Oregon Health Plans

Section 1115 Quarterly Report

1/1/2024 – 3/30/2024

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

During this reporting period, Oregon Health Authority (OHA) continued to work with our partners in the health care and social services delivery system to meet our program and statewide health equity goals. Implementation progress continued and advanced significantly. A few highlights include that OHA:

- Launched the community-capacity building funds (CCBF) grant program, which will disburse DSHP Infrastructure dollars across the state.
- Launched the health-related services needs (HRSN) climate supports program, allowing OHP to cover HRSN climate services for OHP members facing certain life transitions.
- Achieved approval of the HRSN Services Protocol and New Initiatives Implementation plan, both developed collaboratively in previous quarters
- Continued collaboration with Tribes toward DSHP Infrastructure / (CCBF) set aside, to support provisions of HRSN services

Oregon is pleased with the significant progress made this reporting period and remains ready to partner with CMS to complete needed deliverables for implementation.

Vivian Levy, Interim 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 included significant eligibility expansion authority as well as new services for individuals who have health-related social needs (HRSNs) and are experiencing life transitions. Collectively, these reforms are expected to further OHA's goal to eliminate health inequities by 2030 by connecting underserved populations with effective health care and supports.

Several of Oregon's proposals are still being negotiated with CMS. These provisions include Tribal-related requests, a limited Medicaid benefit package for individuals in a state hospital or a carceral setting, and community investment collaboratives to fund local health equity efforts.

Voluminous and complex changes are included in the waiver, impacting many populations and creating new opportunities to address historical health inequities. 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 because of short-term changes in eligibility, e.g., temporary income fluctuations.

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 target populations. Effective 2024, Oregon will provide HRSN benefits (such as housing and nutrition services) to people who are experiencing specific transitions in their lives. Eligible populations include:

- Youth with special health care needs aged 19 – 26
- Youth who are child welfare involved, including leaving foster care at age 18
- People who are experiencing homelessness or at risk of homelessness
- Older adults who have both Medicaid and Medicare health insurance
- People being released from custody
- People at risk of extreme weather events due to climate change

Under the new waiver, OHP members will get increased care and social supports in more situations. OHA is committed to working collaboratively with Tribal governments, communities of color and members of other historically underserved populations to design a benefit and implementation approach that expands health care access, quality and improves the lifelong health of everyone in Oregon.

C. State contacts

Interim Medicaid Director
Vivian Levy, Interim Medicaid Director
503-519-3512 phone
503-945-5872 fax

Interim Deputy Director
Nikki Olson, Interim Deputy Director
503-740-2717 phone
503-945-5872 fax

Demonstration and Quarterly and Annual Reports
Tom Wunderbro, Medicaid Demonstration Waiver Manager
503-510-5437 phone
503-945-5872 fax

State Plan
Jesse Anderson, State Plan Manager
503-945-6958 phone
503-945-5872 fax

Coordinated Care Organizations
David Inbody, CCO Operations Manager
503-756-3893 phone
503-945-5872 fax

Quality Assurance and Improvement
Veronica Guerra, Quality Assurance and Contract Oversight Manager
503-437-5614 phone
503-945-5872 fax

Oregon Health Authority
For mail delivery, use the following address:
Oregon Health Authority
Health Policy and Analytics
500 Summer Street NE, E54
Salem, OR 97301-1077

II. Title

Oregon Health Plan
Section 1115 Annual Report
Reporting period: 1/1/2024 – 3/30/2024
Demonstration Year (DY): 21 (10/1/2023 – 9/30/2024)
Federal Fiscal Year: 2024

III. Overview of the current quarter

Oregon Health Authority (OHA) made significant progress this quarter to build relationships critical to delivery HRSN services and work with partners in the health care and social services delivery system to meet program and statewide health equity goals. Highlights include that OHA:

- Launched the community-capacity building funds (CCBF) grant program, which will disburse DSHP Infrastructure dollars across the state. These funds will support capacity building for providers and partners that plan to deliver HRSN services. Coordinated care organizations (CCOs) will administer a majority of CCBF, except for those funds reserved for Tribal Governments. CCOs will be responsible for activities including conducting outreach regarding funding opportunities, receiving and reviewing applications, and awarding funding to eligible entities.
- Awarded HRSN third-party contractor (TPC) contract for provision of HRSN services to FFS members.
- Achieved approval of the HRSN Services Protocol and New Initiatives Implementation plan, both developed collaboratively in previous quarters and critical for implementation of all HRSN services.
- Launched the HRSN climate supports program, allowing Oregon Health Plan (OHP) to cover HRSN climate services for OHP members facing certain life transitions.
- Achieved approval of the HRSN Services Protocol and New Initiatives Implementation plan, both developed collaboratively in previous quarters and critical for implementation of all HRSN services.
- Continued collaboration with Tribes toward DSHP Infrastructure / CCBF set aside, to support provisions of HRSN services.
- Continued identifying changes needed to enhance the Medicaid Management Information System (MMIS) functionality to be able to facilitate service-based payments for HRSN Services. This functionality is expected to be implemented by July of 2024.

Oregon is pleased with the significant progress made this reporting period and remains ready to partner with CMS to complete needed deliverables for implementation.

A. Enrollment progress

1. Oregon Health Plan eligibility

The Public Health Emergency (PHE) unwinding period renewals are almost complete. A certain level of expected attrition has occurred as individuals are redetermined and found to no longer qualify or fail to respond to renewal requests. The PHE unwinding period has been extended in Oregon to allow for some additional time for proper renewal and timely notice periods for some remaining households.

Oregon has pending State Plan Amendments (SPAs) that will change its Children's Health Insurance Program (CHIP) designation from a State Children's Health Insurance Program (SCHIP) to a Medicaid Children's Health Insurance Program ((MCHIP /Medicaid expansion). All children receiving CHIP were systematically moved to MCHIP as of January 1. Once approved, the SPAs will be effective retroactively to January 1, 2024. Moving forward, only those who are Citizenship Waived Medical (CWM) and pregnant or newborns of CWM individuals will be reported under Title XXI.

2. Coordinated care organization enrollment

Total Coordinated Care Organization (CCO) enrollment for January to March 2024 grew by 0.8%, across all plan levels (CCOA, CCOB, CCOE, CCOG). Specific CCO membership growth ranged between -0.7% - 1.9%. The Trillium Community Health Plan serving Lane County and parts of Douglas County was the only CCO that saw a reduction in enrollment (-0.7%).

Across all16 CCOs, there are 48 unique CCO-county service areas. The following table provides context for geographic variability in membership growth trends.

DY22 Q2 (Jan-Mar 2024) Member Growth Zone	CCO Service Areas
Greater than 5.001%	2
3.00 - 4.99%	0
2.00 – 2.99%	8
0.00 – 1.99%	34
Reduction in enrollment	4

Overall enrollment growth was lower than previous quarters. The table below shows a comparison of enrollment growth across all quarters.

DY20EP 1/22-3/22	DY20EP 4/22-6/22	DY20EP 7/22-9/22	DY21EP 10/22-12/22	DY21EP 1/23-3/23	DY21EP 4/22-6/22	DY21EP 7/23-9/23	DY22EP 10/23-12/23	DP22EP 1/24-3/24
2.6%	1.4%	2.9%	2.5%	2.4%	1.8%	3.8%	1.9%	0.8%

As noted in previous reports, on May 1, 2020, OHA waived the requirement to limit each CCO's enrollment to the county limit(s) and grand total limit listed in its contract to mitigate enrollment challenges during the pandemic. This requirement was initially established for CCO contract year 2020, extended for contract year

2021 and has since been extended through contract year 2023. This requirement was reinstated as of January 2024. CCOs may request increases to their contract capacity for OHA to review.

B. Benefits

Health Evidence Review Commission (HERC): On January 1, 2024, the prioritized list went into effect and was reported in a Notification of Interim Changes. A change log and errata for the 1/1/2024 prioritized list was published on January 8 and January 22, 2024.

P&T Committee: New and revised Prior Authorization (PA) criteria was developed for the following drugs: Oncology Agents; Orphan Drugs; Spravato® (esketamine); Antipsychotics in Children; Lantidra™ (donislecel); Long-acting Muscarinic Antagonist-Long-acting Beta Agonist (LAMA-LABA) and LAMA-LABA-ICS Combination Inhalers; Elevidys™ (delandistrogene moxeparvovec); Duchenne Muscular Dystrophy (DMD).

The Committee also recommended the following changes to the preferred drug list (PDL): maintain Airsupra™public f (albuterol-budesonide) and Symbicort® Aerosphere™ (budesonide 160 mcg-formoterol 4.8 mcg) as non-preferred; make Arnuity™ Ellipta® preferred; make Agamree® (vamorolone) and Emflaza® (deflazacort) non-preferred; designate all targeted DMD treatments: Amondys-45 (casimersen), Elevidys (delandistrogene moxeparvc-rokl), Exondys-51 (eteplirsen), Viltepso (viltolarsen), Vyondys-53 (golodirsen) as non-preferred.

C. Access to care (ANNUAL)

D. Quality of care (ANNUAL)

E. Complaints, grievances, and hearings

1. CCO and FFS complaints and grievances

The information provided in the charts below is a compilation of data from all 16 CCOs and fee-for-service (FFS)

Trends

	Apr – Jun 2023	Jul -Sep 2023	Oct – Dec 2023	Jan – Mar 2024
Total complaints received	4,563	4,970	4,543	4,834
Total average enrollment	1,621,449	1,664,830	1,539,494	1,605,776
Rate per 1,000 members	2.81	2.99	2.95	3.01

Barriers

The number of complaints CCOs reported from January 1 to March 31, 2024 shows a 6.4% increase in the total number of complaints from the previous quarter. The Access to Care category continues to have the highest number of complaints, with an increase of 5.4% this quarter. The Interaction with Provider or Plan category also increased 12.9% compared to the previous quarter. Quality of Care continues to be the third highest category of complaints with a slight increase of 2.85% from the previous quarter. FFS data shows the highest number of

complaints this annual reporting period remains the Quality of Care category and Access to Care issues show the next highest number.

Interventions

COs: Non-emergent Medical Transportation (NEMT) and dental issues continue to see the highest numbers of complaints across all CCOs. To help try to resolve NEMT complaints, one CCO established a process for providers to by-pass the NEMT call center and talk directly to someone at the brokerage to resolve issues. This is helping improve their overall NEMT system. Another CCO improved their process for gas mileage reimbursements, which improved overall services to members.

CCOs report they are continuing to meet monthly with specific categories of providers, such as NEMT, dental, mental health, and substance use disorder (SUD) to review grievance data for their areas. Through this process, one CCO was able to identify a specific provider who was having difficulties, and proactively helped re-assign members to other providers. This helped to alleviate disruption in the members treatments that were already in process. Some CCOs continue to report they are having difficulty with dental provider availability in their local areas and are continuing to assist with hiring staff.

NOTE: This quarter Yamhill Community Coordinated Care Organization received an extension to submit their report to OHA due to challenges following the implementation of a new A&G system. Updated data will be provided in the next April – June 2024 reporting period.

Fee-For-Service (FFS): For this reporting period, there were 150 complaints from OHP members with FFS coverage. There were 360 records identified as calls received from members enrolled in CCOs and these calls were referred to the appropriate CCO. There were also 8,017 informational calls received during this reporting period, with requests for a variety of information, including questions about member coverage, CCO enrollment, and ID cards.

Statewide rolling 12-month complaints totals

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

Complaint category	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024
Access to care	1,588	1,687	1,563	1,648
Client billing issues	397	457	434	438
Consumer rights	419	399	334	349
Interaction with provider or plan	1,475	1,561	1,407	1,589
Quality of care	473	605	595	612
Quality of service	211	261	210	198
Other	0	0	0	0
Grand Total	4,563	4,970	4,543	4,834

Related data

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

Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs between January 1 and March 31, 2024. The NOABDs are listed by reason, 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 highest number of NOABDs issued were in pharmacy, dental and diagnostics. 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 verbiage and with appropriate citations. Tracking for timeliness, as well as reviewing for utilization and appropriateness of care, are processes CCOs report they are doing to ensure NOABDs are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024
a) Denial or limited authorization of a requested service.	32,277	29,722	29,559	29,981
b) Single PHP service area, denial to obtain services outside the PHP panel	1,028	1157	921	1,914
c) Termination, suspension, or reduction of previously authorized covered services	67	61	57	163
d) Failure to act within the timeframes provided in § 438.408(b)	3	6	11	6
e) Failure to provide services in a timely manner, as defined by the State	99	144	72	146
f) Denial of payment, at the time of any action affecting the claim.	125,305	133,919	163,969	206,658
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	158,779	165,009	194,589	238,868
Number per 1000 members	117.7	117.9	139.5	176.9

CCO Appeals

The table below shows the number of appeals the CCOs received. OHA has implemented a new process requirement for reporting appeals with the appropriate NOABD identified. Over the past twelve months, CCOs have been given extensions in meeting reporting deadlines for appeals, due to this change in the reporting requirement. We are providing the past three quarters in this report, as they were not reported at the time of the respective reporting periods. Because extensions for the current reporting period have also been given, the appeal data for the current reporting period is not available. The updated data will be reported in the next quarter.

