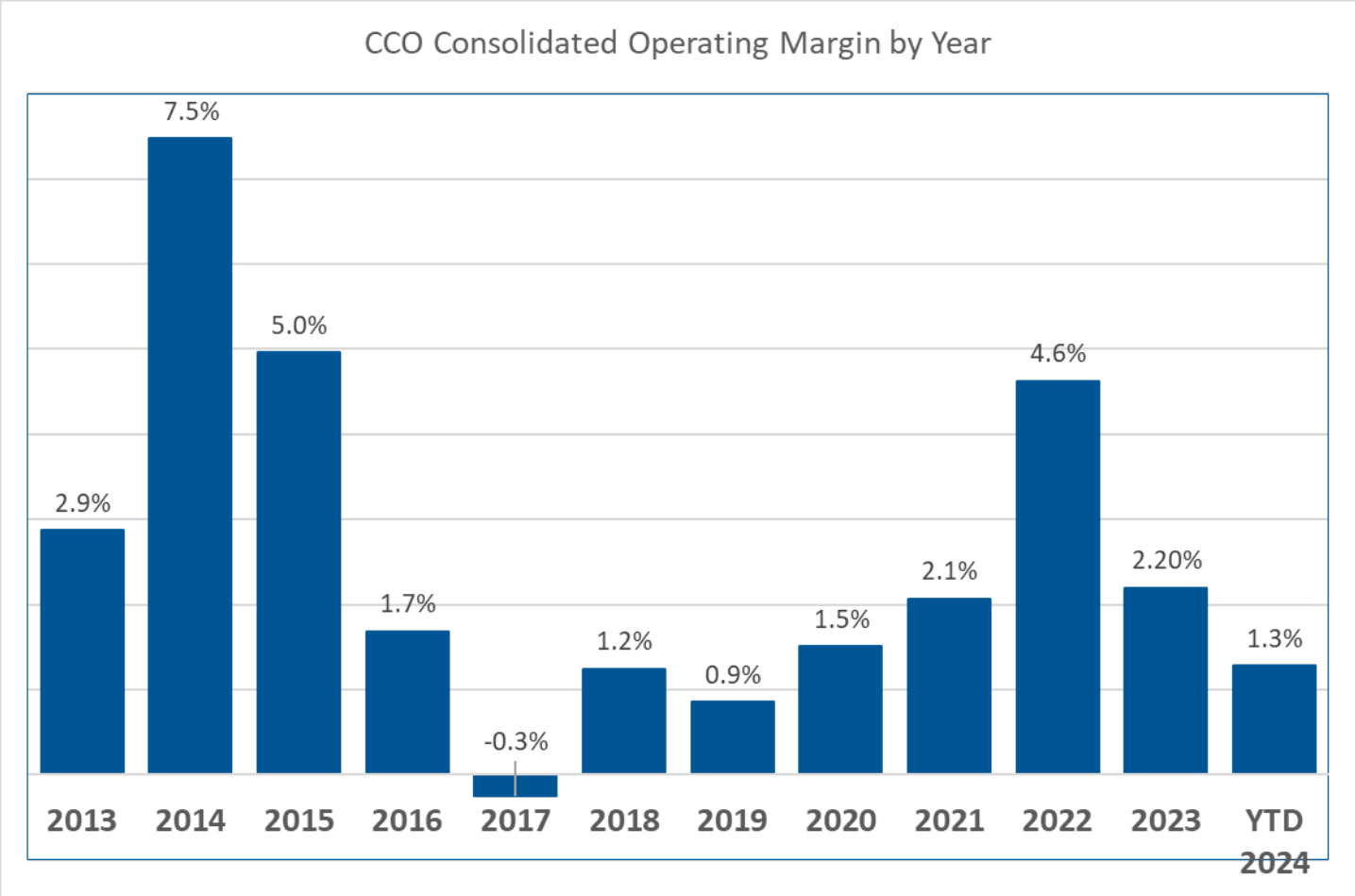
5. Contract compliance

During the reporting period, four CCOs were placed on an improvement plan due to being unable to ensure timely deployment of compliant Grievance and Appeal System Member Notice templates following changes to OHA requirements. The four CCOs include: Eastern Oregon CCO, InterCommunity Health Plan, PacificSource (all regions) and Trillium Community Health Plan (all

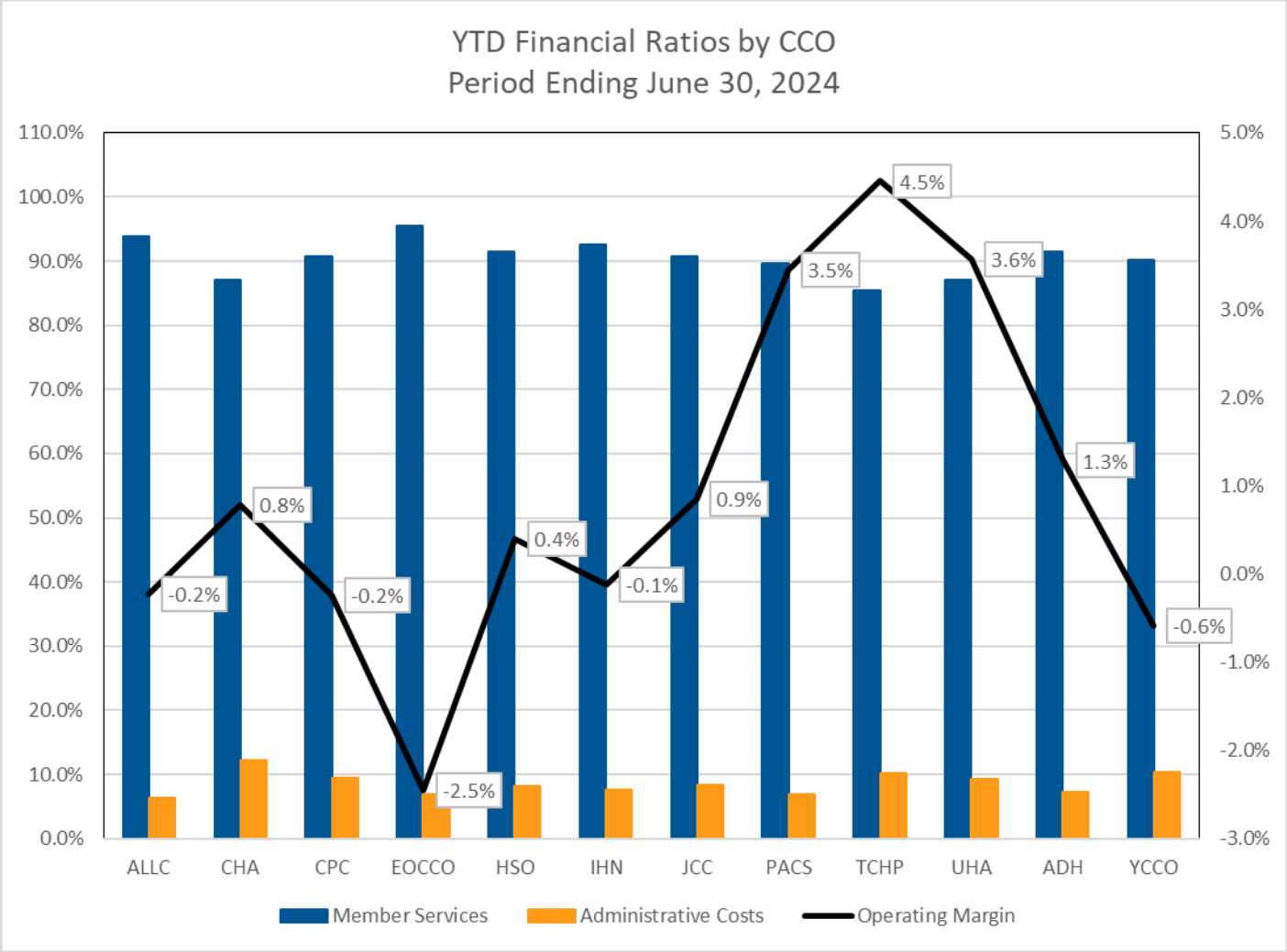
regions). The four CCOs faced the following challenges implementing OHA requirements for Appeal and Grievance System member notices: system limitations; subcontractor level implementation limitations, implementation of rule changes impacting language translation of the notices, and difficulties implementing requirements around sending notices to authorized representatives at the CCO and subcontractor level.

