Oregon Health Plan

Section 1115 Quarterly Report

12/1/2022 – 3/31/2022

Demonstration Year (DY): 20 (7/1/2021 – 6/30/2022)

Demonstration Quarter (DQ): 3

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I. Introduction

A. Letter from the State Medicaid Director

During this reporting period, the Oregon Health Authority (OHA) continued to partner with Coordinated Care Organizations (CCOs) and continued to collaborate with providers and community partners to meet the goals of our 1115 waiver.

The Oregon Legislative Assembly convened for the 2022 legislative session and made crucial short-term and long-term investments to address the emergent needs stemming from the Covid-19 Public Health Emergency, as well as to advance OHA's goal of eliminating health inequities in Oregon by 2030.

Oregon's legislative actions in 2022 support OHA's efforts to improve health care coverage and access, to create a behavioral health system that is simple, responsive, and meaningful for the people it serves, to support and strengthen Oregon's health care workforce, as well as building healthier Oregon communities to improve social determinants of health like housing, access to food, neighborhood safety, education, transportation, and involvement with the criminal justice system.

Dana Hittle, Interim State Medicaid Director

B. Demonstration description

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

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

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

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

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

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

- Conversion of the Tribal uncompensated care payments to a Medicaid benefit;
- Clarifying health-related services that meet the requirements as specified in the Code of Federal Regulations;
- Allowing passive enrollment of Medicare and Medicaid dually-eligible individuals into CCOs with the option for each individual to opt-out at any time;
- Specifying the demonstration will not impact American Indian and Alaska Natives rights to exemption from managed care, or the requirements to comply with the Medicaid Managed Care Regulations;
- Offering incentive payments to Patient-Centered Primary Care Homes and Comprehensive Primary Care Plus providers for enhanced fee-for-service delivery of care to Medicaid recipients; and
- Establishing minimum requirements for CCOs to collaborate and communicate in a timely and equitable manner with tribes and Indian Health Care providers.

C. State contacts

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II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 12/1/2022 – 3/31/2022
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III. Overview of the current quarter

Enrollment in the Oregon Health Plan continued to increase during this quarter as more Oregonians seek coverage and existing members remain enrolled during the COVID-19 Public Health Emergency, although the rate of increased enrollment was less during this period than during the same period in 2021.

This report contains a summary of the bills and budget items passed during the 2022 state legislative session that will impact Oregon's Medicaid program. Those legislated items are summarized under the following headings:

- Increasing and Maintaining Access to Health Care
- Transforming the Behavioral Health System
- Strengthening Oregon's Health Care Workforce
- Building Healthier Communities

The legislation reported represents significant investments that will support the health care system and individuals who are working to achieve the goals of this demonstration.

A. Enrollment progress

1. Oregon Health Plan eligibility

Title XIX and Title XXI enrollment has continued to slightly increase each month as more Oregonians seek medical coverage and as most ongoing recipients continue to remain enrolled (with a few exceptions), even if changes in circumstances would have otherwise made them ineligible. This is due to Oregon's election to apply

continued eligibility protections during the COVID-19 public health emergency period as permitted under the Families First Coronavirus Response Act.

An ongoing backlog of work has continued to be a challenge, however aggressive measures in system automation and staff resourcing are proving to be successful in moving the state closer to processing work within required timeframes. Increases in managed care and fee-for-service enrollment can be attributed to larger numbers of applications and case changes being processed as a result of backlog reduction efforts.

2. Coordinated care organization enrollment

Total CCO enrollment for January 2022 – March 2022 grew by 2.6%, across all plan levels (CCOA, CCOB, CCOE, CCOG). Specific Coordinated Care Organization membership growth ranged between 1.3% – 3.0%, with the exception of Trillium Community Health Plan in the Portland metro tri-county area, which continued to experience greater growth at 17.5% as it continued to establish itself in this new market.

Across the 16 Coordinated Care Organizations, there are 48 unique CCO-county service areas. To provide context for geographic variability in membership growth trends, please see the table below.

DY20Q3 Member Growth Zone	**CCO Service Areas**
Greater than 5.00%	3
3.00%-4.99%	13
2.00%-2.99%	19
0.00%-1.99% Growth	13
Reduction in Enrollment	0

Overall enrollment from January 2022 – March 2022 enrollment growth was slightly higher than the previous quarter, but a slow-down from the same period in 2021.

DY19Q1 7/20-9/20	**DY19Q2 10/20-12/20**	**DY19Q3 1/21-3/21**	**DY19Q4 4/21-6/21**	**DY20Q1 7/21-9/21**	**DY20Q2 10/21-12/21**	**DY20Q3 1/22-3/22**
3.3%	3.9%	3.5%	2.4%	2.2%	2.4%	2.6%

As noted in previous reports, on May 1, 2020, Oregon Health Authority waived the requirement to limit each Coordinated Care Organization's enrollment to the county limit(s) and grand total limit listed in its contract to mitigate enrollment challenges during the pandemic. This requirement was initially established for CCO contract year 2020, was extended for contract year 2021 and has since been extended through contract year 2022 (December 31, 2022).

During 2021, 14 CCO county service areas – representing three distinct CCOs – have required adjustments above their 2021 contract limits in order to sustain auto-enrollment algorithms. New enrollment limits have

been established for 2022. Between January 2022 and March 2022, one CCO has required adjustment above its 2022 contract limit in three service areas in order to sustain auto-enrollment algorithms.

B. Benefits

Health Evidence Review Commission (HERC):
The January 1, 2022 prioritized list went into effect on January 1, 2022 and was reported in a Notification of Interim Changes. Errata to the January 1, 2022 prioritized list were published on January 10, 2022.

P&T Committee:
For the recent period of **January 1 – March 31, 2022 t**he P&T Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: Oncology Agents; Respiratory Syncytial Virus (RSV); Pompe Disease drugs; Targeted Immune Modulators (TIMS); belimumab; voclosporin; and anifrolumab-fnia. The committee also recommended the following changes to the preferred drug list (PDL): make Invega Hafyera™ preferred; make fosinopril, quinapril, and candesartan preferred; make Nexviazyme™ (avalglucosidase alfa) non-preferred; add the Oral Glucocorticoids class to the PDL and make the following agents non-preferred: Hemady®, Alkindi® Sprinkle, Pediapred®, Millipred™, prednisolone sodium phosphate solution, and prednisolone sodium phosphate disintegrating tablets; make all other currently available oral glucocorticoids formulations 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 the current 16 coordinated care organizations (CCO) and fee-for-service (FFS) data. The quarterly reporting period covers January 1, 2022 through March 31, 2022.

Trends

	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
Total complaints received	3,895	4,415	4,152	4,262
Total average enrollment	1,389,453	1,394,117	1,427,347	1,452,054
Rate per 1,000 members	2.80	3.17	2.91	2.94

Barriers
The first quarter of 2022 shows an increase in the overall number of grievances from the fourth quarter of 2021. The Access to Care category increased 11.8% over the fourth quarter of 2021. The Interaction with Provider/Plan category shows a 3.8% increase over the fourth quarter of 2021. Quality of Care continues to be the third highest category of complaints with a 2.04% increase over the 2021 third and fourth quarter totals. CCOs report the increases in some areas are caused by staffing shortages due to continued pandemic issues. FFS data shows the highest number of complaints are again the Billing category, with Quality of Care the next highest category.

Interventions
CCOs – Some CCOs continue to report increasing memberships and staffing issues in providers offices causes an increase in grievances. CCOs are reporting continued work on NEMT issues, with some CCOs reporting good results with new automated systems, increased communication and listening to community input. Some CCOs continue to indicate staffing issues are problematic in some areas. CCOs continue to report they have

established committees and taskforces specifically to address provider capacity within their networks. CCOs are assigning liaisons to work with providers to improve education and awareness of Medicaid member's needs. CCOs continue to report they have increased care coordination and are providing more health navigators to assist members in making appointments, attending appointments, etc. to improve services to members. One CCO reported they have established a Member Experience taskforce. CCOs report they monitor trends on a monthly basis and continue to work towards improving services for members.