CCO Appeals	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024
a) Denial or limited authorization of a requested service.	781	890	573	Data not available
b) Single PHP service area, denial to obtain services outside the PHP panel.	18	40	29	Data not available
c) Termination, suspension, or reduction of previously authorized covered services.	2	1	1	Data not available

d) Failure to act within the timeframes provided in § 438.408(b).	0	0	0	Data not available
e) Failure to provide services in a timely manner, as defined by the State.	0	1	1	Data not available
f) Denial of payment, at the time of any action affecting the claim.	562	811	520	Data not available
g) Denial of a member's request to dispute a financial liability.	26	0	0	Data not available
Total	1,389	1,743	1,124	Data not available
Number per 1,000 members	1.03	1.25	.81	Data not available
Number overturned at plan level	198	266	219	Data not available
Appeal decisions pending	0	0	0	Data not available
Overturn rate at plan level	14.3%	15.3%	19.5%	Data not available

CCO and FFS Contested Case Hearings

The following information is a compilation of data from all 16 CCOs and FFS.

During this reporting period, OHA received 329 hearing requests related to the denial of medical, dental, and behavioral health services, including NEMT. Of those received, 296 were from CCO-enrolled members and 33 were from FFS members. Of those, 292 cases were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. In every quarter there is an overlap of processed cases with those received. For instance, cases processed and resolved in January of 2023 may be cases OHA received as far back as November or December of 2023.

OHA dismissed 172 cases that were determined not-hearable cases. Of the not-hearable cases, 142 were forwarded to the member's respective CCO to process as an appeal. Per Oregon Administrative Rule, 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 a NOAR. One case was dismissed as not hearable because the hearing request was not submitted within the timelines identified in rule.

Of the 120 cases that were determined to be hearable:

- 28 were approved prior to hearing
- 53 cases were withdrawn by OHP members after an informal conference with an OHA hearing representative
- 24 cases went to hearing, where an administrative law judge upheld the OHA or CCO decision and
- 12 cases were dismissed for the members failure to appear

An administrative law judge set aside the decision stated in the denial notice in 2 cases.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	28	10%
Client withdrew request after pre-hearing conference	53	18%
Dismissed by OHA as not hearable	172	59%
Decision affirmed*	24	8%
Client failed to appear*	12	4%
Dismissed as non-timely	2	1%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	1	0%
Set Aside	2	0%
Total	292	

* Resolution after an administrative hearing.

Related data

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

F. CCO activities

1. New plans

Oregon awarded 15 CCO contracts under a procurement conducted in 2019. Current CCOs are previously existing plans, and one expanded 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 –serves Lane County and applied to expand into Clackamas, Multnomah, and Washington counties (the Tri-County). OHA denied the request and gave Trillium until June 30, 2020, to demonstrate a sufficient provider network. OHA's denial informed that without further action, the Tri-County service area would be removed from Trillium's 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.

In the spring of 2023, the state legislature extended existing CCO contracts by two years. The new end date for the contracts is December 31, 2026.

2. Provider networks
There were no significant changes to the provider networks for the current quarterly report.

3. Rate certifications
OHP is the state Medicaid program and provides health coverage for low-income Oregonians including working families, children, pregnant women, single adults, and seniors. OHA has contracted with managed care entities - or CCOs -to manage and deliver health care for most of the individuals eligible for Medicaid. OHA pays for CCOs to cover physical, behavioral, dental and transportation needs for these individuals. CCO's receive capitation rates that are a predetermined payment that depends on an individual's OHP eligibility status and is paid to CCOs monthly, for each member enrolled with them.

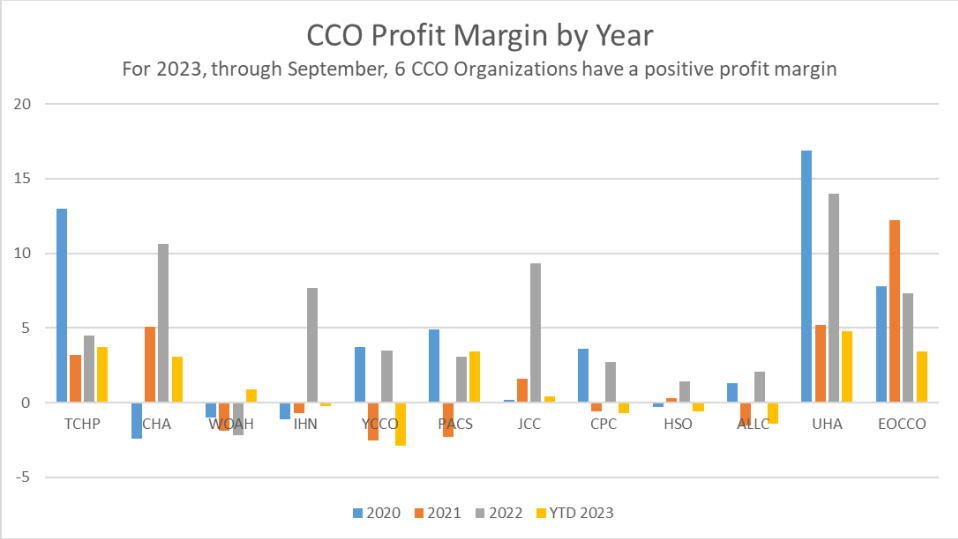
Capitation rates are developed and certified by OHA's contracted actuaries on a yearly basis. The process and methodology used to develop capitation rates are governed by federal and state regulations. CMS requires Oregon's capitation rates be Actuarially Sound and follow applicable Actuarial Standards of Practice, which are developed by the Actuarial Standards Board. OHA delivered the final CY24 CCO rates package to CMS in October 2023, which included the Oregon CY24 rate certifications and contract rate Sheets.

In preparation for the CY25 Rate Development year, OHA is preparing 2023 data to support the rate process and evaluating additional contract and rate changes for the 2025 rate development process. This includes 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 2023.

4. Enrollment/disenrollment
All significant changes are described in other areas of this report.

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

6. Relevant financial performance
CCOs have reported a variety of profit/losses through the nine months ending September 30, 2023. Through September 30, 2023, CCOs have received revenues of $6 billion. In comparison to 2022, all but one CCO had a positive profit margin by the end of the year and received revenue of $7.3 billion.



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (this includes physical, behavioral, and dental health, substance use services and other adjustments) as a percentage of total revenue. A breakdown of key statewide financial ratios by year indicates that the Member Services component as a percent of the payments which CCOs received has remained relatively consistent over the last two years. Through the first six months of 2023, spending on Member Services was at 89.5%. Administrative costs of 7.5% through the first half of 2023 is in line with the 2022 CCO-wide average, which was 7.5%.

7. Corrective action plans

For the current quarter, OHA does not have Corrective Action Plans in place with any CCO.

8. One-percent withhold

For this quarterly report, OHA analyzed encounter data received for completeness and accuracy for the subject months finalized for June 2023 through August 2023.

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of June 2023 through August 2023. 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) (also known as Closed Loop Referral Technology)

Federal Funding: Oregon requested CMS Medicaid Enterprise Systems funding for CIE via an Implementation Advance Planning Document (IAPD) on March 11, 2024. The IAPD is requesting 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.

Health IT Strategic Plan: ***Strategy to support, accelerate, and improve statewide CIE efforts:***
The Health Information Technology Oversight Council (HITOC) 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 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 (PSU). Through this IGA, PSU will function as a neutral party to assess readiness for statewide CIE governance among community and healthcare partners to help ensure alignment, transparency, and accountability. Interviews and focus groups are expected to occur over the summer and fall of 2024.

H. Metrics development

At the January meeting of Metrics & Scoring, the committee revisited the changes coming to the CCO Incentive Program regarding the requirement to choose downstream measures from the CMS Core Sets beginning in 2025. This meeting focused on the cigarette smoking prevalence measure and the committee's options to either 1) reclassify the measure as upstream and continue it into the 2025 measure set, or 2) explore other smoking-related measures on the CMS Core Set for inclusion in the 2025 measure set. The committee heard a presentation about commercial tobacco use in Oregon and the progress made towards reducing cigarette smoking in Oregon since the current measure was incentivized.

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 February meeting of Metrics & Scoring, the committee heard a presentation about potential upcoming changes to the health assessments for children in Oregon Department of Human Services (ODHS) custody measure. OHA also gave their recommendations for the 2025 incentive measure set. The recommendations are as follows:

1. Continue the seven current downstream incentive measures that are also on the CMS Core Set into 2025:
    a. Postpartum care
    b. Depression screening and follow-up
    c. HbA1c poor control
    d. Initiation and engagement with substance use disorder treatment
    e. Childhood immunization status (Combo 3)
    f. Immunizations for adolescents (Combo 2)
    g. Child and adolescent well-care visits, ages 3-6 (Kindergarten readiness)

2. Continue the four upstream incentive measures into 2025 (Senate Bill 966 requires at least four upstream measures in the set):
    a. Health assessments for children in ODHS custody
    b. System-level social emotional health (Kindergarten readiness)
    c. Meaningful language access
    d. SDOH screening and referral

3. Classify the cigarette smoking prevalence measure as upstream and continue it into 2025.

4. Continue incentivizing oral health care for children by replacing the current preventive dental and oral health services measure – which isn't on the CMS Core Set – with one or more child dental measures on the Core Set:
    a. Oral evaluation, dental services
    b. Sealant receipt on permanent first molars
    c. Topical fluoride for children

5. Continue incentivizing oral health care for adults by continuing the oral evaluation for adults with diabetes measure if no adult measures are added to the CMS Core Set by March 1, 2024. If adult measures are added to the Core Set by March 1, 2024, replace the oral evaluation for adults with diabetes measure with one or more adult oral health measures from the Core Set.

6. Because it is not on the CMS Core Sets, the screening, brief intervention and referral to treatment measure (SBIRT) must be retired. As there are not analogous measures on the Core Set that could be used to replace SBIRT, OHA is not making a recommendation on whether to replace this measure with something else from the CMS Core Sets. Options for the Committee are:
    a. Retire SBIRT without replacement
    b. Retire SBIRT and replace with a different substance use disorder measure on the Core Set
    c. Retire SBIRT and replace with a Core Set measure from a different domain

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 March meeting of Metrics & Scoring, the committee again revisited the changes coming to the CCO Incentive Program regarding the requirement to choose downstream measures from the CMS Core Sets beginning in 2025. The committee heard a presentation on the screening, brief intervention, and referral to treatment (SBIRT) measure, which is not on the CMS Core Set and therefore, cannot be included on the 2025 incentive measure set. The committee reviewed performance data for two of the CMS Core Set substance use disorder (SUD) measures that the committee may consider as replacements for the SBIRT measure:

1. Use of pharmacotherapy for opioid use disorder
2. Follow-up after emergency department visit for substance use

The committee also heard a presentation about the transition of the social-emotional health measure from CCO-level to child-level in 2025.

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

OHA is unable to report on the current waiver Budget Neutrality Workbook template. The agency is working to have 1115 system configurations implemented by July 1, 2024 to align with the current waiver reporting requirements; however, system configuration data is dependent on other system change requests, including Continuous Eligibility (CE) indicators, and may not be ready by July 1, 2024. We hope to submit the report by September 2024 with available data retroactive to the beginning of the waiver.

J. Legislative activities

The 2024 legislative session did not produce legislation specifically focused on the demonstration waiver; however, there are some enactments will impact or supplement the work and are therefore worth mentioning:

SB 1529 authorizes OHA to distribute air conditioners and air filters to community partners, who in turn will distribute them to individuals facing heightened medical needs during climate emergencies like heat waves or wildfires. This bill continues funding for the state program started under SB 1536 in 2022. Importantly, it allows OHA to provide air conditioners and air filtration devices in advance of the formal declaration of a climate emergency, something disallowed under the current 1115 demonstration waiver. This expands the population of eligible recipients beyond those who can be served by the waiver. OHA is expected to provide 4,000 air conditioners to eligible Oregonians. This is in addition to the estimated 1,300 air conditioners we expect to provide through the 1115 waiver climate supports program.