6. Relevant financial performance

The state's 16 CCOs generated Net Operating Income of $50 million, and a 6-month Operating Margin of 1.3% through June 2024. In the prior year, the CCOs generated $119 million and an Operating Margin of 3.1% during the same time 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. 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. Operating Margin for CCOs was 1.3%. This is $50 million of Net Operating Income off of $3.9 billion of Operating Revenue. Operating Income is measured as Operating Revenue less Member Expenses and Administrative Expenses, and is before Non-Operating activities, provisions for taxes, or SHARE Obligations. Net Income for this period is $10.9 million.



For the 6-months ended June 30, 2024, the majority of the 16 CCOs met or exceeded the 85% target for MSR, a key indicator for MLR (1 CCO was below the 85% MSRs, and four of the CCOs had MSRs above 90%).

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

There are no issues with Coordinated Care Organization contract compliance that warranted a corrective action plan during this reporting period.

8. One percent withhold

This annual report is for data from October 1, 2023, through September 2024.

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of April 2023 through March 2024.

All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

G. Health Information Technology

Community Information Exchange (CIE)
During the reporting period, OHA continued to implement the state's community information exchange to support closed-loop referrals for HRSN services. CIE is a network of collaborative partners using a multidirectional technology platform to connect people needed services and supports. The state made the following progress on CIE implementation and adoption:

Quarter 1 (October 2023 - December 2023)

To address inquiries from CCOs and ensure a shared understanding of terminology, OHA developed and refined definitions of CIE and closed loop referrals that are included in the 2024 CCO contract amendment and 2024 HRSN Guidance document, as well as in Oregon Administrative Rules (OARs). OHA outlined a plan in these to support HRSN Service Providers with adoption and use of CIE while increasing requirements for CIE use over time.

OHA engaged CCOs on CIE in various forums, including the Health Information Technology Advisory Group (HITAG) on October 26, 2023. OHA also engaged CCOs at an October 19, 2023, HRSN work session on plans for closed loop referrals and CIE resulting in modifying 2024 CCO contract definitions and requirements.

To support the 2022-2027 1115 Waiver and meet the CMS requirement of closed loop referrals for HRSN services, OHA finalized a seven-year budget plan which includes the procurement and implementation of CIE state-wide for Fee-for-Service and OHA and Oregon Department of Human Services' (ODHS) use as it relates to HRSN. OHA prepared a CMS Medicaid Enterprise Systems (MES) funding request to support these activities.

Quarter 2 (January 2024 - March 2024)

Federal Funding: Oregon requested CMS MES funding for CIE via an Implementation Advance Planning Document (IAPD) on February 1, 2024. The IAPD requests support to implement and administer design, development, and implementation activities of CIE to meet closed loop referral requirements for Oregon's 2022-2027 1115 Medicaid waiver. CMS reviewed and approved the IAPD funding request on March 11, 2024, with funds approved for April 1, 2024-September 30, 2025.

Health IT Strategic Plan - *Strategy to support, accelerate, and improve statewide CIE efforts:*
The Health Information Technology Oversight Council (HITOC) public committee released their draft Oregon Strategic Plan for Health IT 2024-2028 which provides guidance and direction to partners in the Oregon health IT landscape, including OHA. The Strategic Plan includes a CIE strategy and four activities including guidance to provide support for community-based organizations (CBOs) and additional partners to participate in CIE, and that OHA should support and participate in statewide CIE efforts by using CIE where appropriate and supporting CIE advancement efforts.

Governance: In February, OHA signed an Inter-Governmental Agreement (IGA) with Portland State University's (PSU) Oregon Consensus Program. PSU is to function as a neutral party to assess

readiness through interviews and focus groups for statewide CIE governance among community and healthcare partners to help ensure alignment, transparency, and accountability.

CCO Contract Amendment and HRSN Guidance: The CIE team provided feedback for the 2024 CCO Contract amendment and accompanying HRSN Guidance finalized 2/14/24 for the HRSN climate benefit launched in March 2024.

Quarter 3 (April 2024 - June 2024)

Health IT Strategic Plan - *Strategy to support, accelerate, and improve statewide CIE efforts:* HITOC's five-year health IT strategic plan received support from the Oregon Health Policy Board, the citizen policy-making oversight body for OHA, on May 7, 2024. The Strategic Plan provides direction to OHA and partners and includes a strategy to advance CIE with four activities:

1. Provide support for CBOs and additional partners to participate in CIE.
2. OHA and the ODHS should support and participate in statewide CIE efforts (including using CIE where appropriate and participating in/supporting governance).
3. Aggregate CIE data so it can be used for policy recommendations and resource allocation.
4. Align privacy and security efforts with principles of community/individual decision-making.

Governance: PSU's Oregon Consensus Program continued the CIE governance readiness assessment. An interview guide and outreach list were finalized in June and interviews and focus groups started.

Executive Steering Committee: OHA's CIE Executive Steering Committee (ESC) launched on April 30, 2024, and includes state agency representatives from OHA, ODHS, Oregon's Department of Administrative Services, and Legislative Fiscal Office. The CIE ESC provides oversight of CIE technology procurement and supports focused on Medicaid 1115 Waiver use cases for OHA to successfully support delivery of HRSN services and meet CMS requirements for Waiver implementation, as well as improving health equity and reducing disparities.

OHA engaged with HRSN Providers at a training session in May sharing information and answering questions on closed loop referrals and CIE.

CCO Contract, HRSN Guidance, and OARs: From April through June, the CIE team provided edits for the 11/1/24 CCO Contract amendment and the HRSN Guidance document to incorporate information for the HRSN housing benefit, as well as sections of OARs and the 2025 CCO Contract restatement related to HRSN services.