Fee-For-Service – The number of complaints from members who were on Fee for Service coverage during the Jan – Mar first quarter of 2022 was 175. An additional 499 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 75 complaints from members enrolled in Dental Care Organizations. 7452 informational calls were received asking for a variety of information, such as information about their coverage, CCO enrollment, request ID cards, etc.

Statewide rolling 12-month Complaints totals

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

Complaint category	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
Access to care	1,324	1,566	1,395	1,559
Client billing issues	278	394	390	381
Consumer rights	301	288	475	344
Interaction with provider or plan	1,281	1,451	1,210	1,256
Quality of care	498	539	538	549
Quality of service	213	177	144	173
Other	0	0	0	0
Grand Total	3,895	4,415	4,152	4,262

Related data

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

CCO Notices of Adverse Benefit Determinations and Appeals

Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs during the first quarter of 2022. The NOABDs are listed by reason, as per 42 CFR 438.400(b)(1-7) and are the total number of NOABDs issued, regardless of whether or not an appeal was filed. During this quarter CCOs report that the highest number of NOABDs issued were Pharmacy related. Specialty Care was the next highest and issues with Diagnostics were the third highest. CCOs report that eligibility remains one of the highest reasons for denials. Some CCOs are working to provide information about OHP members who are terminating to assist the provider in reducing confusion and the numbers of requests for services that end in denials. CCOs continue to monitor NOABDs to ensure written notices are sent to members in easily understood language and includes the appropriate citations. Tracking for timeliness, as well as reviewing for utilization and appropriateness of care are processes CCOs report they are doing to ensure NOABDs are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
a) Denial or limited authorization of a requested service.	29,931	27,636	26,931	26,862
b) Single PHP service area, denial to obtain services outside the PHP panel	490	897	820	835
c) Termination, suspension, or reduction of previously authorized covered services	129	224	153	109

d) Failure to act within the timeframes provided in § 438.408(b)	15	7	3	9
e) Failure to provide services in a timely manner, as defined by the State	28	59	84	82
f) Denial of payment, at the time of any action affecting the claim.	64,915	46,204	63,703	54,606
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	95,508	75,027	91,694	82,503
Number per 1000 members	86.8	66.6	79.5	70.03

CCO Appeals

The table below shows the number of appeals the CCOs received over the first quarter of 2022. The CCOs reported the highest number of appeals were issues with Outpatient services. Pharmacy was the next highest category and appeals related to Specialty Care were the next highest. CCOs report they review the overturn rates which leads to more in-depth discussions and reviews, monitoring, and process changes. Some CCOs are reporting that Peer Reviews with Providers is resulting in improvements to services. CCOs report they are continuing to do activities such as staff education and monitoring for providers to improve understanding of the appeal process. CCOs also work with members to assist them in finding services they need or assist them with finding alternative covered options.

CCO Appeals	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
a) Denial or limited authorization of a requested service.	1,145	1,116	1,041	1,072
b) Single PHP service area, denial to obtain services outside the PHP panel.	7	29	23	34
c) Termination, suspension, or reduction of previously authorized covered services.	10	5	10	2
d) Failure to act within the timeframes provided in § 438.408(b).	0	0	0	0
e) Failure to provide services in a timely manner, as defined by the State.	1	0	1	0
f) Denial of payment, at the time of any action affecting the claim.	357	245	222	244
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	1,520	1,395	1,297	1,352
Number per 1000 members	1.38	1.24	1.12	1.15
Number overturned at plan level	436	388	444	401
Appeal decisions pending	9	0	10	8
Overturn rate at plan level	28.68%	27.8%	34.2%	29.7%

2. CCO and FFS Contested Case Hearings

The following information is a compilation of data from 16 Coordinated Care Organizations (CCOs), 5 Dental Care Organizations (DCOs) and Fee-for-Service (FFS). FFS members may be enrolled with a DCO for dental coverage.

During the third quarter (January 1, 2022, through March 31, 2022), the Oregon Health Authority (OHA) received 205 hearing requests related to the denial of medical, dental, and behavioral health services, including Non-

Emergent Medical Transportation (NEMT). Of those received, 178 were from CCO-enrolled members and 27 were from FFS members.

201cases 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 2022 may be cases OHA received as far back as November and December of 2021.

OHA dismissed 105 cases that were determined to be not hearable cases. Of the not-hearable cases, 86 were forwarded to the member's respective CCO to process as an appeal. Per Oregon Administrative Rule, Oregon Health Plan (OHP) members must exhaust their appeal rights at the CCO level and receive a Notice of Appeal Resolution (NOAR) before they can request a contested case hearing at the state level. Hearing requests received by OHA prior to the appeal being exhausted are dismissed as not hearable with a letter to the member explaining their appeal rights through the CCO and their hearing rights after receiving an NOAR.

Of the 96 cases that were determined to be hearable, 14 were approved prior to hearing. Members withdrew from 40 cases after an informal conference with an OHA Hearing Representative. 28 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. The Administrative Law judge reversed the decision in two cases during this quarter.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	14	7%
Client withdrew request after pre-hearing conference	40	20%
Dismissed by OHA as not hearable	105	52%
Decision affirmed*	28	14%
Client failed to appear*	12	6%
Dismissed as non-timely	0	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	2	1%
Set Aside*	0	0%
Total	201	

* Resolution after an administrative hearing.
Reports are attached separately as an Appendix – Contested Case Hearings.

F. CCO activities

1. New plans

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

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

2. Provider networks
No significant changes during this reporting period.

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

At the end of 2021, OHA underwent a procurement process to hire a new Actuarial Firm to develop the Capitation Rates. The procurement resulted in OHA hiring Mercer Health & Benefits in March 2022 as the new Actuarial Firm. Mercer will be responsible to develop the CY2023 capitation rates. OHA and Mercer met with CCOs in March 2022 to discuss the change in actuarial firm. OHA and collaboration with Mercer provided the CCOs 2023 rate development methodology, rate development timeline and the 2023 proposed contract changes.

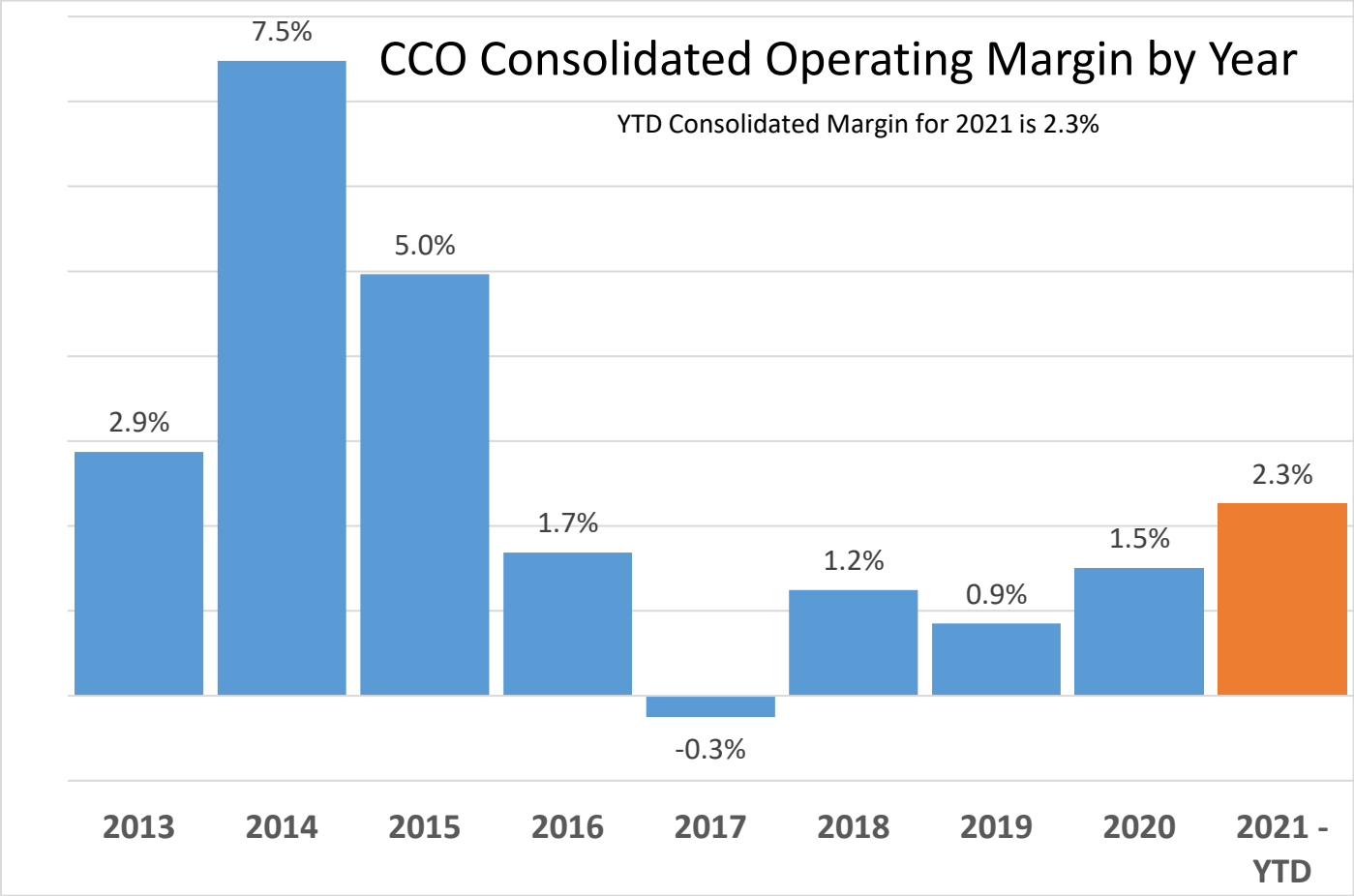
In preparation for the CY23 Rate Development year OHA provided the annual rates package to the CCOs which outlined deadlines and the data grouping process utilized by OHA and Mercer for categories of services to aid CCOs.