SB 1530 provides funds for various housing initiatives, including affordable housing production and homelessness prevention. Health-related initiatives include:

- $18 million for twelve community partners to provide recovery housing.
- $15 million for the Healthy Homes Repair Fund
- $3.5 million for air conditioners and air filters to help people with medical needs during climate emergencies.

While not directly tied to the waiver's HRSN housing benefit, funding under this bill will supplement OHA's ability to mitigate the harmful health effects of houselessness in Oregon.

SB 1557 focuses on home and community-based services for youth under 21. The bill directs OHA and the ODHS to collaborate on strategies for providing youth with complex health needs access to medically appropriate care, including behavioral health care at home and in the community. The intent of the bill is to maximize the use of state and federal funds to expand services that are more responsive to meeting the needs of highly vulnerable children and their families in the most appropriate and least restrictive settings possible.

K. Litigation status

There are no open lawsuits or legal actions related to OHP during this reporting period.

L. Public forums

HERC: Each HERC meeting in this reporting period discussed issues related to coverage of health services and medical necessity criteria to be reflected in the Prioritized List of Health Services. Complete agendas, materials and minutes for each meeting are available here.

January 18, 2024

Verbal comments:

An OHP member and advocate voiced support for PANDAS/PANS treatment and subspecialist timeline changes. Two advocates spoke about Gender Affirming Treatment; one asked for a technology review and the other spoke about de-transitioning.

Written comments:

An OHP provider wrote to support coverage of PSA for Prostate Cancer Screening; three OHP members offered comments support for PANDAS/PANS treatment and subspecialist timeline changes. Two advocates spoke about Gender-Affirming Treatment; one asked for a technology review of the topic, while the other spoke about a personal experience with de-transitioning. Two OHP providers offered support for coverage of Peristeen Plus and one OHP member wrote in about AMA Weight Loss Treatment Recommendations.

Written comments – A Written comments – B

Value-based Benefits Subcommittee

January 18, 2024

Verbal comments:

One industry representative urged support for coverage of Peristeen Plus.

Written comments:

Ten OHP providers wrote to offer their support for coverage of Vulvodynia and vulvar vestibulitis. Three providers and one caregiver supported coverage of benign paroxysmal positional vertigo (BPPV). Two OHP providers, two OHP patients and one industry representative urged coverage of Peristeen Plus. One industry representative and nine OHP providers lent their support to coverage of Coronary Lithotripsy.

Evidence-based Guidelines Subcommittee

Verbal comments:

One OHP provider and two advocacy groups supported coverage of community-centered peer-led self-management programs (SMP).

Written comments:

Two advocacy groups support coverage of community-centered peer-led self-management programs (SMP), one OHP patient supported IVIG treatment for PANDAS/PANS.

Written comments

Health Evidence Review Commission

March 14, 2024

Verbal comments:

One OHP provider and one advocacy organization added their support for coverage of community-centered peer-led self-management programs (SMP).

Written comments:

None received.

Value-based Benefits Subcommittee

March 14, 2024

Verbal comments:

None received.

Written comments:

Two OHP providers encouraged hemorrhoid coverage. One OHP member did not support radiation cancer treatment. One OHP provider and three advocacy organizations added their support for coverage of community-centered peer-led self-management programs (SMP). One advocacy organization encouraged broader coverage for Continuous Glucose Monitors. One OHP member wrote that all treatments being considered should be covered.

Written comments

Medicaid Advisory Committee

Medicaid Advisory Committee (MAC) Meeting

January 31, 2024

The contractor designing Oregon's 1115 Waiver implementation evaluation presented to the MAC regarding elements of the plans for serving Youth with Special Health Care Needs (YSCHN).

MAC members had these questions:

(a) Q: If a disabled child is getting their qualification for Medicaid, will that change?

(b) Q: I'm not clear on the approach that you're taking to setting the baseline and how that is going to measure improvement for 19–26-year-olds.

(c) Q: Is the group doing an analysis on the limitations of how to collect this data?

(d) Q: Curious about the timing of the evaluation of the TME since the timeline is very short relative to other components of the waiver.

Written testimony

Medicaid Advisory Committee (MAC) meeting

February 28, 2024

The contractor designing Oregon's 1115 Waiver implementation evaluation presented to the MAC regarding elements of the plans for serving Youth with Special Health Care Needs.

MAC members had these questions and comments:

1. Will the evaluation track members who seek resources but do not fall within the HRSN covered populations and/or additional criteria?
2. Has population eligibility been more defined?
3. Am I correct in understanding that collecting data for the so-called softer measures that are harder to track through EMR data like climate, nutrition, etc., will be done through surveys?
4. Are you pulling from other data sources for housing outcomes?
5. What target size response are you hoping for in surveys?

6. Comment: The MAC has thought about how we are really leveraging this opportunity to make a radical change in health disparity and improve outcomes for communities. We hope this help moves the dial. I think that's a great place to take a peek using population comparisons.
7. I hope we get to ratifying population audiences that we're wanting to focus on. I love the plan of how you're looking at implementation, but I would love as a MAC member to make sure that when we're picking eligible populations that there's enough consistency across the three benefits and that we're honing-in to reduction of health disparities. I strongly advocate that the guidance be very targeted towards helping us achieve our health disparity outcomes. I think you're on the right track and I want to see more.

Comment from a member of the public: *I'd like to be sure that there is tracking of people who are seeking these resources who do not qualify in the specific populations that are covered by HRSN.*

Metrics and Scoring Committee

Oregon Health Policy Board:

- 3/5/24: Steph Jarem, 1115 Waiver Policy Director, presented an update on the 1115 waiver. The presentation was focused specifically on key accomplishments to-date, an overview of the climate-related services and an update on the rolling out of the CCBF (infrastructure funds). Board members asked some questions about eligibility categories including definition of clinical need, eligibility for dual coverage members, transitional categories and the member journey. One member asked about evaluation and learnings that will be associated with the demonstration period. They also expressed enthusiasm for the value of these future benefits for OHP members.

All Come Webinars

2/21/24: Steph Jarem, 1115 Waiver Policy Director at OHA, presented an update on HRSN climate services, including covered devices, member eligibility, and social risk factors. The session, which was delivered in English, also outlined recent updates based on CMS feedback and updates on the upcoming CCBF application process.

3/20/24: Steph Jarem, 1115 Waiver Policy Director at OHA, provided an overview of the steps that OHP members will go through to access the new HRSN benefits. The session also included updates on CCBF and the third-party evaluation of the waiver. This was an English language webinar.

Summary of All Come Comments:

During the All-Come Webinars in February and March, participants provided more than 60 different questions and comments to OHA facilitators. Common topics included how to apply for CCBF grants, requests for guidance and clarity on member eligibility, questions about how to enhance CCO-to-member communications and applying for HRSN benefits, and requests for clarity on what services or types of services local HRSN partners are responsible for delivering to members. Our qualitative analysis catalogued the All-Come comments into 14 different themes across both months. The top four, representing 55% of all comments are:

1. Eligibility for services
2. Channels and processes for CCO-to-member communications related to accessing and receiving benefits

3. Scope and delivery of services
4. CCBF grant funding

Partners provided comments on these themes in both February and March. Included below are the themes and examples of comments relating to each theme.

1. Eligibility for services

   Example: "Does incarceration include individuals recently released from an immigration detention center?"
2. Channels and processes for CCO-to-member communications related to accessing and receiving benefits

   Example: "A member received a call from a California number claiming to be from Health-Related Social Needs (HRSN) and asking for PHI. The member was unable to speak at the time but stated they would call back. A concern that highlighted the importance of OHP"
3. Scope and delivery of services

   Example: "The question asks how to determine if we should use Flex funding or the HRSN benefit for climate-related needs."

During qualitative analysis, some comments were flagged as representing equity concerns. Included below are two examples of feedback pertaining to equity:

1. "Will the eligible populations possibly change in the future? There is an exclusion of those who need these resources and do not fit in the current narrow and subjective definition of 'at risk.'"

   Equity concern: Individuals that may need benefits or are on the fringe of eligibility are unable to apply and receive HRSN benefits.
2. "Are clients responsible for repairing/maintaining climate devices? Concerned clients may not take up on offer for devices if they feel they are liable and financially responsible for expensive electronics."

   Equity concern: Members may not have the financial capability to pay for or perform maintenance on covered devices, especially after the initial 12-month warranty period.

Para Todos Webinars

2/21/24: Kristty Polanco, OHA Operations and Policy Analyst, presented an update on HRSN climate services, including covered devices, member eligibility, and social risk factors. The session, which was delivered in Spanish, also outlined recent updates based on CMS feedback and updates on the upcoming CCBF application process.

3/20/24: Kristty Polanco, OHA Operations and Policy Analyst, provided an overview of the steps that OHP members will go through to access the new HRSN benefits. The session also included updates on CCBF and the third-party evaluation of the waiver. This was a Spanish language webinar.

Summary of Para Todos Comments:

In the February and March Para Todos sessions, participants asked questions and made comments about the program timeline, accessing resources on HRSN benefit information, and how community-based organizations (CBOs) deliver services to the community. In total, nine comments were received in Spanish during the reporting period. Most consisted of general questions or comments about timelines, when services would be

available, and where to find more information. Four themes arose from the qualitative review of the Spanish language comments:

1. Billing and reimbursement processes
2. Reimbursement models for smaller CBOs
3. Processes for members to access benefits
4. CCBF grant funding

One comment was flagged as representing an equity concern. The comment is included below in the original Spanish followed by an English translation:

1. Ustedes preguntaron que qué nos gustaria tener a disposicion para nosotros, seria bueno que hubiera algunos talleres o asesoria de como llenar grants, no todas las organizaciones tienen personal 100% capacitado para llenar este tipo de grants y de alguna manera las pequenas organizaciones quedan en desventaja con las grandes organizaciones que ya tienen personal especifico para escribir por grants y siempre obtienen los fondos.

   You asked what we would like to have available for us, it would be good to have some workshops or advice on how to fill out grants, as not all organizations have 100% trained staff to help fill out these types of grants and somehow small organizations are at a disadvantage with large organizations that already have trained staff to write grants and they always get the funds.

   Equity concern: Smaller CBOs do not have the financial or staffing resources to efficiently apply for benefits and operate in the existing reimbursement model. These smaller CBOs often serve populations who have historically faced and/or currently face structural and policy barriers to accessing Medicaid and other government services.

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, OHA has provided a brief overview of implementation progress and milestones, including community/systems engagement and IT configuration. 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.

Oregon has completed 91 percent of the state's 1.5 million renewals for the public health emergency unwinding and more than four out of five Oregonians are keeping their Oregon Health Plan (OHP) or other Medicaid benefits.

Currently, Oregon has an 82 percent renewal rate, which continues to be the third highest in a national comparison of state renewal rates. Oregon's high renewal rates are due to proactive efforts by the state to keep people covered, including extended response timelines, and the upcoming launch of OHP Bridge for adults with higher incomes. Of those renewals, more than 36 percent are children and young adults, age 0 to 19.

An update this month to the state's ONE Eligibility system will enable Oregon to use an improved process for the remaining renewals. These changes are a substantial set of small adjustments to the renewal process that together will make it easier for the people of Oregon to keep their medical benefits.

Early Periodic Screening, Diagnosis and Treatment

The EPSDT team is moving forward with the addition of the lead screening rules into the EPSDT rules division. A RAC exception was approved after consultation with rule coordinators. The public comment period is now closed, and public comment for legislators is open.

OHA is partnering with the Public Health Division (PHD) on community engagement and provider education to increase awareness on the requirement of lead screening for OHP-enrolled children.

The Young Adults with Special Health Care Needs (YSHCN On May 16th, in collaboration with the CCO QA team, The EPSDT leads met with the CCO for whom we had conducted a review of denial notices in April (due to a grievance filed against the CCO for how it was denying services). The CCO had been presented with the findings of the review by letter, and we met to discuss the actions being taken by the CCO in response to the findings. The findings had predominantly showed that dental services were not being reviewed for medical necessity and dental appropriateness and may have been inappropriately denied for EPSDT members. The CCO's dental contractors attended the meeting and detailed the steps they are taking to correct their processes, and the CCO described how they are providing oversight of their contractors' processes. A follow-up review is planned to ensure the updated processes are working correctly; timeline is TBD.