Quarter 4 (July 2024 - September 2024)

Governance: In September OHA presented a contract amendment to PSU to complete the Governance Readiness Assessment using information collected from interview and focus groups participants with a final report anticipated by the end of the calendar year.

Technical Assistance: In August, OHA contracted with Oregon Health and Science University's (OHSU) Oregon Rural Practice-based Research Network (ORPRN). OHSU conducted interviews with

CCOs about the needs of CBOs and HRSN Service Providers related to CIE, particularly for gaps in technical assistance and areas OHA could provide support generally. Interviews will continue through the Fall and will lead to all CCO meeting discussions and a final report in early 2025.

CCO CIE HRSN Work Sessions: OHA launched the CCO CIE HRSN Work Session meeting series on August 8, 2024. The meetings provide a dedicated space to share with CCOs CIE information relevant for HRSN services, to obtain CCO input and feedback, and for OHA staff to address CIE questions. An additional session was hosted on September 11, and sessions will continue into 2025.

CCO Contract and HRSN Guidance: Final CIE team review of the 2025 CCO Contract restatement and updates to HRSN Guidance were completed in August and September.

Procurement of Closed Loop Referral Technology: DAS released a Special Procurement for two closed loop referral technology vendors, Unite Us and find help, in August 2024 given the current presence in Oregon with Medicaid CCOs. This will result in statewide price agreements that allow state agencies, like OHA, and Oregon Cooperative Procurement Program (OrCPP) members, like county and city government, to initiate individual work orders with the vendors. OHA intends to execute a work order with each CIE vendor on behalf of OHA and ODHS users, Fee-for-Service contractors, and Tribes to participate in sending and receiving closed loop referrals as well as using data for evaluation and analytics. DAS began statewide price agreement negotiations in September 2024.

H. Metrics development

At the July meeting of Metrics & Scoring, the committee voted to classify the preventive dental or oral health services as upstream for both age groups and include it in the draft 2025 incentive measure set. The committee then finalized the 2025 incentive measure set for the CCO Quality Incentive Program. The final measure set is as follows:

1. Assessments for children in ODHS custody
2. Meaningful language access
3. Child-level social emotional health
4. SDOH: Social needs screening & referral
5. Preventive dental or oral health services, ages 1-5 and 6-14
6. Postpartum care rate
7. Child and adolescent well-care visits
8. Immunizations for adolescents (Combo 2)
9. Childhood immunization status (Combo 3)
10. Diabetes care: Hemoglobin A1c (HbA1c) poor control
11. Screening for depression screening and follow-up plan
12. Adults with diabetes - Oral evaluation
13. Initiation and engagement of substance use disorder treatment

The committee then chose to include the following four measures in the draft 2025 Challenge Pool:

Oregon Health Authority

1. Child and adolescent well-care visits
2. Postpartum care
3. Child-level social emotional health
4. Preventive dental or oral health services, ages 1-5 and 6-14

For more information about the meeting, including a video link to the meeting and minutes, please visit the committee's website: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metric-Scoring-Committee-Archives.aspx#a990ed04-a843-426e-b790-dbc458a6cca9

At the August meeting of Metrics & Scoring, the committee finalized the 2025 Challenge Pool:

1. Child and adolescent well-care visits
2. Postpartum care
3. Preventive dental or oral health services, ages 1-5 and 6-14
4. Diabetes: HbA1c poor control

The final Challenge Pool is slightly different from the draft Challenge Pool that the committee chose at the previous meeting, with the HbA1c poor control measure replacing the child-level social emotional health measure.

The committee also began selecting draft benchmarks for the 2025 incentive measures.

For more information about the meeting, including a video link to the meeting and minutes please visit the committee's website at: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metric-Scoring-Committee-Archives.aspx#a990ed04-a843-426e-b790-dbc458a6cca9

At the September meeting of Metrics & Scoring, the committee continued to select draft benchmarks for the 2025 incentive measures. All benchmarks will be finalized at the committee's October meeting.

For more information about the meeting including a video link to the meeting and minutes please visit the Committee's website at: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metric-Scoring-Committee-Archives.aspx#a990ed04-a843-426e-b790-dbc458a6cca9

I. Budget neutrality

Oregon Health Authority is unable to report on the current waiver Budget Neutrality Workbook as discussed with CMS.

The request for the Budget Neutrality report extension has been communicated with CMS and the Agency is awaiting response.

J. Legislative activities

There were no bills passed in the 2024 legislative session that dealt specifically with the demonstration waiver. However, OHA continues to engage in regular dialogue with legislative partners on waiver progress and developments. This dialogue and information sharing generally

occurs in two venues: 1) monthly updates geared for legislators and staff; and 2) presentations to legislative committees during interim Legislative Days.

OHA leadership provided several coordinated legislative updates regarding waiver implementation during the reporting period. Topics included:

- Updates on the housing modification device benefit roll-out in March of 2024,
- Information on HRSN community capacity building funds,
- The proposed roll-out plan, eligibility criteria and provider/member resources for additional HRSN services including housing, outreach and engagement and nutrition
- Approach to evaluating the 1115 waiver
- Next steps for implementing expanded services for Young Adults with Special Health Care Needs (YSHCN).
- Overview of the state's carceral re-entry demonstration
- Overview of the benefit update project (BUP), which will transition Oregon Health Plan from the use of a prioritized list authorized under the waiver, to the use of the traditional benefits package in the Medicaid State Plan by 1/1/27

OHA's Medicaid division submitted a policy option package and accompanying legislative concept related to the carceral reentry demonstration. The policy option package requests funding for the state share of this waiver component, and the legislative concept focuses on clarifying Oregon statute to allow for the delivery of certain OHP benefits up to 90 days pre-release. At this juncture OHA awaits the Governor's recommended budget and will proceed accordingly as we move into the 2025 legislative session.

K. Litigation status

There has been no significant litigation activity during this reporting period.

L. Public forums

The state facilitated several public forums related to the implementation of the state's 1115 waiver. The state provided updates on progress at various state committees including the Oregon Health Policy Borad, the Metrics and Scoring Committee and the Medicaid Advisory Committee. OHA also developed a regular cadence of meetings with CCOs to provide critical updates on HRSN implementation and provide a forum for questions. In addition, and to support the seamless roll out of 1115 waiver initiatives, the state facilitated regular public facing webinars to educate partners about HRSN, YSHCN and other 1115 waiver topics.

Comments and questions received across public forums were largely focused on the following topics:

- Approach to evaluating 1115 waiver initiatives
- Eligibility for various HRSN benefits
- Service authorization approach for all HRSN benefits
- Process for serving as an HRSN provider

- How to access HRSN community-capacity building funding
- Payment approach for HRSN benefits
- Approach to YSHCN benefits
- Eligibility and list of benefits covered by YSHCN

IV. Progress toward demonstration goals

A. Improvement strategies

Oregon's Triple Aim: Better health, better care, and lower costs
For each of the topics in this section, provide a brief overview of implementation progress & milestones, including community/systems engagement, IT configuration, etc. Specific items include the following (as appropriate to the topic): 1) Expanding social service organization (SSO) capacity as part of HRSN infrastructure investments. SSOs include any government, private, for-profit, or nonprofit organizations that provide social services.