4. Enrollment/disenrollment
No significant updates during this reporting period.

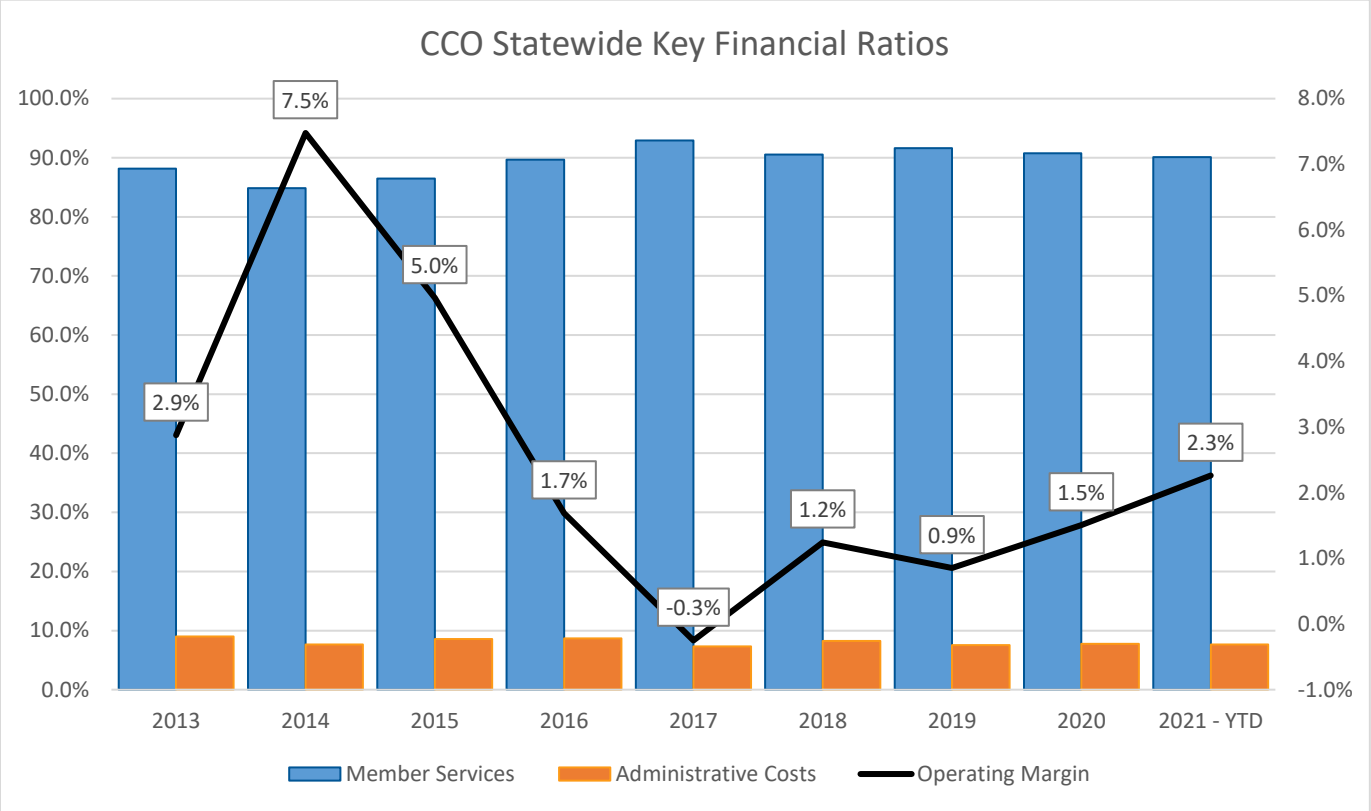
5. Contract compliance
There are no issues with CCO contract compliance other than as described in the Corrective Action Plans section.

6. Relevant financial performance

CCOs achieved a statewide operating margin of 2.3% through the nine months ending September 30, 2021. This is 2.3% of the year-to-date gross premiums reported on Exhibit L of $5.57 billion. The YTD margin has decreased by 6 points from 3.2% reported in Q1, but is still an increase from 2020's 1.5% statewide margin.



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (this includes medical, behavioral, dental and health-related services, reinsurance premiums and recoveries, and other adjustments) as a percentage of total revenue. A breakdown of key statewide financial ratios by year indicates that the Member Services component as a percent of the payments which CCOs received has remained relatively consistent over the last two years.



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 nine months of 2021, spending on Member Services was at 90.1%, which is 0.7% higher than the average Member Services expense from the previous 8 years of 89.4%. Administrative costs of 7.6% tracks with prior years' percentage.

For additional CCO financial information and audited financials please follow the link below - http://www.oregon.gov/oha/FOD/Pages/CCO-Financial.aspx

7. Corrective action plans

For the current quarter, two CCOs continue to be on Corrective Action Plans (CAPs):

CONTINUING CAPs

• *Entity name:* Health Share of Oregon (HSO)

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

• *Start date of CAP:* October 14, 2019

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

• *Action sought:* Development and implementation of a plan for correcting the issues identified by OHA; submission of weekly reports to OHA for the duration of the CAP. The areas for improvement identified in the CAP are provider (driver) no-shows, on-time (pick-up) performance, call wait times, call abandonment, and member grievances. In a letter dated January 29, 2021, OHA formally notified HSO that it is satisfied with the improvements made in four of the five areas. Per that letter, all CAP areas for improvement were "closed", except for member grievances. HSO is required to continue to submit monthly progress reports for the area of member grievances as well documentation relating to specific NEMT concerns identified through member grievances. Also, weekly reporting changed to monthly reporting effective for the report due in February 2021.

• *Progress during current quarter:* During the January-March 2022 quarter, OHA reviewed HSO's responses submitted in December 2021 to follow-up questions about member grievance documentation. OHA has determined that HSO has resolved the issues relating to member grievances and that the CAP can be closed. OHA will provide the formal CAP closure notice to HSO in the April-June 2022 quarter.

• *Entity name:* Trillium Community Health Plan

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

• *Start date of CAP:* March 5, 2021

• *End date of CAP:* Original end date: September 5, 2021. Current end date: March 1, 2022, or when OHA determines that the CAP can be "closed".