Engagements with CCOs work began in April. These engagements provide a refresher to CCOs about EPSDT requirements as well as noting that CCOs will need to provide EPSDT coverage to YSHCN members up to their 26th birthday.

In order to fully implement EPSDT we have hired a matrixed position with the MMIS team and are working on system changes those include a change request for reporting purposes (distinguishing between EPSDT and family planning services). We are starting the requirements phase (documenting what is needed) of this CR #176222. We are tracking status as this change will require development of a billing guide to reflect these changes.

New: 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.

Since the start of the full scope implementation of EPSDT, we have made some updates in the school-based health services claim processing. Reference the claims processing above. The SBHS claims for 6–21-year-olds are being reviewed for medical necessity and medical appropriateness.

- We realized a need for school-based provider education with the implementation of EPSDT program. On May 13, we sent out a memorandum to the school districts explaining EPSDT and the claims process. We will be adding to our website as well.
- Development of a provider guidance document is in progress to specifically highlight the changes in school-based services coverage, written authorization requirements, billing and reimbursement process.

The intersection of BH and EPSDT continues and the work to have the BH system match the Physical Health side for reviewing claims continues.

- The Young Adult Service Planning group (18-21) continues to meet, and some sub workgroups are being 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.
- BHMC which is the clinical team for BH meets weekly to work through BH/MH needs for EPSDT population
- The EPSDT team continues it work with the other 1115 Waiver implementation teams: Health-Related Social Needs (HRSN) – EPSDT, YSHCN and the Nutrition workstream leads meet together and are coordinating policy decisions and implementation.
- Young Adults with Special Health Care Needs (YSHCN) – YSHCN rules are being drafted and the EPSDT team is participating in review. Changes include updates to the definition of EPSDT Beneficiary to include YSHCN effective 1/1/25. The project manager for the YSHCN workstream is also the Project Manager for EPSDT. The EPSDT lead and the project manager for both EPSDT/YSCHN participate in bi-weekly meetings with YSHCN staff on waiver implementation and monthly meetings with YSHCN staff and ODDS colleagues. The EPSDT lead continues to participate on the YSHCN Policy Oversight Committee.
- Youth in Carceral Settings – Ongoing: This team has been in transition. The EPSDT team has met with the new team and will continue to meet with team members. This population will receive Screening and Diagnosis up to 90 days prior to release. Upon release will be enrolled in OHP and then receive Treatment and care coordination.

Expanded Access to Supports that Address Health-Related Social Needs

Between January and March of 2024, significant progress was made related to the implementation of Oregon's HRSN services. In February, Oregon received CMS approval of the HRSN Services Protocol and New Initiatives Implementation Plan (NNIP). Approval of the Services Protocol and NIIP allowed Oregon to finalize the CCO HRSN Contract Amendment the Third-Party Contractor (TPC) HRSN Contract for Fee-For-Service (FFS), an HRSN Guidance Document for CCOs, and various tools such as an HRSN Eligibility Screening Template.

The approval of the Services Protocol prompted an update to Oregon Administrative Rules (OARs). A Rules Advisory Committee (RAC) was convened on March 14th to gather feedback on proposed rule changes needed to align with the approved Services Protocol.

In addition to the CMS-approved HRSN Services Protocol, to support the development of contracts, rules, and guidance, Oregon staff facilitated four CCO HRSN work sessions to gather feedback related to the

implementation of HRSN Climate-Related Supports and Outreach and Engagement Services, specifically addressing the tops of data sharing, ICD-codes for clinical risk criteria, and CCBF. The work sessions also included the review of member and provider journeys, tools used to clarify the process and steps involved in accessing HRSN services. Finally, with the implementation of the HRSN Climate-Related Supports in March, the focus of the CCO HRSN work sessions shifted to discussions on eligibility for HRSN housing and nutrition services, which will implemented in November of 2024 and January for 2025.

On March 1, Oregon opened the application window for the CCBF grant program. The grant program is being administered by CCOs, who will disburse DSHP infrastructure funds to support eligible community partners develop capacity to provide HRSN services. The funding application window closes May 31, 2024. CCOs will be required to report to the state on key elements, which will inform subsequent years of CCBF. Tribal Governments will receive a set aside amount of this funding to be administered through a different process.

Oregon staff also facilitated five external engagements (in addition to the public engagements described above) to share information about HRSN services and gather feedback. Specifically, staff facilitated three HRSN partner sessions to gather feedback on proposed policy and HRSN tools, as well as one housing partner session to gather feedback on HRSN housing eligibility and service definitions. Finally, staff conducted one training session for potential HRSN Service Providers, which addressed HRSN Provider Qualifications and the Medicaid Provider enrollment process.

Progress was also made on identifying changes needed to enhance MMIS functionality to be able to facilitate service-based payments for HRSN Services. This functionality is on track to be implemented by July of 2024.

To further support the HRSN implementation work, Oregon hired two new staff between January and March 2024 to work full time on HRSN Services.

During this quarter, Oregon continued to meet with CMS on a biweekly cadence to discuss questions related to external 1115 waiver evaluation requirements and additional CMS deliverables.

Designated State Health Programs

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

- Medicaid coverage to YSCHN
- HRSN for eligible OHP members
- HRSN capacity building for community partners

In March 2024, Oregon began claiming DSHP on some of the 14 approved programs. Through March, Oregon had claimed 50% match on $23 million in expenditures. An additional 13 programs are pending CMS approval.

Alignment with tribal partners' priorities

Between January and March 2024, Oregon's staff working on implementing HRSN services continued to partner with OHA's Office of Tribal Affairs to facilitate a Tribal HRSN Work Session to design HRSN Climate-Related Supports with Tribal leaders. Additionally, on March 8, the OHA Tribal Affairs team sent a Dear Tribal Leader Letter to the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program offering consultation and confer on HRSN Community Capacity Building Funding. To support Tribal

investments, Oregon has set aside 10% of the total CCBF authorized amount to support Tribes in delivering HRSN Services.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately

2. State reported enrollment table

Enrollment	January/2024	February/2024	March/2024
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,311,490	1,301,839	1,306,627
Title XXI funded State Plan	144,063	138,415	135,250
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%	42,825	127,063	-45%	-49.20%
Optional	**Title XIX**	PLM women FPL 133-170%	N/A	N/A	N/A	N/A
	Title XXI	SCHIP FPL < 170%	103,238	290,014	-44.00%	-40.58%
Mandatory	**Title XIX**	Other OHP Plus	488,314	1,323,159	37.00%	115.37%
		MAGI adults/children	1,010,012	2,804,451	-1.50%	0.17%

		MAGI pregnant women	20,285	51,179	1.80%	1.51%
		QUARTER TOTALS	1,621,849			
** Due to retroactive eligibility changes, the numbers should be considered preliminary*						

OHP eligible and managed care enrollment

OHP eligible*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
January	1,420,719	1,329,155	68	59	10,053	81,247	N/A
February	1,418,997	1,330,226	65	57	10,043	78,861	N/A
March	1,411,139	1,323,667	59	52	9,986	76,890	N/A
Quarter average	1,416,952	1,327,683	64	60	10,027	78,999	

** Total OHP eligibles include TANF, GA, PLM-Adults, PLM-Children, MAGI Adults/Children, MAGI Pregnant Women, OAA, ABAD, CHIP, FC, and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.*
***CCOA: Physical, dental and mental health; CCOB: Physical and mental health; CCOE: Mental health only; and CCOG: Mental and dental health*

B. Complaints and grievances

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

C. CCO appeals and hearings

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

D. Neutrality reports (reported separately)

CHIP Statistical Enrollment Data Reports

Form 21E | OR | 2024 | Quarter 2

Conception to birth:

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

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

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

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

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

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

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

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

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.0	0	2.0	0	0	**2.0**
B. Managed Care Arrangements	0	0	0	0	0	**0.0**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**2.0**	**0.0**	**2.0**	**0.0**	**0.0**	**2.0**

Values will not appear until source data is provided

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

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

Birth through age 12 months:

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

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

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

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

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

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

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

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

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	0	0	0	0	**0.0**
B. Managed Care Arrangements	0	0	0	0	0	**0.0**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Values will not appear until source data is provided

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

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

Age 1 year through age 5 years:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	1	1	0	0	**2**
B. Managed Care Arrangements	0	76	27	20	0	**123**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**77**	**28**	**20**	**0**	**125**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	0	0	0	0	**0**
B. Managed Care Arrangements	0	9	1	1	0	**11**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**9**	**1**	**1**	**0**	**11**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	0	0	0	0	**0**
B. Managed Care Arrangements	0	5	2	2	0	**9**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**5**	**2**	**2**	**0**	**9**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	3	2	0	0	**5**
B. Managed Care Arrangements	0	224	80	58	0	**362**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**227**	**82**	**58**	**0**	**367**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	3.0	2.0	0	0	**2.5**
B. Managed Care Arrangements	0	2.9	3.0	2.9	0	**2.9**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**0.0**	**2.9**	**2.9**	**2.9**	**0.0**	**2.9**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	1	1	0	0	**2**
B. Managed Care Arrangements	0	74	26	19	0	**119**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**75**	**27**	**19**	**0**	**121**

Age 6 years through age 12 years:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	0	0	1	0	**1**
B. Managed Care Arrangements	0	168	67	74	0	**309**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**168**	**67**	**75**	**0**	**310**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	0	0	0	0	**0**
B. Managed Care Arrangements	0	7	4	7	0	**18**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**7**	**4**	**7**	**0**	**18**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	0	0	1	0	**1**
B. Managed Care Arrangements	0	5	0	8	0	**13**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**5**	**0**	**9**	**0**	**14**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	0	0	1	0	**1**
B. Managed Care Arrangements	0	501	200	210	0	**911**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**501**	**200**	**211**	**0**	**912**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	0	0	1.0	0	**1.0**
B. Managed Care Arrangements	0	3.0	3.0	2.8	0	**2.9**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**0.0**	**3.0**	**3.0**	**2.8**	**0.0**	**2.9**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	0	0	0	0	**0**
B. Managed Care Arrangements	0	165	67	69	0	**301**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**165**	**67**	**69**	**0**	**301**

Age 13 years through age 18 years:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	3	0	2	0	**5**
B. Managed Care Arrangements	0	110	50	72	0	**232**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**113**	**50**	**74**	**0**	**237**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	0	0	0	0	**0**
B. Managed Care Arrangements	0	3	0	7	0	**10**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**3**	**0**	**7**	**0**	**10**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	0	0	0	0	**0**
B. Managed Care Arrangements	0	12	0	6	0	**18**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**12**	**0**	**6**	**0**	**18**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	9	0	6	0	**15**
B. Managed Care Arrangements	0	317	150	208	0	**675**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**326**	**150**	**214**	**0**	**690**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	3.0	0	3.0	0	**3.0**
B. Managed Care Arrangements	0	2.9	3.0	2.9	0	**2.9**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**0.0**	**2.9**	**3.0**	**2.9**	**0.0**	**2.9**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	3	0	1	0	**4**
B. Managed Care Arrangements	0	103	50	67	0	**220**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**106**	**50**	**68**	**0**	**224**

Add any notes here to accompany the form submission:

Form 21E | OR | 2024 | Quarter 2

CHIP Statistical Enrollment Data Reports

Form 64.EC | OR | 2024 | Quarter 2

Birth through age 12 months:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	691	0	0	0	0	**691**
B. Managed Care Arrangements	20,423	0	0	0	0	**20,423**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**21,114**	**0**	**0**	**0**	**0**	**21,114**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	498	0	0	0	0	**498**
B. Managed Care Arrangements	10,388	0	0	0	0	**10,388**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**10,886**	**0**	**0**	**0**	**0**	**10,886**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	37	0	0	0	0	**37**
B. Managed Care Arrangements	351	0	0	0	0	**351**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**388**	**0**	**0**	**0**	**0**	**388**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	1,182	0	0	0	0	**1,182**
B. Managed Care Arrangements	57,388	0	0	0	0	**57,388**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**58,570**	**0**	**0**	**0**	**0**	**58,570**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	1.7	0	0	0	0	**1.7**
B. Managed Care Arrangements	2.8	0	0	0	0	**2.8**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**2.8**	**0.0**	**0.0**	**0.0**	**0.0**	**2.8**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	676	0	0	0	0	**676**
B. Managed Care Arrangements	20,267	0	0	0	0	**20,267**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**20,943**	**0**	**0**	**0**	**0**	**20,943**