1. Making planned IT infrastructure enhancements.
2. Establishing data-sharing agreements with its HRSN partners.
3. Funding SSOs to develop business or operational procedures.
4. Providing workforce development opportunities.
5. Conducting outreach, engagement, and convening.
6. Expanding Medicaid beneficiaries' enrollment in SNAP, WIC, and TANF.
7. Establishing partnerships with health care providers and SSOs.

Continuous Eligibility for Adults and Children

Implemented Continuous Eligibility policies as approved via Oregon's 1115 Demonstration Waiver. Continuous Eligibility (CE) allows most Oregonian's receiving Oregon Health Plan benefits to maintain a continuous coverage period of at least 24 months, even if circumstances like income or household structure change. CE also provides coverage for children through end of the month in which they turn 6 years old, regardless of when they initially became eligible, or 24 months, whichever produces a longer enrollment period.

Early and Periodic Screening, Diagnostic and Treatment

OHA continues to make progress towards the EPSDT requirements outlined in the state's waiver. The state has shifted towards operational updates to support this progress, including related to billing, intersection with behavioral health services, program monitoring, data collection on key metrics and alignment with other 1115 waiver activities.

Billing and Payment
In order to ensure billing and payment for EPSDT services are streamlined the following change requests are being built:

- A change request for reporting purposes (distinguishing between EPSDT and family planning services) was implemented in Production 11/17/24. The EPSDT team coordinated updates to OHP billing guidance to align with these changes.
- We are continuing initial discussions regarding a new change request (CR) as part of requirements put forward by CMS in 2022 to ensure EPSDT coverage for former foster care youth up to the 26th birthday. This was originally going to be rolled out in alignment with YSHCN and the re-entry demonstration but those are now moving with different roll out plans so we are exploring options for implementing as an individual CR. We are currently waiting on additional clarification from CMS about these requirements and timeline for compliance. Once we have some understanding of potential timeline for implementation, we will begin conversations about updating CCO contracts, guidance etc.
- An additional change request is being looked at to update the school-based health services processing for claims in MMIS. Since Early Learning is required to bill Medicaid for services for ages 0-5 and most of those claims are for mandatory services we are going to auto approve for provider 62 (school-based providers) for those claims. SBHS claims for ages 6-21 will continue to suspend for individual review. We are now reviewing the design document for this change.
- There are also two change requests underway for youth and young adults transitioning from carceral settings, we are in the statement of understanding (SOU) & requirements meetings.

Behavioral Health intersection

- The Young Adult Service Strategy group (17-26) continues to meet, and sub workgroups have formed.
- Continuing to work with behavioral health subject matter experts and Child & Family Behavioral Health team to develop policies, rule updates and prior authorization process changes.
- The Behavioral Health Management Committee (BHMC) meets weekly to work through BH/MH needs for EPSDT population. When the BH reviewer position (now on the HCBS team) is hired, that position will participate in BHMC.
- Behavioral Rehabilitative Services prior authorizations and claims are going through BHMC as an interim process fix.

Program Monitoring

OHA continues to ensure that Medicaid and other data collected across OHA and ODHS is monitored, evaluated and reported to inform quality and process improvements for child and young adult OHP benefits.

Updates:

OHA continues to make progress on the approach to EPSDT, including through the following:

- Advancing the Medicaid Child and Youth analytic dataset:
    - MMIS queries are ready for peer review to view EPSDT beneficiary Medicaid enrollment over time since 2014, by eligibility group (PERC) and age.

  - Data processing to flag indicators related to benefit plans (intellectual or developmental disability status, former foster care or child welfare) and PERC codes (CHIP and non-CHIP) are created each EPSDT beneficiary for each CMS year (October to September).
  - Flag indicators related to claims data will be added next (e.g., pediatric medical complexity, behavioral health complexity, no utilization, and well-care visits).
  - REALD data has been received from E&I and will also be incorporated.

- Analyzing CCO Performance Metrics with a child and young adult lens ahead of CCO 3.0.
- The draft EPSDT monitoring and evaluation plan has been reviewed by EPSDT managers, currently incorporating feedback and developing workplan.

Expanded Access to Supports that Address Health-Related Social Needs

Between October 2023 and September 2024, Oregon made significant progress on the design and implementation of the new Health-Related Social Needs (HRSN) Services, which include housing and nutrition-related supports for eligible members, as well as outreach and engagement services to promote connection to other services members may need. Overall progress was aided by the ability to support partners in building capacity and infrastructure needed to deliver HRSN services through community capacity building funds, as well as robust collaboration with system partners, including coordinated care organizations (CCOs) and HRSN service providers. Specific progress on key design elements of the HRSN initiative is described in further detail below.

Infrastructure funds – Community capacity building grant program

OHA and coordinated care organizations (CCOs) awarded a combined $37 million to community organizations across the state to help support the delivery of HRSN benefits in this period. Funded through Designated State Health Program (DSHP) HRSN Infrastructure funds, the grants – described as Community Capacity Building Funds (CCBF) - will support health providers and organizations to develop what they need to be able to participate in the Medicaid delivery system.

The CCBF grants will help prepare community-based organizations to deliver these new benefits and improve health outcomes by preventing homelessness, heat-related illnesses and costly urgent care visits. Community-based organizations (CBOs) and partners will be integral to delivering these new services - partnering and aligning with existing community groups to reduce siloes in services for OHP members is a primary goal of this effort.

2024 Community Capacity Building Funds overview:

1. More than $37 million was awarded to 161 organizations across Oregon.
2. 40% of the funds ($14.7 million) went to organizations that will provide housing benefits.
3. Nearly 70% of the funding (almost $26 million) went to support workforce development.
4. More than 25% of funds went to community-based organizations with no prior relationships with CCOs – helping to expand provider networks in local communities.
5. Funding was distributed relatively evenly across geographic regions.
6. Additional CCBF will be provided in 2025. Currently, the state is analyzing feedback on the 2024 CCBF process to determine any updates needed to meet 2025 HRSN goals.

In honoring the government-to-government relationship with the Nine Federally Recognized Tribes of Oregon, an additional $11.9 million of CCBF funding has been set aside for the Nine Tribes. Tribes have the opportunity to build their own HRSN programs to best serve their community members who will qualify. During this period, OHA worked with the Tribes on the scope of work for each grant within the allowable uses of these funds and began the contracting process.

HRSN Outreach and Engagement Service

The goal of HRSN Outreach & Engagement benefit is to identify members who may be eligible for HRSN services and help them understand the process to access needed services in a culturally specific and responsive manner, and connect members to HRSN, healthcare, and non-healthcare services to address social determinant of health needs, including Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women Infants and Children (WIC) to support their ability to realize improved health outcomes.

During this period, OHA conducted significant research on similar services and related benchmarks, facilitated monthly HRSN Partner Work Sessions, HRSN CCO Work Sessions, and technical assistance trainings to gather feedback from CCOs and potential HRSN Service Providers (i.e., community-based organizations, clinics, etc.) to develop fee schedule rates ($20 per 15-minute increment for HRSN Service) and benefit cap requirements (30 hours per year, per member, per health plan) for HRSN Outreach and Engagement Services. During this period, over 40 organizations enrolled as HRSN Outreach & Engagement Service Providers.