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

• *Progress during current quarter:* The areas for improvement identified in the CAP are network development, health equity and language access, community engagement, and intensive care coordination. OHA's review of Trillium's progress reports for January-March 2022 indicates significant progress in all areas of the CAP. By the end of the quarter, all areas of the CAP have been closed except for one element of "community engagement".

8. One-percent withhold

This quarterly report is for data from Jan 1, 2022, through March 31, 2022. OHA analyzed encounter data received for completeness and accuracy for the subject months finalized for June 2021 through August 2021.

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of June 2021 through August 2021. All CCOs except for two met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

One CCO did not meet the Administrative Performance (AP) standard for the month of June 2021 subject month no 1% withhold was taken as the CCO put remediation in place to ensure ongoing compliance and a decision was made by OHA leadership that due to the current pandemic affecting recent submissions, no withhold would be applied.

The second CCO did not meet the Administrative Performance (AP) standard for the months of July and August 2021 subject month no 1% withhold was taken as the CCO put remediation in place to ensure ongoing compliance and a decision was made by OHA leadership that due to the current pandemic affecting recent submissions, no withhold would be applied.

9. Other significant activities

All activities reported in other sections of this report.

G. Health Information Technology

CCO Health IT Roadmap & Data Reporting

Per the CCO 2.0 Contract, CCOs are required to maintain an OHA-approved health information technology (HIT) Roadmap describing how they use/will use HIT to achieve outcomes, including population health management and value-based payment arrangements, and how they will support physical, behavioral, and oral health providers with EHR adoption and health information exchange (HIE) for care coordination and hospital event notifications (as well as CCO use of hospital event notifications). OHA compiled strategies described in CCO 2021 HIT Roadmaps into EHR Adoption and HIE for Care Coordination and Hospital Event draft summaries. Starting in 2022, CCOs are also required to report how they use/will use and support/will support providers with HIT to support social needs screening and referrals for addressing social determinants of health (SDOH) needs. 2022 HIT Roadmaps are due 4/28/2022.

In the last quarter of 2021, OHA collaborated with CCOs and Medicaid dental care organizations to collect HIT information from contracted provider organizations via an online survey, which closed January 21, 2022. The survey was distributed to all available contacts at CCO-contracted physical, oral, and behavioral health organizations to collect EHR, HIE, and other HIT information. This information will be used to inform CCO efforts to support their providers with HIT adoption and use to increase care coordination and engagement in value-based payment models. OHA compiled a preliminary draft summary of the survey results.

HIT Commons

The HIT Commons is a public/private partnership to coordinate investments in HIT, leverage funding opportunities, and advance HIE across the state. HIT Commons is co-sponsored by the Oregon Health Leadership Council (OHLC) and OHA, and is jointly funded by OHA, hospitals, health plans and CCOs. For more information see the HIT Commons website.

EDIE and the Collective Platform (formerly known as PreManage)

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

The Collective Platform (aka PreManage) is a companion software tool to EDIE. The Collective Platform brings the same real-time hospital event notifications (ED and Inpatient Admit, Discharge, and Transfer (ADT) data) to those outside of the hospital system, such as health plans, Medicaid CCOs, providers, and care

coordinators. In Oregon, Physician Orders for Lifesaving Treatment (POLST) forms are available to view for clinics, Skilled Nursing Facilities (SNFs), payers, and hospitals who receive EDIE alerts through paper/fax.

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

Recent highlights:

- The HIT Commons EDIE Steering Committee met on February 25, 2022. Topics of discussion included review of quarterly EDIE analytics dashboards; product and support updates from Collective Medical; a new use case queue management process used by HIT Commons; discussion of emerging use cases including assigned-unseen patients functionality, multi-drug resistant organism flags, and HEDIS Transitions of Care (TRC) Metric support; and updates on previously identified integration use cases including the HERO Kids Registry, and Jails and Housing data. Materials from that meeting are available here.

Public Health Data Sharing Workgroup

HIT Commons, in partnership with OHA, has convened a Public Health Data Sharing Workgroup to discuss and assess efforts to integrate public health data into HIT or HIE systems, and make policy and operational recommendations to HIT Commons and OHA. Workgroup membership includes representation from OHA's Public Health Division, payers/CCOs, health systems, and providers. In Q1 2022, HIT Commons and OHIT staff started meeting with OHA Public Health Division leadership to explore public health data sharing priorities that the Workgroup should focus on moving forward. The broader workgroup will likely be reconvened later in 2022.

Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative

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

- 18 new organizations went live with PDMP Integration in Q1 2022.
- 332 organizations have integrated access to Oregon's PDMP data – either through their EDIE alerts, or through one-click access at the point of care (EHR or HIE). 17 retail pharmacy organizations are also live. In the 18 months leading up to March 31, 2023, 19,371 users (prescribers and pharmacists) and 1,301 facilities have successfully accessed data via PDMP Integration.

Health IT Stakeholder Groups

Health IT Oversight Council (HITOC)

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

Strategic Plan:

Updating the Oregon HIT Strategic Plan is a HITOC priority in 2022. HITOC will center equity in its recommendations and process, and focus on the HIT strategies needed to support health system transformation and achieve health equity, including prioritizing efforts that support Medicaid priorities (as identified in CCO 2.0, 1115 waiver renewal), legislative priorities (including demographic data collection of race, ethnicity, language, disability (REALD) and sexual orientation and gender identity (SOGI), behavioral health investments), and broader priorities identified in the State Health Improvement Plan. Areas HITOC will explore under the Strategic Plan Update include community information exchange (CIE), statewide HIE, patient access to data, EHRs, public health, and more. In April HITOC will review and vote on the HIE workgroup slate and charter. After approval, the group will begin meeting in May 2022 and along with the Community Information Exchange (CIE) Workgroup (see below) will provide input and recommendations to HITOC for the Strategic Plan. Once drafted, the plan will be submitted to the Oregon Health Policy Board. Target date for completion is early 2023.

Other focus areas:

Additional priorities for HITOC in 2022 include HIT needed to support COVID response and recovery, onboarding four new HITOC members, EHR adoption, and further work related to HIT and social determinants of health and health equity.

Health IT Advisory Group (HITAG)

The HIT Advisory Group (HITAG) provides input to OHA about CCOs' HIT needs and efforts and informs OHA's work on the Oregon HIT Program. Each CCO designates a representative to attend HITAG meetings.

OHA works with HITAG to:

- Gather input on ongoing HIT efforts so that OHA's work supports and aligns with CCOs' efforts and provides some accountability back to CCOs
- Raise awareness of OHA's HIT efforts and progress to inform CCOs as they plan their own technology efforts
- Identify challenges and opportunities from CCO perspectives to inform OHA's planning for HIT efforts
- Provide a forum for CCOs to learn from each other and from presenters sharing information of value to CCOs

In March 2022, the HITAG convened to discuss CCO 2022 HIT Roadmap requirements, the HITOC Strategic Plan Update, and CCO strategies for supporting HIE for care coordination and hospital event notifications for

their contracted physical, behavioral, and oral health providers. OHA shared a summary of these strategies and a selected panel of CCO representatives presented on successful strategies.

Community Information Exchange (CIE)

CIE is a network of collaborative partners using a multidirectional technology platform to connect people to the services and supports they need.

- Partners may include human and social service, healthcare, and other organizations.
- Technology functions must include closed loop referrals, a shared resource directory, and informed consent.

CIEs are developing rapidly across the state with two main CIE vendors: findhelp and Connect Oregon (powered by Unite Us). To learn more, see the OHA CIE webpage.

HB 4150 passed in 2022 that requires HITOC to lead a Workgroup focused on how to accelerate, support, and improve statewide CIE. HITOC chartered the CIE Workgroup which brings together individuals representing Oregon's diverse landscape of community, health care, and social services partners to help advance health equity by providing recommendations on strategies to accelerate, support, and improve CIE across the state. Workgroup recommendations will be included a report to the legislature, as well as inform HITOC's Health IT Strategic Plan for Oregon and OHA efforts. The Workgroup began meeting in March and will meet monthly in 2022. At the March meeting, the Workgroup focused on the CIE definition and vision.