Age 1 year through age 5 years:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	1,468	0	0	0	0	**1,468**
B. Managed Care Arrangements	85,414	0	0	0	0	**85,414**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**86,882**	**0**	**0**	**0**	**0**	**86,882**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	345	0	0	0	0	**345**
B. Managed Care Arrangements	32,281	0	0	0	0	**32,281**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**32,626**	**0**	**0**	**0**	**0**	**32,626**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	165	0	0	0	0	**165**
B. Managed Care Arrangements	3,612	0	0	0	0	**3,612**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**3,777**	**0**	**0**	**0**	**0**	**3,777**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	3,830	0	0	0	0	**3,830**
B. Managed Care Arrangements	252,179	0	0	0	0	**252,179**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**256,009**	**0**	**0**	**0**	**0**	**256,009**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.6	0	0	0	0	**2.6**
B. Managed Care Arrangements	3.0	0	0	0	0	**3.0**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**2.9**	**0.0**	**0.0**	**0.0**	**0.0**	**2.9**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	1,410	0	0	0	0	**1,410**
B. Managed Care Arrangements	83,373	0	0	0	0	**83,373**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**84,783**	**0**	**0**	**0**	**0**	**84,783**

Age 6 years through age 12 years:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	2,198	0	0	0	0	**2,198**
B. Managed Care Arrangements	104,464	0	0	0	0	**104,464**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**106,662**	**0**	**0**	**0**	**0**	**106,662**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	378	0	0	0	0	**378**
B. Managed Care Arrangements	39,186	0	0	0	0	**39,186**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**39,564**	**0**	**0**	**0**	**0**	**39,564**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	216	0	0	0	0	**216**
B. Managed Care Arrangements	6,207	0	0	0	0	**6,207**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**6,423**	**0**	**0**	**0**	**0**	**6,423**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	5,923	0	0	0	0	**5,923**
B. Managed Care Arrangements	303,025	0	0	0	0	**303,025**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**308,948**	**0**	**0**	**0**	**0**	**308,948**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.7	0	0	0	0	**2.7**
B. Managed Care Arrangements	2.9	0	0	0	0	**2.9**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**2.9**	**0.0**	**0.0**	**0.0**	**0.0**	**2.9**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	2,098	0	0	0	0	**2,098**
B. Managed Care Arrangements	100,399	0	0	0	0	**100,399**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**102,497**	**0**	**0**	**0**	**0**	**102,497**

Age 13 years through age 18 years:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	2,617	0	0	0	0	**2,617**
B. Managed Care Arrangements	90,188	0	0	0	0	**90,188**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**92,805**	**0**	**0**	**0**	**0**	**92,805**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	393	0	0	0	0	**393**
B. Managed Care Arrangements	33,581	0	0	0	0	**33,581**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**33,974**	**0**	**0**	**0**	**0**	**33,974**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	223	0	0	0	0	**223**
B. Managed Care Arrangements	5,018	0	0	0	0	**5,018**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**5,241**	**0**	**0**	**0**	**0**	**5,241**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	7,175	0	0	0	0	**7,175**
B. Managed Care Arrangements	261,985	0	0	0	0	**261,985**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**269,160**	**0**	**0**	**0**	**0**	**269,160**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.7	0	0	0	0	**2.7**
B. Managed Care Arrangements	2.9	0	0	0	0	**2.9**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**2.9**	**0.0**	**0.0**	**0.0**	**0.0**	**2.9**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	2,505	0	0	0	0	**2,505**
B. Managed Care Arrangements	86,821	0	0	0	0	**86,821**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**89,326**	**0**	**0**	**0**	**0**	**89,326**

Age 19 years through age 20 years:

1. What is the unduplicated number of children between the ages of 19 and 20 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	1,214	0	0	0	0	**1,214**
B. Managed Care Arrangements	40,339	0	0	0	0	**40,339**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**41,553**	**0**	**0**	**0**	**0**	**41,553**

2. What is the unduplicated number of new enrollees between the ages of 19 and 20 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	279	0	0	0	0	**279**
B. Managed Care Arrangements	14,466	0	0	0	0	**14,466**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**14,745**	**0**	**0**	**0**	**0**	**14,745**

3. What is the unduplicated number of disenrollees between the ages of 19 and 20 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	137	0	0	0	0	**137**
B. Managed Care Arrangements	3,460	0	0	0	0	**3,460**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**3,597**	**0**	**0**	**0**	**0**	**3,597**

4. What is the number of member-months of enrollment for children between the ages of 19 and 20 in the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	3,198	0	0	0	0	**3,198**
B. Managed Care Arrangements	116,726	0	0	0	0	**116,726**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**119,924**	**0**	**0**	**0**	**0**	**119,924**

5. What is the average number of months of enrollment for children between the ages of 19 and 20 ever enrolled during the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.6	0	0	0	0	**2.6**
B. Managed Care Arrangements	2.9	0	0	0	0	**2.9**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**2.9**	**0.0**	**0.0**	**0.0**	**0.0**	**2.9**

Values will not appear until source data is provided

6. What is the number of children between the ages of 19 and 20 enrolled at the end of the quarter?

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	1,150	0	0	0	0	**1,150**
B. Managed Care Arrangements	38,384	0	0	0	0	**38,384**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**39,534**	**0**	**0**	**0**	**0**	**39,534**

Add any notes here to accompany the form submission:

Form 64.EC | OR | 2024 | Quarter 2

CHIP Statistical Enrollment Data Reports

Form 64.21E | OR | 2024 | Quarter 2

Birth through age 12 months:

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

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

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

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

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

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

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

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

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	0	0	0	0	**0.0**
B. Managed Care Arrangements	0	0	0	0	0	**0.0**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Values will not appear until source data is provided

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

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

Age 1 year through age 5 years:

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

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

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

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

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

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

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

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

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	3.0	0	0	0	0	**3.0**
B. Managed Care Arrangements	0	0	0	0	0	**0.0**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**

Values will not appear until source data is provided

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

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

Age 6 years through age 12 years:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	32,255	0	0	0	0	**32,255**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**32,255**	**0**	**0**	**0**	**0**	**32,255**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	7,830	0	0	0	0	**7,830**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**7,830**	**0**	**0**	**0**	**0**	**7,830**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	6,851	0	0	0	0	**6,851**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**6,851**	**0**	**0**	**0**	**0**	**6,851**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	81,471	0	0	0	0	**81,471**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**81,471**	**0**	**0**	**0**	**0**	**81,471**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.5	0	0	0	0	**2.5**
B. Managed Care Arrangements	0	0	0	0	0	**0.0**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**2.5**	**0.0**	**0.0**	**0.0**	**0.0**	**2.5**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	27,564	0	0	0	0	**27,564**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**27,564**	**0**	**0**	**0**	**0**	**27,564**

Age 13 years through age 18 years:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	26,566	0	0	0	0	**26,566**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**26,566**	**0**	**0**	**0**	**0**	**26,566**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	5,754	0	0	0	0	**5,754**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**5,754**	**0**	**0**	**0**	**0**	**5,754**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	5,604	0	0	0	0	**5,604**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**5,604**	**0**	**0**	**0**	**0**	**5,604**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	67,697	0	0	0	0	**67,697**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**67,697**	**0**	**0**	**0**	**0**	**67,697**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.5	0	0	0	0	**2.5**
B. Managed Care Arrangements	0	0	0	0	0	**0.0**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**2.5**	**0.0**	**0.0**	**0.0**	**0.0**	**2.5**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	22,748	0	0	0	0	**22,748**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**22,748**	**0**	**0**	**0**	**0**	**22,748**

Add any notes here to accompany the form submission:

Form 64.21E | OR | 2024 | Quarter 2

CHIP Statistical Enrollment Data Reports

Form GRE | OR | 2024 | Quarter 2

Conception through age 18 years:

1. What is the number of enrollees by gender?

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
1. Female	199	29,194	**29,393**	170,340	0	**199,733**
2. Male	506	30,389	**30,895**	178,676	0	**209,571**
3. Unspecified Gender	0	0	**0**	0	0	**0**
Totals:	**705**	**59,583**	**60,288**	**349,016**	**0**	**409,304**

2. What is the number of enrollees by race?

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
1. White	244	19,725	**19,969**	125,626	0	**145,595**
2. Black or African American	14	1,233	**1,247**	10,613	0	**11,860**
3. American Indian or Alaska Native	6	707	**713**	6,035	0	**6,748**
4. Asian Indian	0	75	**75**	283	0	**358**
5. Chinese	8	332	**340**	1,267	0	**1,607**
6. Filipino	1	97	**98**	393	0	**491**
7. Japanese	2	12	**14**	75	0	**89**
8. Korean	1	53	**54**	322	0	**376**
9. Vietnamese	11	324	**335**	1,377	0	**1,712**
10. Other Asian	11	431	**442**	2,157	0	**2,599**
11. Asian Unknown	0	0	**0**	109	0	**109**
12. Native Hawaiian	0	30	**30**	286	0	**316**

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
13. Guamanian or Chamorro	0	24	**24**	165	0	**189**
14. Samoan	1	33	**34**	343	0	**377**
15. Other Pacific Islander	1	191	**192**	1,167	0	**1,359**
16. Native Hawaiian or Other Pacific Islander Unknown	4	192	**196**	1,624	0	**1,820**
17. Some other race	27	3,403	**3,430**	19,341	0	**22,771**
18. Two or more races (regardless of ethnicity)	214	13,242	**13,456**	71,817	0	**85,273**
19. Unspecified Race	160	19,479	**19,639**	106,016	0	**125,655**
Totals:	**705**	**59,583**	**60,288**	**349,016**	**0**	**409,304**

3. What is the number of enrollees by ethnicity?

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
1. Not of Hispanic, Latino/a, or Spanish origin	389	29,099	**29,488**	186,002	0	**215,490**
2. Mexican, Mexican American, Chicano/a	0	0	**0**	0	0	**0**
3. Puerto Rican	0	0	**0**	0	0	**0**
4. Cuban	0	0	**0**	1,500	0	**1,500**
5. Another Hispanic, Latino, or Spanish Origin	0	0	**0**	0	0	**0**
6. Hispanic or Latino Unknown	72	11,666	**11,738**	56,145	0	**67,883**
7. Unspecified Ethnicity	244	18,818	**19,062**	105,369	0	**124,431**
Totals:	**705**	**59,583**	**60,288**	**349,016**	**0**	**409,304**

Add any notes here to accompany the form submission:

Form GRE | OR | 2024 | Quarter 2

Appendix B

CY 2024 Q1	Advanced Health	AllCare	Cascade Health	Columbia Pacific	Eastern Oregon
ACCESS - "A"					
TOTAL:	26	8	13	15	63
PENDING:	0	0	0	0	0
RESOLVED:	26	8	13	15	63
INTERACTION WITH PROVIDER OR PLAN - "IP"					
TOTAL:	32	19	38	22	122
PENDING:	0	0	0	0	0
RESOLVED:	32	19	38	22	122
CONSUMER RIGHTS - "CR"					
TOTAL:	7	13	1	4	28
PENDING:	0	0	0	0	0
RESOLVED:	7	13	1	4	28
Quality-of-Care - "QC"					
TOTAL:	28	14	0	6	35
PENDING:	0	0	0	0	0
RESOLVED:	28	14	0	6	35
QUALITY OF SERVICE - "QS"					
TOTAL:	7	2	2	3	9
PENDING:	0	0	0	0	0
RESOLVED:	7	2	2	3	9
CLIENT BILLING ISSUES - "CB"					
TOTAL:	66	0	2	13	13
PENDING:	0	0	0	0	0
RESOLVED:	66	0	2	13	13
OTHER	0	0	0	0	0
PENDING:	0	0	0	0	0
GRAND TOTAL	166	56	56	63	270
Enrollment Numbers: as of 3/31/2024	29,442	68,164	27,562	31,842	81,791
Per 1000 members:	5.64	0.82	2.03	1.98	3.30

Health Share	IHN	Jackson Care	PCSC CG	PCSC CO	PCSC Lane	PCSC MP	Trillium Lane	Trillium TriCo
678	57	38	15	110	245	245	48	18
0	0	0	0	0	0	0	0	0
678	57	38	15	110	245	245	48	18
752	102	40	10	63	147	139	39	26
0	0	0	0	0	0	0	0	0
752	102	40	10	63	147	139	39	26
133	28	9	1	22	36	36	5	2
0	0	0	0	0	0	0	0	0
133	28	9	1	22	36	36	5	2
310	24	16	3	13	45	48	11	1
0	0	0	0	0	0	0	0	0
310	24	16	3	13	45	48	11	1
57	15	6	0	10	9	23	8	3
0	0	0	0	0	0	0	0	0
57	15	6	0	10	9	23	8	3
106	20	26	2	19	18	25	38	68
0	0	0	0	0	0	0	0	0
106	20	26	2	19	18	25	38	68
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
2036	246	135	31	237	500	516	149	118
481,302	88,795	58,518	18,210	76,599	91,832	151,752	37,835	65,623
4.23	2.77	2.31	1.70	3.09	5.44	3.40	3.94	1.80

* This quarter NOTE: This quarter Yamhill Community Coordinated Care Organization received an ex
challenges following the implementation of a new A&G system. Updated data will be provided in t

Umpqua	*Yamhill County	FFS	Totals
33	0	36	1648
0	0	0	0
33	0	36	1648
31	0	7	1589
0	0	0	0
31	0	7	1589
17	0	7	349
0	0	0	0
17	0	7	349
4	0	54	612
0	0	0	0
4	0	54	612
14	0	30	198
0	0	0	0
14	0	30	198
6	0	16	438
0	0	0	0
6	0	16	438
0	0	0	0
0	0	0	0
105	0	150	4834
41,103	-	255,406	1,605,776
2.55	0.00	0.59	3.01

tension to submit their report to OHA due to
he next April – June 2024 reporting period.