Engagements with potential HRSN Service Providers for sharing information and answering questions began in March 2024 and continues through 2025. As of September 2024, over 50 meetings were held reaching hundreds of community partners throughout the state.

HRSN Outreach & Engagement contract language, Guidance Document, Administrative Rules (OARs) and member-facing, plain language, and transcreated HRSN Climate and Housing Request forms were developed during this period.

HRSN Housing Supports

The goal for the HRSN Housing supports is to focus on preventing homelessness and promoting housing retention, and improving health equity. During the reporting period, OHA advanced the HRSN Housing support benefit, including:

- Launched HRSN climate services for qualifying members on March 1, 2024.
- Determined technical components of the HRSN service descriptions, including specifying activities, limits, units, duration, and required documentation.
- Determined eligibility for each HRSN Housing service, in alignment with the CMS-approved HRSN Services Protocol.
- Collected data to determine the fee schedule.
- Wrote Oregon Administrative Rule (OAR) drafts for public comment, integrated public comment, and finalized OARs. Wrote contracts for Coordinated Care Organizations and the Fee-for-Service implementation contractors.

- Developed robust monitoring and oversight mechanisms to ensure delivery of high-quality HRSN housing services, and avoid fraud, waste, and abuse.
- Conducting engagement and feedback sessions with housing providers, community-based organizations, and housing coordination entities (e.g., Continuums of Care, Community Action Agencies, etc.).

Initial Housing Services Launch: Medically Necessary Climate-Related Home Modifications/Remediation

OHA launched a set climate devices as the first set of medically necessary home modification services on March 1, 2024. These essential devices seek to keep people safe and healthy in their homes during extreme weather and wildfire smoke events. Eligible OHA members received qualifying devices (e.g., air conditioners, and air filters) through their CCO or FFS contractor. During this period, there has been a steady increase of members receiving devices. Preliminary data of devices delivered in the first four months of the program, between March 1 and June 30 of 2024, shows that about 1,700 climate devices have been delivered to close to 1,000 eligible OHP members.

The most frequently delivered devices were air conditioners, making up 44% of devices delivered, followed by air filtration devices at 26%. Early data shows an additional 4,000 or more devices were distributed through this program in July and August.

Planning for Subsequent Housing Services Launch

During the reporting period, OHA continued working towards the launch of additional housing services in November 2024. As described above, the majority of the work during this period focused on fleshing out the technical specifications of each HRSN housing service including service-level eligibility criteria, Through the year, Housing supports available November 2024will include:

- Rent and utility assistance for up to 6 months
- Additional home modification and remediation services (e.g., ramps, handrails, environmental remediation)
- Tenancy support services (e.g., housing application, case management, eviction prevention)

Nutrition Supports

Nutrition Benefits launch January 2025, starting with Medically Tailored Meals and Nutrition Education. This past quarter (July 2024 – September 2024) was dedicated to fleshing out the technical specifications of each HRSN nutrition service to be offered starting in 2025, including service specific eligibility criteria, additional provider qualifications, to inform program design.

Additional deliverables include developing and finalizing:

- CCO contract language: 7/31/2024
- HRSN Nutrition Benefit Guidance Document: 9/7/2024
- HRSN Nutrition Benefit Oregon Administrative Rules (OARs): 10/31/2024

Provider, CCO, and Partner Engagement

OHA conducted an HRSN Roadshow to promote awareness and provide education to potential HRSN Service Providers and community-based organization staff, internal agency staff, and Oregon Department of Human Services (ODHS) staff. This work included over 50 opportunities to engage with housing partners across the state which provided feedback on fees schedules, providers requirements and guidance for development of OARS, and meeting one on one with CCOs and housing and nutrition providers.

Alignment of HRSN with tribal partners' priorities

Addressing health-related social needs (HRSN) is a priority for Oregon's nine Federally Recognized Tribes. To support Tribes in delivering HRSN services in Tribal communities, between October 2023 and September 2024, Oregon's staff consulted and collaborated with Tribal leaders on designing and implementing HRSN services as a Medicaid covered service for Tribal members enrolled in the Oregon Health Plan. Additionally, to support Tribal HRSN investments, Oregon set aside 10% of the total Community Capacity Building Funds (CCBF) authorized amount to support the Tribes' ability to build capacity and invest in the infrastructure needed to deliver HRSN services.

During this time, a total of four Dear Tribal Leader Letters were sent offering consultation on HRSN services, CCBF, proposed rule-making, and HRSN fee schedule development. This resulted in two Tribal consultations with all nine Federally Recognized Tribes, as well as one individual consultation with Cow Creek Band of Umpqua Tribe of Indians. It also resulted in all nine Tribes agreeing to accept CCBF awards.

Furthermore, Oregon staff facilitated a total of seven Tribal HRSN work sessions with Tribal Leaders, five of which included all nine Federally Recognized Tribes, and two which were individual work sessions with the Confederated Tribe of Warm Springs and the Klamath Tribe. The goal of the work sessions was to discuss the design and implementation of the new HRSN benefits. Finally, Oregon staff participated in three Tribal monthly meetings with Tribal Leaders to discuss the status of HRSN service implementation and opportunities for further collaboration. It is anticipated that Tribes will receive their CCBF awards in early 2025 and make further progress on implementing HRSN services within their communities in the spring of 2025.

Reentry Demonstration Initiative

The Reentry Initiative approved on July 2,2024 authorizes the state to provide a targeted set of OHP benefits to adults and youth transitioning out of carceral settings. Since approval, OHA has conducted several coordinated planning measures to support the launch of the initiative in 2026, including:

- Initiating baseline readiness assessments of correctional facilities across the state to understand current capabilities across key service areas.
- Planning for disbursement of capacity building funding to qualifying entities.
- Updating Medicaid systems to support new/updated enrollment and suspension processes to allow for the limited reentry benefit package and to ensure full OHP enrollment upon release.
- Developing policy and operational guidance (including CCO contracts, administrative rules and service standards manuals for correctional facilities) to support implementation.

Oregon Health Authority

Designated State Health Programs

Designated State Health Program (DSHP) allows for limited federal matching funds on approved existing state-funded expenditures. The new funding may be used to help pay for:

- Medicaid coverage to Young Adults with Special Health Care Needs (YSHCN)
- Health-Related Social Needs (HRSN) for eligible Oregon Health Plan members
- HRSN capacity building for community partners (more details provided above)
- Carceral Capacity Building

Between July – September 2024, Oregon claimed a 50% match through the DSHP program on $58.7 million in expenditures, bringing the total claimed for FFY24 to $115.5 million. See the attached CMS Summary Worksheet for details.