H. Metrics development

1. Kindergarten Readiness

This developmental work comprises a multi-year measurement strategy:

1) Adopt two metrics for the 2020 CCO incentive measure set (complete):
• Well-child visits for children 3-6 years old
• Preventive dental visits for children 1-5 years old

2) Adopt a CCO-level attestation metric focused on children's social-emotional health (complete; included in 2022 measure set and learning collaborative launching).

3) Replace the existing developmental screening metric with a new follow-up to developmental screening metric in after development work completed. (future work area - timing TBD)

2. SDOH/Health-related Social Needs Measure

Several public meetings in March featured discussion of the social needs screening and referral measure. First, the Oregon Health Policy Board had an educational webinar to learn about the measure. Next, the Metrics and Scoring Committee unanimously voted to request that the Health Plan Quality Metrics Committee (HPQMC) add the measure to the aligned measures menu. Finally, at the end of March, HPQMC unanimously voted to add the measure to the menu, making it available for the Metrics and Scoring Committee to select as an incentivized measure. Over the spring and summer, the Metrics and Scoring Committee will make final decisions about the 2023 CCO incentive measure set.

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

No change from last quarter. This work continues to be on hold.

In early 2018, the Metrics and Scoring Committee and Health Plan Quality Metrics Committee requested the development of an incentive metric focused on obesity using evidence-based strategies. In response, extensive measure development occurred in a workgroup with members including Oregon Health Authority staff from the Public Health Division and the Health Policy and Analytics Division, and CCO and Local Public Health representatives.

The Metrics and Scoring Committee, after much discussion, ultimately did not select the measure the workgroup developed. Since then, Public Health Division staff have engaged with community groups about equity-centered revisions to the measure. However, further work on this measure continues to be delayed by other priorities, particularly COVID response.

I. Budget neutrality

There are currently no system/issues with financial accounting, budget neutrality, or CMS-64 reporting during this reporting period.

J. Legislative activities

Below are highlights of the 2022 session of the Oregon Legislature relating to bills and budget items expected to most significantly impact the health of Oregonians and the work of Oregon Health Authority (OHA). These bills and budget items are sorted by topic (though these topics are interrelated, and many items could be listed under more than one):

- Increasing and Maintaining Access to Health Care
- Transforming the Behavioral Health System
- Strengthening Oregon's Health Care Workforce
- Building Healthier Communities

As it implements these legislative bills and budgets, as in all its work, OHA seeks to eliminate health inequities in Oregon by 2030. The vision of health equity that OHA and the Oregon Health Policy Board are working to achieve is:
Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address the equitable distribution or redistribution of resources and power; and recognizing, reconciling and rectifying historical and contemporary injustices.

OHA's legislative implementation is also guided by collaboration with community partners, especially those individuals and communities most harmed by health inequities stemming from contemporary and historical racism, oppression, discrimination, bigotry and bias.

Increasing and Maintaining Access to Health Care

Coverage of and access to health care is a critical factor in the health outcomes of individuals and communities. After passage of the federal Affordable Care Act, the percentage of Oregonians with health care coverage increased to about 94%. Last year, the Legislature began investing in the Healthier Oregon ("Cover All People") program, as well as taking other actions toward 100% coverage.

Oregon Health Authority

OHA continues to focus on increasing the number of Oregonians who have health coverage. It also recognizes the importance of ensuring Oregonians can actually access health care, as there are clear regional and community disparities in access. The legislature's actions in 2022 will improve both health care coverage and access in several ways.

HB 4035: Maintaining Health Care Coverage Gains

Many Oregonians will face a challenge in maintaining their health care coverage when the official Public Health Emergency related to COVID-19 ends. Because of "continuous coverage" provisions during the emergency, people enrolled in the Oregon Health Plan (OHP) have been able to keep their coverage even when their income changes. This has increased the percentage of Oregonians with health care coverage to above 95%. The concern is that many people could suddenly lose coverage after the emergency, when those provisions will no longer apply.

Prior to the emergency, people could lose OHP because of a small or temporary income change. Historically, about one-third of people leaving OHP return within 12 months. This "churn" on and off OHP can leave people uninsured, disrupt ongoing treatment, and unnecessarily increase health care costs for people who cannot afford higher out-of-pocket costs.

With a $120 million General Fund investment, HB 4035 maximizes the opportunity for community- and partner-designed and developed outreach, enrollment, assistance, navigation and education strategies to meet people on OHP where they are and help them figure out what's next for their health coverage. Through this legislation – and in negotiations with federal partners – Oregon has an opportunity to reduce unnecessary coverage transitions while preserving existing coverage options for people who are best served through marketplace or employer-sponsored plans. This approach can help close the gaps in the system that currently cause too many people to be uninsured for all or part of the year.

The bill provides for legislative and community involvement in developing a "bridge plan" to keep people covered by their Coordinated Care Organization (CCO) during temporary income fluctuations, instead of having them churn on and off OHP. This plan would enable people who will no longer qualify for OHP, but who earn less than 200% of the Federal Poverty Level, to remain with their CCO and for Oregon to receive full federal funding for this coverage. The bill also seeks to leverage federal funding that is available in the Marketplace for people who are on the edge of Medicaid eligibility, as well as the development of coverage options which use federal funds to allow individuals just above Medicaid eligibility to have continuous coverage through their CCO.

HB 4052: Mobile Health Units

Even when people have health care coverage, that is not the same as actually having access to health care. HB 4052 aims to improve access, starting with communities most affected by health inequities.

The bill requires OHA to provide grants, funded with $1.6 million General Funds ($1.9 million Total Funds), to operate two culturally and linguistically specific mobile health units as pilot programs to improve health outcomes of Oregonians impacted by racism. This effort will be guided by an advisory committee with individuals from priority populations in addition to health professionals. OHA is also directed to study the feasibility of expanding mobile health units throughout the state, including engaging with CCOs, other health care providers, OHP members, and other community members from priority populations.

Finally, the bill requires OHA – guided by task forces consisting of leaders of Black and indigenous communities, people of color, and members of the nine federally recognized tribes in Oregon, and convened by the Oregon Advocacy Commissions Office – to develop recommendations on how to fund robust culturally and linguistically appropriate intervention programs across all relevant state agencies focused on aspects of social determinants of health. This includes housing, access to food, neighborhood safety, education, transportation, and involvement with the criminal justice system.

HB 4095: Veterans Dental Care

HB 4095 creates the Veterans Dental Program to provide oral health care for veterans who have income at or below 400% of the federal poverty level but do not qualify for Medicaid, funding with $1 million Total Funds. OHA will contract with dental care organizations to provide these services, which must be equivalent to the oral health care benefits covered by Medicaid, without copays, cost-sharing, or deductibles.

SB 1538: COFA Dental Care

SB 1538 establishes the COFA Dental Program within OHA to provide dental care to low-income citizens of Pacific Islands in the Compact of Free Association who reside in Oregon, including $300,000 General Funds ($1.5 million Total Funds). OHA is directed to contract with dental care organizations throughout the state and with individual oral health care providers in areas of the state that are not served by dental organizations. OHA will also provide culturally and linguistically appropriate assistance, and conduct outreach.

Budget: Expanded Citizenship Waived Medical

The Citizenship Waived Medical (CWM) program, formerly known as Citizen-Alien Waived Emergent Medical (CAWEM), covers emergency care for adults who would qualify for Medicaid if they met the U.S. citizenship or residency requirements. Previously, emergency coverage was based on the final diagnosis. Unfortunately, this could result in considerable expense for individuals if they go to an emergency room in good faith, but the diagnosis determines there was no serious cause for alarm. The policy could also discourage people with an actual emergency from seeking care, for fear of unexpected charges. The budget includes $5.4 million General Funds ($14.2 million Total Funds) to cover admission to an emergency room when a person presents symptoms a prudent layperson would consider an emergency, even if the final diagnosis turns out to be not serious.