Appendix C

Hearing Outcome Types Completed
DY22 Q2

PlanName	Affirmed	Client Failed to Appear	Clients Withdrew Hearing Request	Decisions Overturned by OHA (FFS)	Decisions Overturned by Plan	Dismissed as Not Hearable	Dismissed as Not Hearable - No Appeal	Dismissed as Not Timely	Reversed	Set Aside
ADVANCED HEALTH			3				4			
ALLCARE HEALTH PLAN, INC.			2		2		5			
CASCADE HEALTH ALLIANCE			1		1					
COLUMBIA PACIFIC CCO, LLC			2				2			
EASTERN OREGON CCO, LLC		1			1		1			
HEALTH SHARE of Oregon	12	3	19		5	10	49			1
INTERCOMMUNITY HEALTH NETWORK			1		3	1	4			
JACKSON CARE CONNECT	1				2		5			
PACIFICSOURCE COMM. SOLUTIONS - Central			2				6			
PACIFICSOURCE COMM. SOLUTIONS - Gorge	2		1		1		2			
PACIFICSOURCE COMM. SOLUTIONS - Lane	2	1	6		2	7	27			
PACIFICSOURCE COMM. SOLUTIONS - Marion Polk	5	2	10		3		21			
TRILLIUM COMM. HEALTH PLAN						3	5			
TRILLIUM COMM. HEALTH PLAN - Tri-County		2			3	1	4			
UMPQUA HEALTH ALLIANCE		1	1			2	3			
YAMHILL CO CARE ORGANIZATION	1						4			
FFS	1	2	9	5		2		2		
Total	**24**	**12**	**57**	**5**	**23**	**26**	**142**	**2**	**0**	**1**

Data Source: DSS
Data Extraction Date: 04/22/2024
Data Analyst: Rosey Ball

Hearing Request's Received DY22 Q2
by CCO and FFS

PlanName	Hearing Requests	Avg. Plan Enrollment *	Per 1000 Members
ADVANCED HEALTH	8	30,694	0.26
ALLCARE HEALTH PLAN, INC.	15	71,607	0.21
CASCADE HEALTH ALLIANCE	1	29,277	0.03
COLUMBIA PACIFIC CCO, LLC	4	41,328	0.10
EASTERN OREGON CCO, LLC	4	84,307	0.05
HEALTH SHARE of Oregon	105	480,886	0.22
INTERCOMMUNITY HEALTH NETWORK	19	93,275	0.20
JACKSON CARE CONNECT	7	71,240	0.10
PACIFICSOURCE COMM. SOLUTIONS - Central	17	83,814	0.20
PACIFICSOURCE COMM. SOLUTIONS - Gorge	8	19,768	0.40
PACIFICSOURCE - Lane	46	99,820	0.46
PACIFICSOURCE - Marion Polk	34	166,993	0.20
TRILLIUM COMM. HEALTH PLAN - Tri-County	10	75,433	0.13
TRILLIUM COMM. HEALTH PLAN	7	40,982	0.17
UMPQUA HEALTH ALLIANCE	7	42,836	0.16
YAMHILL CO CARE ORGANIZATION	4	41,501	0.10
FFS	33	255,406	0.13
Total**	**329**	**1,729,167**	**0.19**

Data Source: DSS
Data Extraction Date: 04/22/2024
Data Analyst: Rosey Ball

*** Avg. Plan Enrollment based on average of Preliminary Member Months for January, February and March**

Hearing Issues Received DY22 Q2

PlanName	Avg. Plan Enrollment *	Ambulance Denial	Per 1000 Members	Billing Issue	Per 1000 Members	Dental Denial	Per 1000 Members	Disenr ollment	Per 1000 Members	DME Denial	Per 1000 Members	ER Denial	Per 1000 Members	Hearing Denial	Per 1000 Members	Mental Health	Per 1000 Members	MISC	Per 1000 Members	Referral Denial	Per 1000 Members	Rx Denial	Per 1000 Members	Surgery Denial	Per 1000 Members	Therapy Denial	Per 1000 Members	Transplant Denial	Per 1000 Members	Transportation	Per 1000 Members	Vision Denial	Per 1000 Members
ADVANCED HEALTH	30,694		0.00	2	0.07	2	0.07		0.00		0.00		0.00		0.00		0.00		0.00	3	0.10	1	0.03		0.00		0.00		0.00		0.00		0.00
ALLCARE HEALTH PLAN, INC.	71,607		0.00	2	0.03	4	0.06		0.00		0.00		0.00		0.00		0.00		0.00	3	0.04	3	0.04	3	0.04		0.00		0.00		0.00		0.00
CASCADE HEALTH ALLIANCE	29,277		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	1	0.03		0.00		0.00		0.00		0.00		0.00		0.00
COLUMBIA PACIFIC CCO, LLC	41,328		0.00	1	0.02		0.00		0.00	1	0.02		0.00		0.00		0.00		0.00		0.00		0.00	2	0.05		0.00		0.00		0.00		0.00
EASTERN OREGON CCO, LLC	84,307		0.00	1	0.01	1	0.01		0.00		0.00		0.00		0.00		0.00		0.00	1	0.01		0.00	1	0.01		0.00		0.00		0.00		0.00
HEALTH SHARE OF OREGON	480,886		0.00	38	0.08	19	0.04		0.00	6	0.01		0.00		0.00		0.00	1	0.00	8	0.02	13	0.03	17	0.04	3	0.01		0.00		0.00		0.00
INTERCOMMUNITY HEALTH NETWORK	93,275		0.00	1	0.01	1	0.01		0.00	1	0.01		0.00		0.00		0.00		0.00	4	0.04	8	0.09	4	0.04		0.00		0.00		0.00		0.00
JACKSON CARE CONNECT	71,240		0.00	4	0.06		0.00		0.00	1	0.01		0.00		0.00		0.00		0.00		0.00	1	0.01		0.00		0.00		0.00		0.00		0.00
PACIFICSOURCE COMM. SOLUTIONS - Central	83,814		0.00	26	0.31	2	0.02		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	1	0.01		0.00		0.00	1	0.01		0.00
PACIFICSOURCE COMM. SOLUTIONS - Gorge	19,768		0.00	4	0.20		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	4	0.20		0.00		0.00		0.00		0.00
PACIFICSOURCE COMM. SOLUTIONS - Lane	99,820		0.00	13		5	0.05		0.00	1	0.01		0.00		0.00	1	0.01	1	0.01	1		3	0.03	5	0.05		0.00		0.00	17	0.17		0.00
PACIFICSOURCE COMM. SOLUTIONS - Marion Polk	166,993		0.00	13		3	0.02		0.00	5	0.03		0.00		0.00		0.00		0.00	4		1	0.01	8	0.05		0.00		0.00		0.00		0.00
TRILLIUM COMM. HEALTH PLAN TRI-COUNTY	75,433		0.00	4	0.05		0.00		0.00		0.00		0.00		0.00	2	0.03		0.00	2	0.03	2	0.03		0.00		0.00		0.00		0.00		0.00
TRILLIUM COMM. HEALTH PLAN	40,982		0.00	1		1			0.00				0.00		0.00							2		3							0.00		0.00
UMPQUA HEALTH ALLIANCE	42,836		0.00	1	0.02		0.00		0.00		0.00		0.00		0.00		0.00		0.00	5	0.12	1	0.02		0.00		0.00		0.00		0.00		0.00
YAMHILL CO CARE ORGANIZATION	41,501		0.00	3	0.07		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	1	0.02		0.00		0.00		0.00		0.00
FFS	255,406		0.00	0	0.00	0	0.00	1	0.00	4	0.02		0.00	0	0.00	4	0.02	2	0.00	3	0.01	13	0.05	2	0.01	1	0.00		0.00	4	0.02		0.00
Total	**1,729,167**	**0**	0.00	**114**	0.07	**38**	0.02	**1**	0.00	**19**	0.01	**0**	0.00	**0**	0.00	**7**	0.00	**4**	0.00	**35**	0.02	**48**	0.03	**51**	0.03	**4**	0.00	**0**	0.00	**22**	0.01	**0**	0.00