Traditional Health Care Practices

Reserved *(initiative approved in October, 2024* and *to be included in subsequent monitoring report*)

Evaluation Activities and Interim Findings

Reserved *(evaluation design approved in December, 2024 and to be included in subsequent monitoring report*)

C. Better care and Better health (ANNUAL)

In October 2022, Oregon began a new five-year Medicaid demonstration period, which supports the Oregon Health Authority's (OHA) goal of eliminating health inequities by 2030. In alignment, the Coordinated Care Organization (CCO) Quality Incentive Program (QIP) is prioritizing upstream metrics that address social issues impacting health (such as access to healthy foods and safe, affordable housing).

Progress reporting

Throughout the demonstration year, the OHA produced regular reports as well as final calendar year 2023 data showing CCOs incentive and state performance. All CCOs had performance data successfully reported for the year. While this report only shows statewide average for CCO members as a whole, the CCO Performance Metrics Dashboard expands on this report. It describes in more detail the progress of Oregon's CCOs on quality measures. Viewers can search by metric and see individual CCO trends over time. The dashboard also has the option to explore breakouts of many measures, by Race, Ethnicity, Language and Disability (REALD) standards.

- This report is available online here: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2023-CCO-Metrics-Annual-Report.pdf
- The metrics dashboard is available here: https://visual-data.dhsoha.state.or.us/t/OHA/views/CCOPerformanceMetrics/welcome?%3Aembed=y&%3AisGuestRedirectFromVizportal=y

Highlights from the demonstration year

New measure launched to improve social determinants of health (SDOH)

In 2023, the CCO Quality Incentive Program launched the new Social Determinants of Health: Social Needs Screening and Referral measure (SDOH measure). This measure requires CCOs to screen members for housing insecurity, food insecurity and transportation needs, as well as provide referrals for each identified need.

The SDOH measure is on a glide path, with new requirements added each year. In the first three years of the SDOH measure (2023 to 2025), CCOs will set up structural components necessary for the measure's success. These include, but are not limited to:

- Preparing for equitable, trauma-informed and culturally responsive screening and referrals
- Working with community-based organizations to build capacity for referrals and meeting social needs
- Supporting data sharing between CCOs, providers, and community-based organizations

In 2023, the first year the metric was incentivized, CCOs were required to attest to completing nine must-pass elements in Component 1. These elements covered:

- Screening practices
- Referral practices and resources
- Data collection and sharing

To meet the measure, CCOs were required to complete all must-pass elements, with no option for partial credit. In 2023, all but one CCO met this measure.

Capacity building continued for the system-level social-emotional health measure

2023 was the second year of the System-Level Social-Emotional Health measure, an upstream measure which is part of the broader health aspects of kindergarten readiness strategy. This measure was developed by the Oregon Pediatric Improvement Partnership (OPIP) and Children's Institute (CI) with support from OHA.

To pass this measure, CCOs were again required to complete an attestation survey, asset map, and action plan. These track CCOs' progress on the four components of the measure:

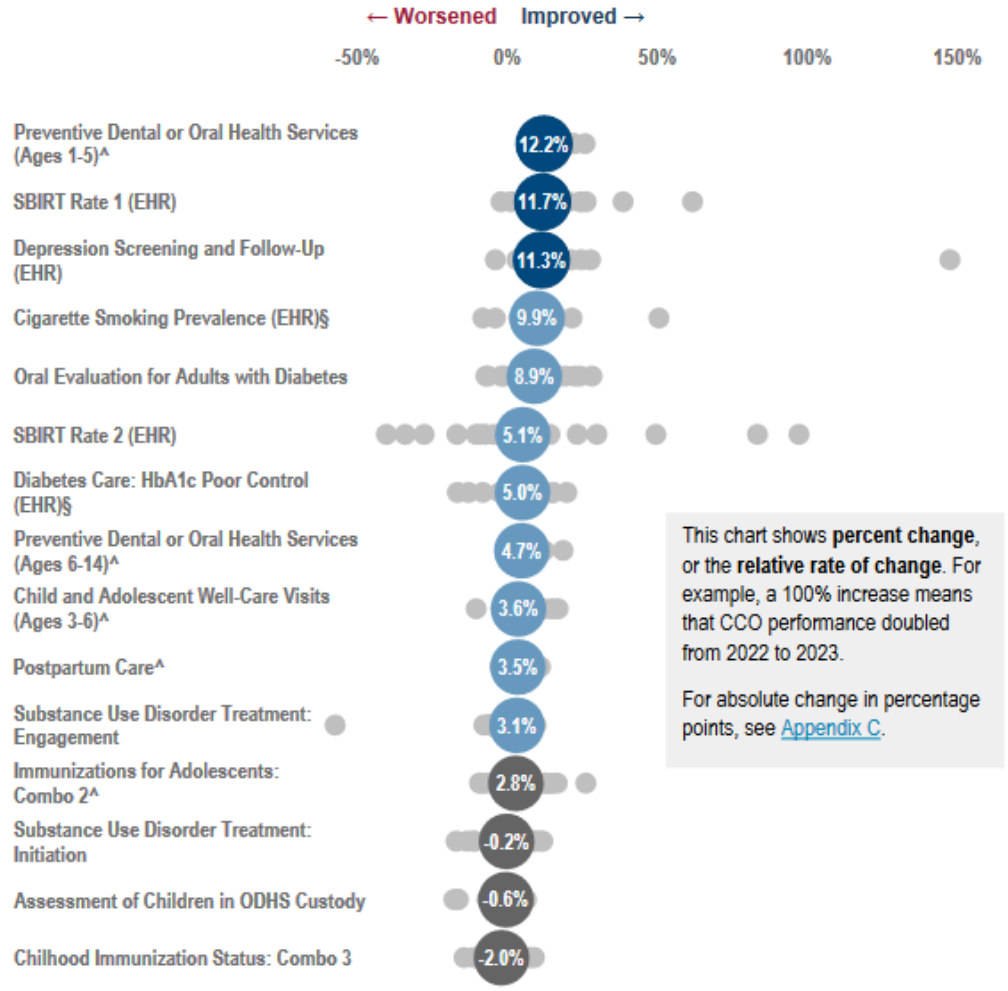
- Social-emotional health reach metric data review and assessment
- Asset map of existing social-emotional health services and resources
- CCO-led cross-sector community engagement
- Action plan to improve social-emotional health service capacity and access

In 2023, CCOs were required to update asset maps with integrated behavioral health clinics, in addition to contracted behavioral health therapy services. CCOs had to complete all must-pass items for the measurement year, with no option for partial credit. In 2023, all CCOs met this measure.

The next two tables are included in the 2023 report. The first shows performance on each incentive measure by CCO for 2022. The second displays performance results for each CCO in achieving benchmarks or improvement targets for each 2023 incentive metric.

At a glance: CCO performance percent change from 2022 to 2023

On average, CCOs statewide slightly improved or improved performance on most measures



This chart shows **percent change**, or the **relative rate of change**. For example, a 100% increase means that CCO performance doubled from 2022 to 2023.

For absolute change in percentage points, see Appendix C.