HB 4134: Covering Out of Network Labor and Delivery

HB 4134 requires, if a person in labor is diverted from an in-network facility to an out-of-network facility due to the public health emergency, health insurers must cover the labor and delivery services, including transportation to the out-of-network facility. This will prevent people in labor from being charged for out-of-network services through no fault of their own.

Budget: Extended Postpartum Eligibility

There are severe racial disparities in maternal mortality among Oregonians, with studies showing American Indian/Alaska Native and Black people at a significantly higher risk of dying from a pregnancy related cause. The state Maternal Mortality and Morbidity Review Committee identified “inadequate access and missed opportunities to health care and medical services” and “inadequate access to wrap-around services” as contributing factors to maternal mortality. The budget includes $2.4 million General Funds ($8.8 million Total Funds) to provide additional months of postpartum health care. This will help ensure the potentially complex health needs following pregnancy can be attended to, resulting in improved health outcomes for all Oregonians.

Transforming the Behavioral Health System

Oregon and OHA are in the midst of long-term transformation of our state's behavioral health system. This involves crafting a behavioral health system that is simple, responsive, and meaningful for the people it serves. OHA aims do this with active involvement of the people and communities who have faced behavioral health challenges and inequities.

In 2021, upon the recommendations of Governor Brown's Behavioral Health Advisory Council, the Legislature invested heavily in behavioral health, including for residential facilities and housing for people with behavioral health needs, training for a diverse behavioral health workforce, and increased community services. It also passed measures to better integrate treatment for co-occurring disorders (substance addiction and mental health disorders together); reduce administrative burdens in behavioral health documentation; analyze pay and equity disparities affecting the behavioral health workforce; and create structures and incentives for OHA, payors, and providers to engage with people they serve and work together to make the behavioral health system function better as a whole.

In 2022, the legislature continued this transformation, with further crucial short- and long-term investments and initiatives.

HB 4004: Behavioral Health Staffing Support

The behavioral health sector in Oregon is experiencing a significant workforce crisis. As an immediate response, HB 4004 provides a $132.3 million General Fund investment for OHA to distribute grants to behavioral health treatment providers for staff compensation and workforce retention and recruitment, no later than May 31, 2022. Providers must use at least 75% of the grant on direct compensation to staff as wages, benefits, and bonuses. The remainder may be spent on programs or other non-compensatory means to increase workforce retention or recruitment. Providers are responsible for reporting back to OHA on how the grants were spent and whether the expenditures resulted in improved compensation for staff.

During the pandemic, residential behavioral health providers approached the Governor and OHA seeking immediate staffing resources for both the children and adult residential system. At that time, OHA contracted with a temporary nurse staffing agency to provide staff paid for by the state to bolster the workforce in residential facilities. This nursing staff was provided at no cost to the providers and paid for by OHA. Now, HB 4004 directs OHA to continue to contract with nurses and behavioral health specialists to provide care in residential behavioral health programs that are short-staffed due to the COVID-19 pandemic, and to seek federal funding for these efforts, including for funds already expended by OHA.

The bill also requires the Oregon Youth Authority to provide similar grants to service providers the meet the treatment and care needs of youths adjudicated to the custody of that agency.

Budget: Behavioral Health Rate Increases

Behavioral health providers have shared that the reimbursement rates they are paid have failed to stay competitive in relation to the national standards even prior to the pandemic, and fell further behind due to the challenges of the last two years. Also, communities have expressed concerns that low rates present a major barrier to increasing or maintaining current capacity in the behavioral health system, as some programs no longer can support operations.

The budget provides $42.5 million General Funds to support an increase in fee-for-service payment rates for behavioral health services, raising rates by an average of 30%, contingent on federal approval. Also, OHA is instructed to propose strategies to measure the extent to which CCOs pass the rate increases through to behavioral health providers, and to measure the impact of the rate increase on provider stability and capacity.

Separately, OHA already implemented a temporary 10% rate increase for residential behavioral health providers earlier in the COVID-19 pandemic. This was first approved in the 2019-21 budget, then extended due to the Omicron surge. The budget provides OHA with $3 million General Funds ($12 million Total Funds) to retroactively cover this extension.

Budget: OSH Staffing

Oregon State Hospital (OSH) has been challenged over the years to provide appropriate staffing levels to achieve a high level of quality care while achieving patient and staff safety. This is primarily due to enhanced patient needs from a dramatic shift of the population OSH serves, and a lack of budgeted position authority necessary to ensure adequate clinical and operational staffing levels. This instability negatively affects the consistency of service delivery, cohesion across care providers, and sense of responsibility to team and to the overall hospital.

Under legislative direction, OSH worked with its union partners, AFSCME and SEIU, to find a sustainable staffing plan for OSH's future stability and the shift in population over the last two years and predicted into the future. Further, OSH has worked with managers in clinical services and in operations to determine the critical needs in those departments, resulting in a need for additional resources above and beyond those "direct care" positions that were discussed with the unions. The budget includes $10.8 million General Funds, as well as 228 positions (188 FTE), to meet these needs at OSH.

Budget: 9-8-8 Crisis Services System

The National Suicide Hotline Act of 2020 established 9-8-8 as the National Suicide Prevention Hotline (similar to 9-1-1 for emergencies) effective July 16, 2022. In 2021, HB 2417 required OHA to begin the creation of a statewide coordinated crisis system, and it funded call centers and enhanced mobile crisis services as part of that system. In January 2022, OHA offered additional recommendations for consideration by the legislature, including adoption of the Crisis Now Model led by the National Association of State Mental Health Program Directors. This model includes a 24/7 service array which includes call centers able to receive calls, texts, and chats, community-based mobile crisis intervention services, and dedicated facility-based crisis service centers designed to prevent or ameliorate a behavioral health crisis and reduce acute symptoms of mental illness by providing support to people who need specialized care in a safe environment but who do not require inpatient hospital services.

This year, the budget provides $1.8 million General Funds ($2.2 million Total Funds) to further support implementation of the statewide coordinated crisis services system consistent with the Crisis Now Model. These funds are primarily for development of standards for statewide mobile crisis teams and crisis stabilization centers, development of Medicaid reimbursement opportunities, business information system and financial management support, and agency operations supporting implementation.

Budget: Behavioral Health Housing

The budget provides $100 million one-time General Funds to OHA to directly distribute to community mental health programs (CMHPs) via a formula using existing funding mechanisms such as *County Financial Assistance* Agreements (CFAA). These funds are primarily to repurpose or build new secure behavioral health

residential treatment facilities, residential treatment homes, and other types of necessary housing. The funds may be used to support operational and administrative expenses related to managing housing, provide supportive services, pay for planning, coordination, siting, or purchasing buildings or land, provide subsidies for short-term shelter beds, provide long-term rental assistance, and support outreach and engagement.

These funds are intended to be distributed rapidly by OHA, with the express goal of addressing the bottlenecks in the continuum of care in the behavioral health residential system. Such bottlenecks in residential capacity have continued despite prior emergency funding action and additional new facilities being brought online during the pandemic. These residential funds are expressly available only to CMHPs and are not related to the series of residential funding Requests for Proposals currently being solicited by OHA (which were funded in 2021), though there may be opportunities to braid some funds together. OHA and CMHPs are expected to work together to define accountability measures and reporting requirements to track progress for these funds.

HB 4012: Child Services Rates

HB 4012 requires Oregon Department Human Services (ODHS), in collaboration with Oregon Youth Authority and OHA, to review the service provider rate structures of child caring agencies, with a focus on those that serve youth in the care and custody of the state. It also requires OHA to determine appropriate rates for providers of private duty nursing for medically fragile children once per biennium. After that, OHA is to request federal approval to adjust rates for these services accordingly every year. This legislation represents a significant departure from how provider rates are governed historically. Previously, provider rates have been at the control and discretion of the legislature. This bill sets up a situation in which rates adjustments – and OHA requests for increased federal funding to pay for rates adjustments – occur regularly without further legislative action.