Data Source: DSS
Data Extraction Date: 04/22/2024
Data Analyst: Rosey Ball

*** Avg. Plan Enrollment based on average of Preliminary Member Months for January, February and March 2024.**

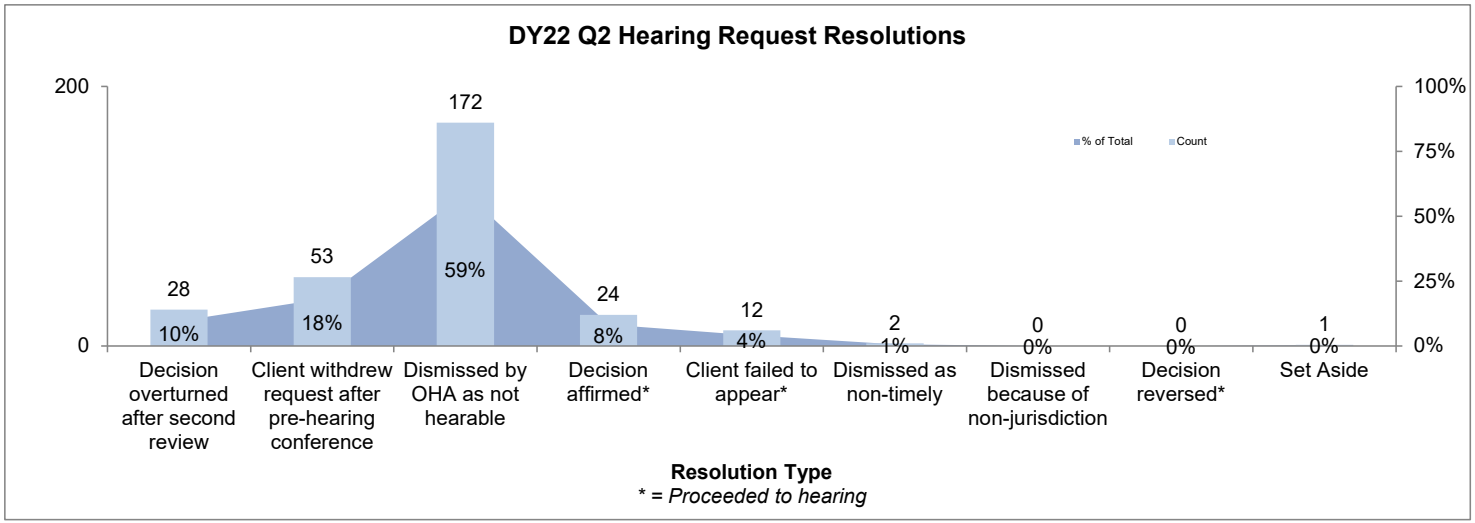
Hearing Outcomes Completed DY22 Q2

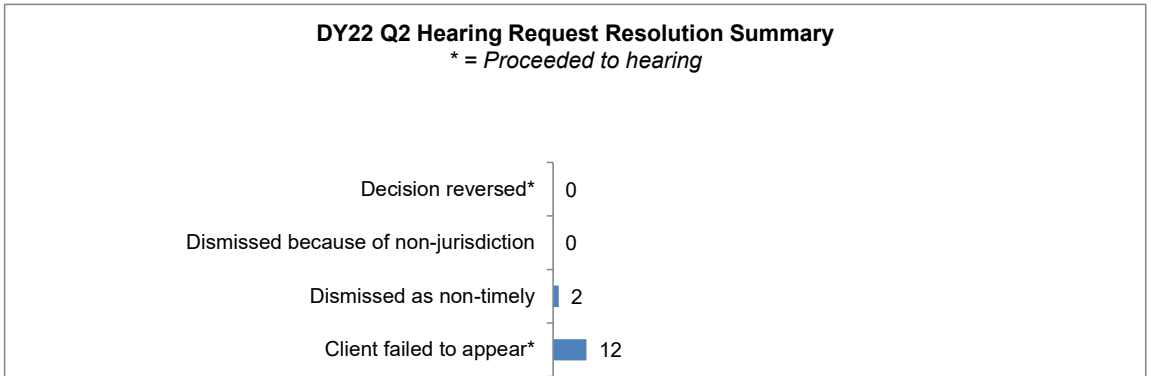
PlanName	Total Hearing Outcomes	Avg. Plan Enrollment *	Per 1000 Members
ADVANCED HEALTH	7	30,694	0.23
ALLCARE HEALTH PLAN, INC.	9	71,607	0.13
CASCADE HEALTH ALLIANCE	2	29,277	0.07
COLUMBIA PACIFIC CCO, LLC	4	41,328	0.10
EASTERN OREGON CCO, LLC	3	84,307	0.04
HEALTH SHARE of Oregon	99	480,886	0.21
INTERCOMMUNITY HEALTH NETWORK	9	93,275	0.10
JACKSON CARE CONNECT	8	71,240	0.11
PACIFICSOURCE COMM. SOLUTIONS - Central	8	83,814	0.10
PACIFICSOURCE COMM. SOLUTIONS - Gorge	6	19,768	0.30
PACIFICSOURCE COMM. SOLUTIONS - Lane	45	99,820	0.45
PACIFICSOURCE COMM. SOLUTIONS - Marion Polk	41	166,993	0.25
TRILLIUM COMM. HEALTH PLAN - Tri County	8	75,433	0.11
TRILLIUM COMM. HEALTH PLAN	10	40,982	0.24
UMPQUA HEALTH ALLIANCE, DCIPA	7	42,836	0.16
YAMHILL CO CARE ORGANIZATION	5	41,501	0.12
FFS	21	255,406	0.08
Total	**292**	**1,729,167**	0.17

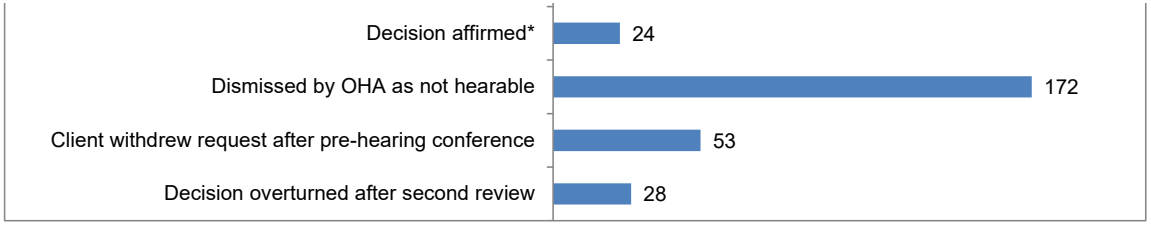
Data Source: DSS
Data Extraction Date: 04/22/2024
Data Analyst: Rosey Ball

*** Avg. Plan Enrollment based on average of Preliminary Member Months for January, February and March 2**

Outcome	Count	% of Total
Decision overturned after second review	28	10%
Client withdrew request after pre-hearing	53	18%
Dismissed by OHA as not hearable	172	59%
Decision affirmed*	24	8%
Client failed to appear*	12	4%
Dismissed as non-timely	2	1%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	0	0%
Set Aside	1	0%
	292	



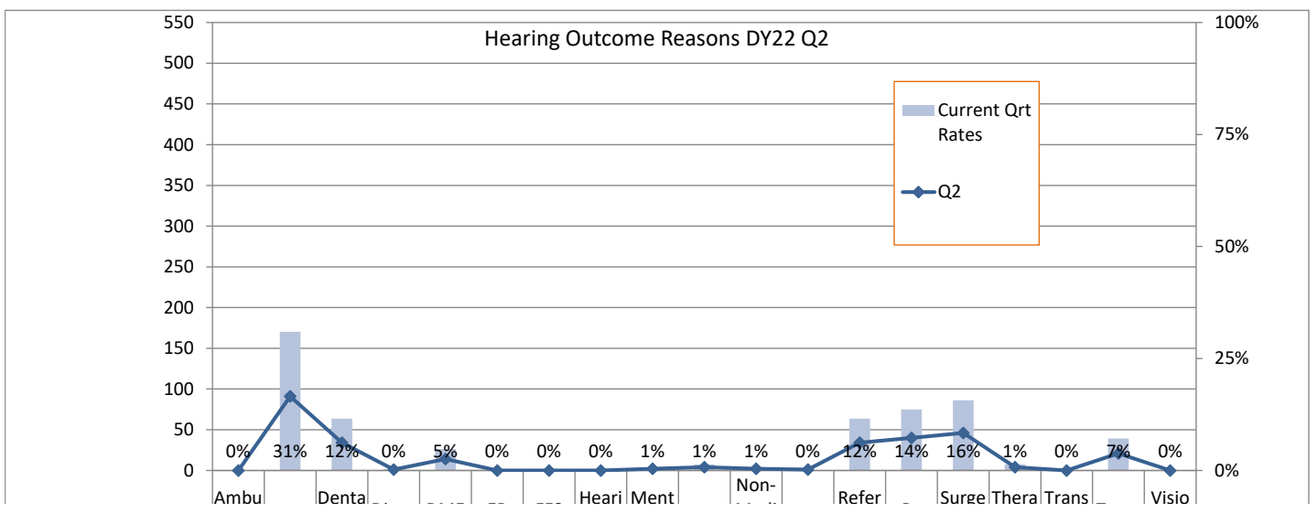




Data Source: DSS
Data Extraction Date: 04/22/2024
Data Analyst: Rosey Ball

Hearing Outcome Reasons DY22 Q2

Issues	Q2	Current Qrt Rates
Ambulance Denial	0	0%
Billing Issue	91	31%
Dental Denial	34	12%
Disenrollment	1	0%
DME Denial	14	5%
ER Denial	0	0%
FFS Denial	0	0%
Hearing Denial	0	0%
Mental Health	2	1%
Misc.	4	1%
Non-Medical Hearing	2	1%
Provider	1	0%
Referral Denial	34	12%
Rx Denial	40	14%
Surgery Denial	46	16%
Therapy Denial	4	1%
Transplant Denial	0	0%
Transportation	21	7%
Vision Denial	0	0%
	294	



DataSource:New_HearingLog.mdb FOM Reports
Data Extraction Date: 06/10/2013
Data Analyst: Kim Rose

	Ambulance Denial	Billing Issue	Dental Denial	Disenrollment	DME Denial	ER Denial	FFS Denial	Hearing Denial	Mental Health	Misc.	Medical Hearing	Provider	Referral Denial	Rx Denial	Surgery Denial	Therapy Denial	Transplant Denial	Transportation	Vision Denial
Current Qrt Rates	0%	31%	12%	0%	5%	0%	0%	0%	1%	1%	1%	0%	12%	14%	16%	1%	0%	7%	0%
Q2	0	91	34	1	14	0	0	0	2	4	2	1	34	40	46	4	0	21	0

Data Source: DSS
Data Extraction Date: 04/22/2024
Data Analyst: Rosey Ball

Outomes by Issue and Plan - DY22 Q2

Plan Name	Outcome Description
ADVANCED HEALTH	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN
ADVANCED HEALTH	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN
ADVANCED HEALTH	CLIENT W/D C7-NON-COVERED/EXCLUDED SERVICE
ADVANCED HEALTH	NOT HEARABLE-NO APPEAL
ADVANCED HEALTH	NOT HEARABLE-NO APPEAL
ALLCARE CCO	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN
ALLCARE CCO	CLIENT W/D C7-NON-COVERED/EXCLUDED SERVICE
ALLCARE CCO	NOT HEARABLE-NO APPEAL
ALLCARE CCO	NOT HEARABLE-NO APPEAL
ALLCARE CCO	NOT HEARABLE-NO APPEAL
ALLCARE CCO	PLAN WILL PAY P1-SERVICE AUTHORIZED
ALLCARE CCO	PLAN WILL PAY P1-SERVICE AUTHORIZED
CASCADE HEALTH ALLIANCE	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN
CASCADE HEALTH ALLIANCE	PLAN WILL PAY P1-SERVICE AUTHORIZED
COLUMBIA PACIFIC	CLIENT W/D C5-BILLING ISSUE
COLUMBIA PACIFIC	CLIENT W/D C7-NON-COVERED/EXCLUDED SERVICE
COLUMBIA PACIFIC	NOT HEARABLE-NO APPEAL
COLUMBIA PACIFIC	NOT HEARABLE-NO APPEAL
EASTERN OREGON CCO	NO SHOW
EASTERN OREGON CCO	NOT HEARABLE-NO APPEAL
EASTERN OREGON CCO	PLAN WILL PAY P1-SERVICE AUTHORIZED
HEALTH SHARE OF OREGON	AFFIRMED
HEALTH SHARE OF OREGON	AFFIRMED
HEALTH SHARE OF OREGON	AFFIRMED
HEALTH SHARE OF OREGON	AFFIRMED
HEALTH SHARE OF OREGON	CLIENT W/D C1-BELOW THE LINE
HEALTH SHARE OF OREGON	CLIENT W/D C5-BILLING ISSUE
HEALTH SHARE OF OREGON	CLIENT W/D C5-BILLING ISSUE
HEALTH SHARE OF OREGON	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN
HEALTH SHARE OF OREGON	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN
HEALTH SHARE OF OREGON	CLIENT W/D C7-NON-COVERED/EXCLUDED SERVICE
HEALTH SHARE OF OREGON	CLIENT W/D C7-NON-COVERED/EXCLUDED SERVICE
HEALTH SHARE OF OREGON	CLIENT W/D C7-NON-COVERED/EXCLUDED SERVICE
HEALTH SHARE OF OREGON	CLIENT W/D C7-NON-COVERED/EXCLUDED SERVICE
HEALTH SHARE OF OREGON	NO SHOW
HEALTH SHARE OF OREGON	NO SHOW
HEALTH SHARE OF OREGON	NOT HEARABLE
HEALTH SHARE OF OREGON	NOT HEARABLE
HEALTH SHARE OF OREGON	NOT HEARABLE
HEALTH SHARE OF OREGON	NOT HEARABLE
HEALTH SHARE OF OREGON	NOT HEARABLE
HEALTH SHARE OF OREGON	NOT HEARABLE-NO APPEAL
HEALTH SHARE OF OREGON	NOT HEARABLE-NO APPEAL
HEALTH SHARE OF OREGON	NOT HEARABLE-NO APPEAL
HEALTH SHARE OF OREGON	NOT HEARABLE-NO APPEAL
HEALTH SHARE OF OREGON	NOT HEARABLE-NO APPEAL
HEALTH SHARE OF OREGON	NOT HEARABLE-NO APPEAL
HEALTH SHARE OF OREGON	NOT HEARABLE-NO APPEAL
HEALTH SHARE OF OREGON	PLAN WILL PAY P1-SERVICE AUTHORIZED
HEALTH SHARE OF OREGON	PLAN WILL PAY P1-SERVICE AUTHORIZED
HEALTH SHARE OF OREGON	PLAN WILL PAY P1-SERVICE AUTHORIZED
HEALTH SHARE OF OREGON	PLAN WILL PAY P1-SERVICE AUTHORIZED
HEALTH SHARE OF OREGON	
INTERCOMMUNITY HEALTH NETWORK	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN

INTERCOMMUNITY HEALTH NETWORK	NOT HEARABLE
INTERCOMMUNITY HEALTH NETWORK	NOT HEARABLE-NO APPEAL
INTERCOMMUNITY HEALTH NETWORK	NOT HEARABLE-NO APPEAL
INTERCOMMUNITY HEALTH NETWORK	NOT HEARABLE-NO APPEAL
INTERCOMMUNITY HEALTH NETWORK	PLAN WILL PAY P1-SERVICE AUTHORIZED
INTERCOMMUNITY HEALTH NETWORK	PLAN WILL PAY P1-SERVICE AUTHORIZED
JACKSON CARE CONNECT	AFFIRMED
JACKSON CARE CONNECT	NOT HEARABLE-NO APPEAL
JACKSON CARE CONNECT	NOT HEARABLE-NO APPEAL
JACKSON CARE CONNECT	PLAN WILL PAY P1-SERVICE AUTHORIZED
JACKSON CARE CONNECT	PLAN WILL PAY P1-SERVICE AUTHORIZED
PACIFICSOURCE CENTRAL	CLIENT W/D C5-BILLING ISSUE
PACIFICSOURCE CENTRAL	CLIENT W/D C7-NON-COVERED/EXCLUDED SERVICE
PACIFICSOURCE CENTRAL	NOT HEARABLE-NO APPEAL
PACIFICSOURCE CENTRAL	NOT HEARABLE-NO APPEAL
PACIFICSOURCE CENTRAL	NOT HEARABLE-NO APPEAL
PACIFICSOURCE GORGE	AFFIRMED
PACIFICSOURCE GORGE	CLIENT W/D C1-BELOW THE LINE
PACIFICSOURCE GORGE	NOT HEARABLE-NO APPEAL
PACIFICSOURCE GORGE	NOT HEARABLE-NO APPEAL
PACIFICSOURCE GORGE	PLAN WILL PAY P1-SERVICE AUTHORIZED
PACIFICSOURCE LANE	AFFIRMED
PACIFICSOURCE LANE	CLIENT W/D C5-BILLING ISSUE
PACIFICSOURCE LANE	CLIENT W/D C5-BILLING ISSUE
PACIFICSOURCE LANE	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN
PACIFICSOURCE LANE	CLIENT W/D C7-NON-COVERED/EXCLUDED SERVICE
PACIFICSOURCE LANE	NO SHOW
PACIFICSOURCE LANE	NOT HEARABLE
PACIFICSOURCE LANE	NOT HEARABLE
PACIFICSOURCE LANE	NOT HEARABLE
PACIFICSOURCE LANE	NOT HEARABLE-NO APPEAL
PACIFICSOURCE LANE	NOT HEARABLE-NO APPEAL
PACIFICSOURCE LANE	NOT HEARABLE-NO APPEAL
PACIFICSOURCE LANE	NOT HEARABLE-NO APPEAL
PACIFICSOURCE LANE	NOT HEARABLE-NO APPEAL
PACIFICSOURCE LANE	NOT HEARABLE-NO APPEAL
PACIFICSOURCE LANE	PLAN WILL PAY P1-SERVICE AUTHORIZED
PACIFICSOURCE LANE	PLAN WILL PAY P1-SERVICE AUTHORIZED
PACIFICSOURCE MARION POLK	AFFIRMED
PACIFICSOURCE MARION POLK	AFFIRMED
PACIFICSOURCE MARION POLK	AFFIRMED
PACIFICSOURCE MARION POLK	AFFIRMED
PACIFICSOURCE MARION POLK	CLIENT W/D C5-BILLING ISSUE
PACIFICSOURCE MARION POLK	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN
PACIFICSOURCE MARION POLK	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN
PACIFICSOURCE MARION POLK	CLIENT W/D C6-MISCELLANEOUS/UNKNOWN
PACIFICSOURCE MARION POLK	CLIENT W/D C7-NON-COVERED/EXCLUDED SERVICE
PACIFICSOURCE MARION POLK	NO SHOW
PACIFICSOURCE MARION POLK	NO SHOW
PACIFICSOURCE MARION POLK	NOT HEARABLE-NO APPEAL
PACIFICSOURCE MARION POLK	NOT HEARABLE-NO APPEAL
PACIFICSOURCE MARION POLK	NOT HEARABLE-NO APPEAL
PACIFICSOURCE MARION POLK	NOT HEARABLE-NO APPEAL
PACIFICSOURCE MARION POLK	NOT HEARABLE-NO APPEAL
PACIFICSOURCE MARION POLK	NOT HEARABLE-NO APPEAL
PACIFICSOURCE MARION POLK	PLAN WILL PAY P1-SERVICE AUTHORIZED
PACIFICSOURCE MARION POLK	PLAN WILL PAY P1-SERVICE AUTHORIZED

TRILLIUM COMM HLTH PLAN TRI-COUNTY	NOT HEARABLE
TRILLIUM COMM HLTH PLAN TRI-COUNTY	NOT HEARABLE
TRILLIUM COMM HLTH PLAN TRI-COUNTY	NOT HEARABLE-NO APPEAL
TRILLIUM COMM HLTH PLAN TRI-COUNTY	NOT HEARABLE-NO APPEAL
TRILLIUM COMMUNITY HEALTH	NO SHOW
TRILLIUM COMMUNITY HEALTH	NOT HEARABLE
TRILLIUM COMMUNITY HEALTH	NOT HEARABLE-NO APPEAL
TRILLIUM COMMUNITY HEALTH	NOT HEARABLE-NO APPEAL
TRILLIUM COMMUNITY HEALTH	NOT HEARABLE-NO APPEAL
TRILLIUM COMMUNITY HEALTH	PLAN WILL PAY P1-SERVICE AUTHORIZED
UMPQUA HEALTH ALLIANCE	CLIENT W/D C1-BELOW THE LINE
UMPQUA HEALTH ALLIANCE	NO SHOW
UMPQUA HEALTH ALLIANCE	NOT HEARABLE
UMPQUA HEALTH ALLIANCE	NOT HEARABLE
UMPQUA HEALTH ALLIANCE	NOT HEARABLE-NO APPEAL
YAMHILL COMMUNITY CARE	AFFIRMED
YAMHILL COMMUNITY CARE	NOT HEARABLE-NO APPEAL
YAMHILL COMMUNITY CARE	NOT HEARABLE-NO APPEAL
YAMHILL COMMUNITY CARE	NOT HEARABLE-NO APPEAL

Data Source: DSS
Data Extraction Date: 04/22/2024
Data Analyst: Rosey Ball

# Req	Issue Type Description
1	BILLING ISSUE
1	SURGERY DENIAL
1	REFERRAL DENIAL
1	BILLING ISSUE
3	REFERRAL DENIAL
1	RX DENIAL
1	BILLING ISSUE
1	BILLING ISSUE
2	RX DENIAL
2	SURGERY DENIAL
1	DENTAL DENIAL
1	SURGERY DENIAL
1	REFERRAL DENIAL
1	REFERRAL DENIAL
1	BILLING ISSUE
1	REFERRAL DENIAL
1	BILLING ISSUE
1	SURGERY DENIAL
1	DENTAL DENIAL
1	REFERRAL DENIAL
1	SURGERY DENIAL
5	DENTAL DENIAL
2	DME DENIAL
1	REFERRAL DENIAL
4	SURGERY DENIAL
2	SURGERY DENIAL
7	BILLING ISSUE
1	THERAPY DENIAL
3	DENTAL DENIAL
2	RX DENIAL
1	DENTAL DENIAL
1	DME DENIAL
1	REFERRAL DENIAL
1	RX DENIAL
1	DENTAL DENIAL
2	SURGERY DENIAL
4	BILLING ISSUE
2	NON-MEDICAL HEARING
1	REFERRAL DENIAL
2	SURGERY DENIAL
1	THERAPY DENIAL
27	BILLING ISSUE
5	DENTAL DENIAL
3	DME DENIAL
2	REFERRAL DENIAL
6	RX DENIAL
5	SURGERY DENIAL
1	THERAPY DENIAL
2	BILLING ISSUE
1	REFERRAL DENIAL
1	RX DENIAL
1	SURGERY DENIAL
1	BILLING ISSUE
1	RX DENIAL

1	REFERRAL DENIAL
1	BILLING ISSUE
1	DENTAL DENIAL
2	RX DENIAL
2	REFERRAL DENIAL
1	SURGERY DENIAL
1	RX DENIAL
4	BILLING ISSUE
1	RX DENIAL
1	DME DENIAL
1	SURGERY DENIAL
1	BILLING ISSUE
1	DME DENIAL
4	BILLING ISSUE
1	DENTAL DENIAL
1	TRANSPORTATION
2	DENTAL DENIAL
1	SURGERY DENIAL
1	BILLING ISSUE
1	SURGERY DENIAL
1	SURGERY DENIAL
2	DENTAL DENIAL
3	BILLING ISSUE
1	SURGERY DENIAL
1	BILLING ISSUE
1	DENTAL DENIAL
1	RX DENIAL
1	BILLING ISSUE
1	SURGERY DENIAL
5	TRANSPORTATION
4	BILLING ISSUE
4	DENTAL DENIAL
2	RX DENIAL
1	SURGERY DENIAL
15	TRANSPORTATION
1	
1	REFERRAL DENIAL
1	SURGERY DENIAL
2	BILLING ISSUE
1	DENTAL DENIAL
1	DME DENIAL
1	SURGERY DENIAL
5	BILLING ISSUE
1	DME DENIAL
1	REFERRAL DENIAL
2	SURGERY DENIAL
1	BILLING ISSUE
1	BILLING ISSUE
1	SURGERY DENIAL
9	BILLING ISSUE
3	DENTAL DENIAL
1	DME DENIAL
4	REFERRAL DENIAL
1	RX DENIAL
3	SURGERY DENIAL
1	BILLING ISSUE
2	DME DENIAL

1	BILLING ISSUE
2	RX DENIAL
2	MENTAL HEALTH
3	REFERRAL DENIAL
2	DENTAL DENIAL
1	RX DENIAL
1	BILLING ISSUE
1	RX DENIAL
2	SURGERY DENIAL
3	SURGERY DENIAL
1	REFERRAL DENIAL
1	RX DENIAL
1	BILLING ISSUE
1	REFERRAL DENIAL
3	REFERRAL DENIAL
1	REFERRAL DENIAL
2	BILLING ISSUE
1	RX DENIAL
1	SURGERY DENIAL

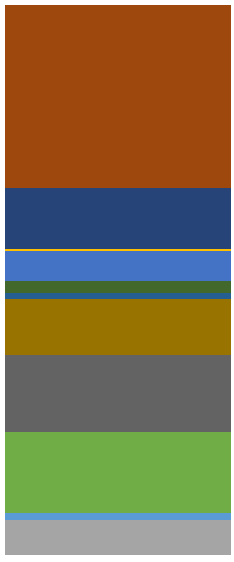
Appendix D

Hearing Requests Received
01/01/2024-03/31/2024
by CCO and FFS

Plan Name	Total Hearing Requests Received	Avg. Plan Enrollment *	Per 1000 Members
ADVANCED HEALTH	8	30,694	0.26
ALLCARE HEALTH PLAN, INC.	15	71,607	0.21
CASCADE HEALTH ALLIANCE	1	29,277	0.03
COLUMBIA PACIFIC CCO, LLC	4	41,328	0.10
EASTERN OREGON CCO, LLC	4	84,307	0.05
HEALTH SHARE of OREGON	105	480,886	0.22
INTERCOMMUNITY HEALTH NETWORK	19	93,275	0.20
JACKSON CARE CONNECT	7	71,240	0.10
PACIFICSOURCE COMM. SOLUTIONS - Central	17	83,814	0.20
PACIFICSOURCE COMM. SOLUTIONS - Gorge	8	19,768	0.40
PACIFICSOURCE COMM. SOLUTIONS - Lane	46	99,820	0.46
PACIFICSOURCE COMM. SOLUTIONS – Mar/Polk	34	166,993	0.20
TRILLIUM COMM. HEALTH PLAN	10	75,433	0.13
TRILLIUM COMM. HEALTH PLAN – Tri-County	7	40,982	0.17
UMPQUA HEALTH ALLIANCE, DCIPA	7	42,836	0.16
YAMILL CO CARE ORGANIZATION	4	41,501	0.10
FFS	33	255,406	0.13
Total	**329**	**1,729,167**	**0.19**

Hearing Requests Received
01/01/2024-03/31/2024
by Issue

Billing	111
Dental	38
Disenrollment	1
DME	19
Hearing Services	0
Mental Health	7
Miscellaneous	4
Referral	35
RX	48
Surgery	51
Therapy	4
Transportation	22
Vision	0
TOTAL	**333**



Data Source: DSS
Data Extraction Date: 04/22/2024
Data Analyst: Rosey Ball
*** Avg. Plan Enrollment based on average of Preliminary Member Months for January, February, and March 2024.**