^ Challenge Pool measure

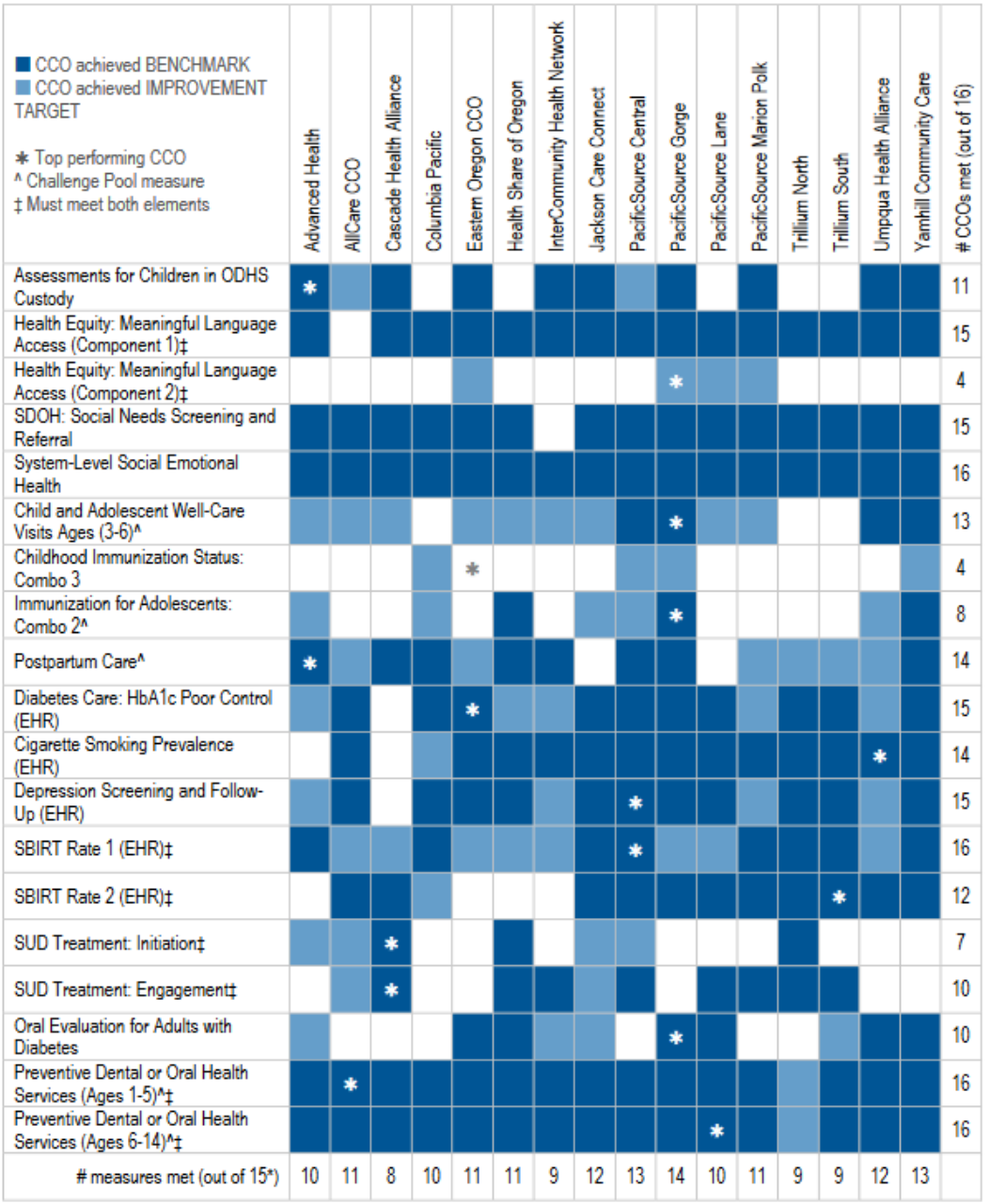
§ A lower rate is better for this measure. For ease of comparison, positive changes are measures that improved and negative changes are those that worsened. For example, 3.6% change in Cigarette Smoking Performance means that the rate decreased, or improved, by 3.6%

- Improved (10% or more)
- Slightly improved (3.01 to 9.99%)
- Held steady (-3 to 3%)
- CCO

✱ May be statistically uncertain; fewer than 12 members were served in one or both years (interpret with caution)

Health Equity: Meaningful Language Access is not included in this chart. Percent changes are exaggerated due to low performance in 2022

2023 incentive measure performance overview



*Measures that require meeting both components are counted as one measure

Quality Pool – Coordinated Care Organization Incentives

Disbursement of the CCO quality pool funds continues to be contingent on CCO performance relative to both the absolute benchmark and improvement targets for the selected measures.

In 2023, the Quality Pool was over $325 million, representing 4.25% of the total amount all CCOs were paid in 2023. This is the largest payment in the history of the program, which began at $47 million in 2013.

The share of these funds that a CCO can earn depends on the number of members it serves and its performance on the 15 incentive metrics. Money left over from the Quality Pool formed the Challenge Pool, which was distributed to CCOs that met benchmarks or improvement targets on a subset of measures. Funds from the Quality Pool are distributed on an annual basis, with the calendar year payment made by June 30 of the following year. These funds are earned in the two stages described below.

Phase 1: Quality Pool

CCOs earn 100% of their Quality Pool by meeting the benchmark or improvement target for 75% of the incentive metrics (12 of 15 metrics in 2023). For CCOs that meet less than 75% of incentive measures, Quality Pool payments are reduced by a set percentage. No “must pass” metrics were selected for the 2023 Quality Pool. “Must pass” metrics have a benchmark or reporting requirement that CCOs must meet to be eligible to receive full Quality Pool payments. Historically, the Metrics and Scoring Committee has selected one to three “must pass” metrics in most years of the program.

Phase 2: Challenge Pool

Unearned Quality Pool funds are funneled into the Challenge Pool. All CCOs can earn additional funds through the Challenge Pool. Even if a CCO did not earn 100% of Quality Pool funds in phase 1, they can earn funds through the Challenge Pool. To earn Challenge Pool funds, CCOs must meet performance expectations on a subset of incentive measures. For 2023, the Challenge Pool focused on kindergarten readiness and postpartum care. Challenge Pool funds were distributed to CCOs according to their performance on each of the four Challenge Pool metrics:

1. Child and Adolescent Well-Care Visits (Ages 3-6)
2. Immunizations for Adolescents: Combo 2
3. Preventive Dental or Oral Health Services, Ages 1-5 and 6-14
4. Postpartum Care