HB 4098: Substance Use Addiction, Prevention, Treatment and Recovery

HB 4098 places parts of the Alcohol and Drug Policy Commission Strategic Plan into statute, expands the list of state agencies that must work with the commission to implement that plan, and requires agencies to meet with commission quarterly to review and report on each agency's progress. Also, the bill establishes an Opioid Settlement Prevention, Treatment and Recovery Fund to receive settlement monies from lawsuits against opioid distributors, manufacturers, and pharmacies, including the Distributor Settlement Agreement, the Janssen Settlement Agreement (Johnson & Johnson), and future settlements. This fund will be guided by a board that includes representatives from state agencies, the Ballot Measure 110 oversight council, city and county officials, a representative of a community mental health program, an individual who has experienced a substance use disorder, and a representative of law enforcement or first responders.

HB 4070: Oregon Consumer Advisory Council

The Oregon Consumer Advisory Council advises OHA on mental health issues. HB 4070 modifies the membership appointment process and adds substance use disorder and addiction services to the council’s scope. It also empowers the council, independent of OHA, to create and publish policy recommendations, impacts, advisories, or fiscal benefits estimates regarding proposed policies, and to communicate concerns and needs related to mental health, substance use disorder, and addiction services.

Budget: Measure 110

The budget provides 13 new staff positions for implementing Measure 110, the Drug Addiction Treatment and Recovery Act passed by voters in 2020.

Strengthening Oregon's Health Care Workforce

Even before the COVID-19 pandemic, Oregon faced health care workforce challenges. Many health care sectors saw a shortage of qualified staff, most markedly in rural and lower income communities. The workforce often was unable to provide culturally and linguistically appropriate services for all Oregonians, and did not fully reflect the diversity of Oregon.

The pandemic heightened these challenges. It added stress, burnout, and higher risk of infection to the already high burden borne by health care workers. Oregon cannot rely solely on the professionalism and commitment of those workers to meet the challenges alone; they need our help.

In response, Governor Brown and the legislature took large steps this year to support and strengthen Oregon's health care workforce. (Note that several additional bills and budget items related to the behavioral health workforce are listed above.)

SB 1545: Future Ready Oregon

To realize the full potential of Oregon's workforce, meet the needs of Oregon's employers today and into the future, advance Oregon's economic competitiveness, and ensure equitable opportunities for a diverse workforce, Governor Brown proposed Future Ready Oregon. Through SB 1545, this initiative will advance opportunities for historically underserved communities, including adult learners, dislocated workers, and disconnected youth. Investments emphasize recruitment, retention, and career advancement opportunities, while prioritizing key populations, including people of color, women, people with low incomes, rural communities, veterans, and Oregonians who are incarcerated and formerly incarcerated.

The $200 million in investments will focus on key sectors with high workforce needs: health care, manufacturing, technology, and construction (pre-apprenticeship programs only). These key sectors provide short-term pathways to meaningful employment, higher learning potential, and opportunities for economic mobility. Using a multifaceted approach through inclusive, culturally specific, and linguistically appropriate career-connected learning, employment services, and related initiatives, Future Ready Oregon 2022 will create equitable prosperity.

SB 1529: Volunteer Health Care Providers, and Primary Care Coverage

SB 1529 allows the deployment of volunteer emergency health care providers (through the SERV-OR program) during a public health emergency. It requires OHA to provide workers' compensation coverage for SERV-OR volunteers injured during training or provision of these healthcare services at the direction of OHA.

The bill also requires that health care coverage reimburse the cost of at least three primary care visits for behavioral or physical health in each plan year, in most cases without copayments, coinsurance, or deductibles, in addition to one annual preventive primary care visit covered without cost-sharing.

HB 4003: Nursing Workforce

HB 4003 directs the Oregon State Board of Nursing (OSBN) to issue a nurse internship license to qualified students in a nursing program, and to support a tax-exempt Oregon nonprofit organization that promotes the well-being of Oregon health professionals through education, coordinated regional counseling, telemedicine services and research. Recognizing the ongoing challenges that the pandemic has placed on the nursing workforce, HB 4003 provides an additional 90-day grace period for nurses operating under an emergency

authorization who are seeking licensure from OSBN. It also directs the Health Care Workforce Committee to study the challenges related to staffing shortages in the nursing field.

SB 1549: Temporary Staffing Agencies

SB 1549 establishes standards for license temporary health care staffing agencies. It also directs OHA, in collaboration with stakeholders, to submit recommendations regarding rates charged by temporary staffing agencies.

SB 1556: Home Care Providers

SB 1556 requires the Oregon Department of Human Services to establish a certification process for direct care providers of home or community-based services, implement an online registry of these providers, and explore ways to improve skill level and training of caregivers and improve caregivers' pathways to continued education and advancement.

Building Healthier Communities

Health is not something that happens only in a doctor's office or hospital. Lifelong health and well-being starts in – and depends on – the community, circumstances, and environment where a person lives, works, learns, and plays. Housing, access to food, neighborhood safety, education, transportation, and involvement with the criminal justice system are among the key social determinants of health. Several bills and budget items in 2022 focus on improving the health of Oregonians by building healthier Oregon communities.

HB 4150: Community Information Exchanges

Systemic inequities and regional variations in the availability and delivery of social and medical services have long plagued many people and communities in Oregon. A Community Information Exchange (CIE) helps address this by enabling community-based organizations, state agencies, health systems, county health departments, social service agencies, and technology partners to coordinate efforts to assess and address the social determinants of health.

HB 4150 instructs OHA's Health Information Technology Council to convene the Community Information Exchange Workgroup to accelerate, support, and improve a secure and confidential statewide Community Information Exchange. The workgroup, with diverse representation and in coordination with the OHA, will help inform a path toward a system that will effectively and equitably improve delivery of coordinated community services while increasing transparency and accountability for the investments made.

HB 4002: Farm Worker Overtime Pay

Farm workers have long been excluded from receiving overtime pay, a policy with its roots in racism in the 1930s. Until now, farm workers in Oregon who work in excess of 40 hours per week were ineligible for the overtime pay that is expected and received by most other workers. HB 4002 requires overtime pay for agricultural workers, phased in over the next four years. Farm workers as a community experience significant health inequities (lower life expectancy, higher rates of heart disease, pesticide exposure, depression, anxiety) related to the manner and circumstances of their work and their social and economic status. As one social determinant of health, overtime pay is expected, among other things, to result in better health outcomes for agricultural workers.

SB 1536: Extreme Heat Emergencies

Recent summer temperatures highlighted how extreme heat can make people and communities susceptible to illness and death. SB 1536 includes several measures to help Oregonians better prepare for future heat emergencies. These include directing OHA to provide portable, standup air conditioners and/or air purifiers to eligible OHP members who have underlying conditions making them more vulnerable to extreme heat. OHA will manage the distribution of these units through community partner organizations.

SB 1554: Reviewing the Public Health Response to COVID-19

As the COVID-19 pandemic seems to be nearing its end, it is important to examine how we responded to it, to help us learn for the future. SB 1554 directs a study of the public health system response to COVID-19 pandemic. This study, to be conducted by a third party, will look at all levels of government and community partners to understand the challenges and successes in response to the COVID-19 pandemic, with a lens on improving public health and addressing public health modernization.

Budget: Healthy Homes

The Health Homes Program assists low-income households and households impacted by environmental justice factors to make health and safety improvements. Such improvements include elimination of lead paint hazards and mold, wood stove smoke, allergens, and other asthma triggers, weatherization and HVAC improvements that protect against wildfire smoke and extreme heat, and disabled access improvements. The budget included $5 million General Funds for healthy homes.

Budget: Reproductive Health Equity

The budget includes $15 million General Funds for contracting with qualified service organizations to support reproductive health equity in Oregon.

HB 4045: Community Violence Prevention

HB 4045 funds grants to organizations for community violence prevention and intervention measures. It also provides funds to OHA to expand hospital-based violence prevention programs.

HB 4077: Environmental Justice

HB 4077 enhances the Environmental Justice Task Force into the Environmental Justice Council within the Office of the Governor. Among other things, the bill directs the council to collaborate with several state entities, including OHA, to develop an environmental justice mapping tool.