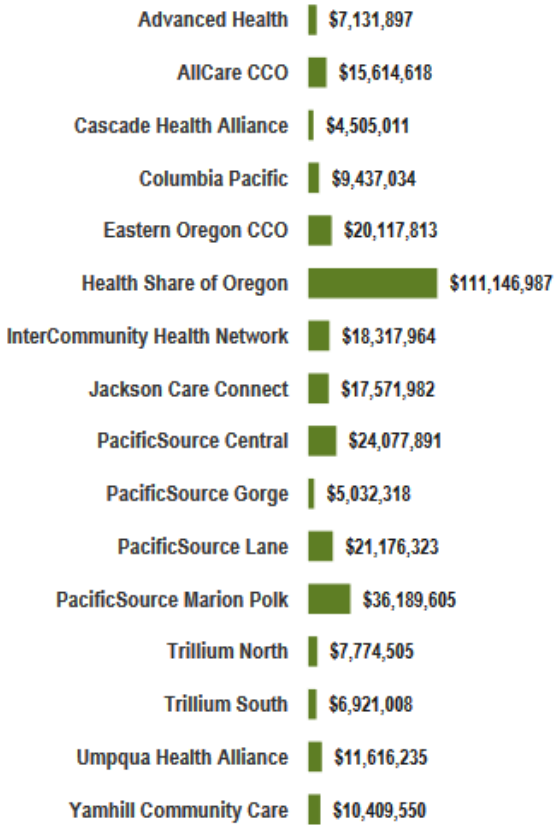
Challenge Pool funds are distributed in equal proportions based on the number of times Challenge Pool measures are met. With the Challenge Pool, CCOs can earn more than 100% of eligible incentive funds. All CCOs—even those that earned all of their Quality Pool—can earn additional bonus money from the Challenge Pool. In all but one year of the program, the majority of CCOs earned more than 100% of their bonus by the addition of the Challenge Pool. Regardless of CCO performance, OHA pays all CCO Quality Incentive Program funds each year to CCOs through the Challenge Pool. No bonus funds are saved or carried over to the next year.

2023 Quality Pool distribution

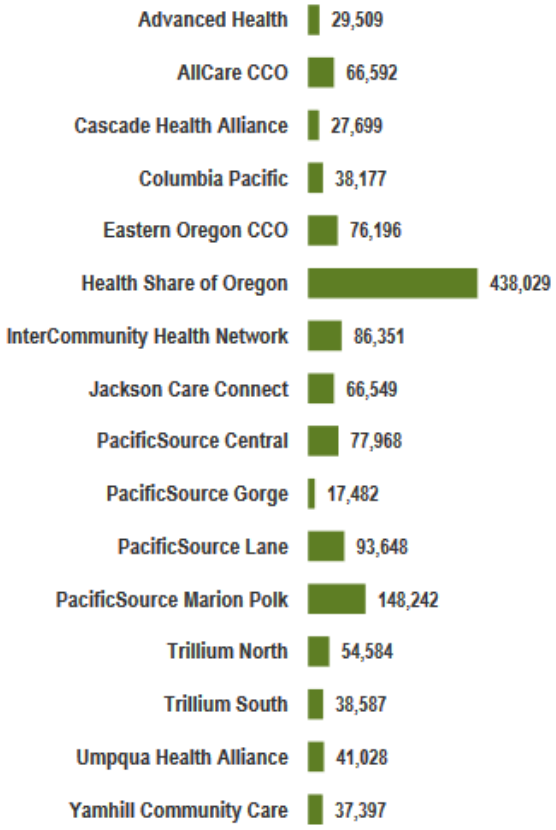
	Phase 1 distribution			Challenge Pool			Total	
	Measures met (15 possible)	% Quality Pool funds earned in Phase 1	Paid in Phase 1	Challenge Pool measures met (4 possible)	Challenge Pool paid in Phase 2	Total % Quality Pool paid	MCO tax[9] cost paid to CCOs	Total payment
Advanced Health	10	80%	$5,935,544	4	$1,053,716	94%	$142,638	$7,131,897
AllCare Health Plan	11	90%	$13,486,781	3	$1,815,545	102%	$312,292	$15,614,618
Cascade Health Alliance	8	60%	$3,659,722	3	$755,189	72%	$90,100	$4,505,011
Columbia Pacific	10	80%	$8,208,989	3	$1,039,304	90%	$188,741	$9,437,034
Eastern Oregon	11	90%	$17,638,059	3	$2,077,398	101%	$402,356	$20,117,813
Health Share of Oregon	11	90%	$93,282,872	4	$15,641,175	105%	$2,222,940	$111,146,987
InterCommunity Health Network	9	70%	$15,597,349	3	$2,354,255	81%	$366,359	$18,317,964
Jackson Care Connect	12	100%	$15,467,182	3	$1,753,361	111%	$351,440	$17,571,982
PacificSource Central	13	100%	$20,812,260	4	$2,784,074	113%	$481,558	$24,077,891
PacificSource Gorge	14	100%	$4,307,419	4	$624,253	114%	$100,646	$5,032,318
PacificSource Lane	10	80%	$19,076,260	2	$1,676,537	87%	$423,526	$21,176,323
PacificSource Marion Polk	11	90%	$31,424,168	3	$4,041,645	102%	$723,792	$36,189,605
Trillium North	9	70%	$6,593,987	2	$1,025,027	81%	$138,420	$7,774,505
Trillium South	9	70%	$6,057,962	2	$724,627	78%	$155,490	$6,921,008
Umpqua Health Alliance	12	100%	$9,918,892	4	$1,465,019	115%	$232,325	$11,616,235
Yamhill Community Care	13	100%	$8,865,973	4	$1,335,386	115%	$208,191	$10,409,550
Total			$280,333,420		$40,166,509			$327,040,743

[9] Oregon requires managed care organizations (MCOs) to pay a tax to support OHP. In 2023, the MCO tax rate was 2.0%. OHA pays the tax gross back to CCOs by building the cost of the tax into capitation rates, qualified directed payments, maternity kick payments and Quality Incentive payments.

Total Quality Pool dollars paid by CCO



Total enrolled by CCO (n = 1,338,040)



Total enrollment is the average of monthly members in 2023. These estimates come from OHA's Office of Financial and Actuarial Services (OAFA) and are used to calculate Quality Pool payments

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately.

2. State reported enrollment table

Enrollment	July/2024		August/2024	September/2024
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,266,408	1,273,937	1,280,664	
Title XXI funded State Plan	132,149	135,597	137,245	
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

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%	N/A			N/A	N/A	N/A
		Pregnant women FPL > 170%	N/A			N/A	N/A	N/A
	Title XXI	SCHIP FPL > 170%	62,132	163,113	0.40%	15%		
Optional	**Title XIX**	PLM women FPL 133-170%	N/A			N/A	N/A	N/A
	Title XXI	SCHIP FPL < 170%	168,636	891,231	-0.35%	18%		
Mandatory	**Title XIX**	Other OHP Plus	**	**	**	**		
		MAGI adults/children	1,190,249	11,421,129	1.41%	2%		
		MAGI pregnant women	32,690	223,118	16.49%	1%		

POPULATION			Total Number of Clients	Member months	% Change from previous quarter	% Change from previous year
		QUARTER TOTALS				

** Due to retroactive eligibility changes, the numbers should be considered preliminary*
*** Complete data on Title XIX populations will be submitted as a separate appendix*

OHP eligible and managed care enrollment

OHP eligible*							Coordinated Care				Dental Care	Mental Health
							CCOA **	CCOB **	CCOE **	CCOG **	DCO	MHO
July	1,370,595	1,293,770	51	48	9,651	66,151	N/A					
August	1,385,649	1,306,648	52	48	9,376	68,858	N/A					
September	1,395,515	1,316,731	49	45	8,994	69,797	N/A					

** 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.

C. CCO appeals and hearings

Attached separately.

D. Neutrality reports (reported separately)