HB 4034: Technical Fixes
HB 4034 is a technical fix bill that amends various health-related statutes. This includes allowing pharmacy interns to dispense pseudoephedrine or ephedrine; extending the sunset on the release of COVID-19 data collected by OHA; changing the requirements for recording dispensation of a biological product by a pharmacy or pharmacist; permitting OHA to implement reproductive health services and education programs; further defining “telemedicine” and permitting the use of telemedicine by physicians or physician assistants; addressing restrictions related to remote access of a pharmacy’s electronic database, final verification of prescriptions, and telepharmacy; and redistributing grant funds administered by OHA for school-based health programs.

Looking Ahead to 2023

Oregon Health Authority

As OHA prepares for the 2023 legislative session, the agency is committed to advancing the goal of eliminating health inequities in Oregon by 2030. It also commits to thoroughly and meaningfully engaging with communities, especially those experiencing health inequities, on policies that impact them.

OHA is focused on systemic and transformational change. This includes continuing to reduce the number of Oregonians who are uninsured, underinsured, or lack access to health care; creating a behavioral health care system that is simple, responsive, and meaningful in meeting the needs of all Oregonians; continuing to modernize the public health system; and addressing the widest range of social determinants of health.

K. Litigation status

Family Care v. OHA

A former coordinated care organization (CCO), FamilyCare, had filed a lawsuit making the following claims against OHA and its former Director: a federal civil rights claim against the former Director; breach of a settlement agreement between OHA and the CCO; and breach of OHA and the CCO's contract governing the CCO's participation in the Oregon Health Plan. The case has settled, and the judge has dismissed the case with prejudice on May 13, 2022. The state agreed to pay Family Care $22,500,000. This case is concluded, and this matter will be taken off the report next quarter.

Bay Area Hospital v. Oregon Health Authority

In December of 2019, Bay Area Hospital, formed by a health district, filed an administrative appeal to challenge a supplemental assessment on hospitals to support the Oregon Health Plan. According to the request for hearing, the supplemental assessment constitutes a tax that may not be imposed on hospitals created by health districts absent an affirmative legislative declaration. Hospital sought refund with interest. A final order denying the hospital's appeal was issued July 30, 2020. Hospital has petitioned for review in the Oregon Court of Appeals. A judgement affirming the denial was issued in December 2021 and an appellate judgment was issued on February 3, 2022. There has been no timely petition for review to the Oregon Supreme Court so this case is concluded, and this matter will be taken off the report next quarter.

Connecticut v. Generic Drug Manufacturers and Wisconsin v. Indivior

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

Sarepta Therapeutics Inc. v. OHA

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

Cal. et. al v. Azar.

Oregon is a co-plaintiff in litigation challenging CMS's Rule revision which removed the ability of the state Medicaid agency to deduct union dues and other voluntary deductions such as health insurance premiums from the providers' payment for services and direct those moneys to third parties. A recent NPRM effectively reverses CMS's Rule revision, which has been enjoined in *California et al. v. Azar*, 501 F.Supp.3d 830 (N.D. Cal. 2020). Defendants appealed the district court ruling, but the appeal was held in abeyance (an administrative stay). The abeyance was set to expire on February 1, 2022, but it was recently extended to June 2, 2022.

L. Public forums

Health Evidence Review Commission

March 10, 2022

There was no public comment received for this meeting.

HERC Value-based Benefits Subcommittee

March 10, 2022

There was no public comment received for this meeting.

Medicaid Advisory Committee

January 26, 2022,

Topics discussed:

1. 1115 Waiver Renewal – MAC letter of support
2. Quarterly Ombuds Program Report and NEMT Update
3. 2022 MAC Workplan Discussion
4. Medicaid Redeterminations and Migration to the Marketplace
5. CCO Updates
6. ODHS Agency Updates

Public comment:

Gabriel Triplett (provided oral and written testimony)

My name is Gabriel Triplett. I am a husband, a father of 3, and community advocate and organizer.

I want to appeal to you today about an issue that effects my family directly and also thousands of families in Oregon. Currently the State of Oregon is allowing parents to qualify as the Paid Support Workers or Direct Service Providers of their underage disabled children. This temporary allowance has resulted in increased stability and improved health for children with disabilities in Oregon

When my son Oscar was born just over 9 years ago, my wife and I began a new chapter in our life, one of raising a medically complex child. This new chapter required we move from a two- income family to a one-income family. Honestly, with the amount of therapy visits, hospital admissions, and level of constant care that my son requires, even holding down one job has proven extremely difficult and at times it has been impossible.

Regularly my wife and I, while barely holding our heads above water, will stop and say, “how would we be able to do this if there was only one of us?” “How we would be able to do this if we didn’t speak English? If we didn’t have back grounds in organizing and system navigation?” The answer of course is, we probably wouldn’t. Talk to any social worker involved in foster care, and they could tell you more stories than you would like to hear about families with disabled children torn apart because it was just too much! But it doesn’t have to be.

When the pandemic hit, families like mine organized. Over 3000 families signed on to a petition to plead that the state amend their 1915 (K) waiver to allow parents to qualify as PSWs and DSP’s. In January we were given a temporary allowance for the duration of the PHE. This allowance has been a literal life saver!

For our families, the pandemic did not bring any new problems, it simply brought our problems into shared timeline and gave typical families a glimpse into “Our normal”. Community spread of virus that threatens our

children's lives and prevents us from accessing outside help, is not new for us. Assessed hours of needed support going unused due to staffing shortages, is not new for us. Losing our jobs, housing, our relationships because we need to stay home, to prioritize the safety and health of children, has been a new experience for so many during this pandemic, but it is not new for families with disabled children! And after the PHE, as everyone returns to "their normal", we will be left behind. Our new normal even harder than the last as we are left to deal with another endemic that disproportionately threatens our kids.

Parents need to be allowed the choice to be our child's PSW/DSP, when we assess that that is the best option for our families. Because we know what is best for our families. We are the experts in the life we live, and WE ARE SAYING WE NEED THIS OPTION.

A group of parents and I met with a state legislator last year about this issue. She shared some concerns that I have heard echoed by others within ODDS and within provider agencies. I'd like to quickly address these.

1. Neither the State nor provider agencies will be able to hold parents accountable as PSW/DSP. This lack of accountability will lead to less community engagement of disabled children
a. Currently, parents are already in charge of their children's level of community engagement.
b. The current system allows for family other than biological and adoptive parent's to be PSW/DSP's. In practical terms, the state has the same level of accountability with these family members as they would with biological and adoptive parents.
c. Parent's care about the wellbeing of their children more than the State and when they don't there ought to be universal policies in place to safeguard all children, despite their level of ability

The second one is more philosophical and it goes something like this.

2. Parents should not be paid to parent. Some children just require "more parenting" and that just part of the deal.
a. However, just like our counterparts with disabled children over the age of 18, who *are* allowed to be PSW/DSP for their children, we are not asking to be paid for our parenting. The State has already assessed a need above and beyond what a parent is expected to perform. What we are saying is, if we assess that it is in the best interest of our families, and we do the that work, that is above and beyond, we ought to be paid the same as anyone else.

The State of Oregon made a change to allow parents of underage children with disabilities to be PSWs/DSPs and it has been a huge success! Disability families are more stable and children with disabilities are healthier. We should not go back. This change needs to be made permanent.

Myself and the group of families I am organizing with would love to talk with you further about how we can get this done in a way that strengthens, empowers, and protects our children with disabilities and our families.

Thank you.
Gabriel Triplett

Emily Fern Dayton (written testimony)
I am writing to you today to ask that an exemption be placed within the Medicaid 1915i Waiver to allow biological and adoptive parents to be paid caregivers to their children who have disabilities and chronic, complex medical conditions. I am requesting that parents be paid the same hourly rate as DSP/PSW's.
The state of California pays parents of children who have disabilities and are medically fragile. We have had members in our support group who have been forced to relocate to California in order to be able to successfully support their child's medical needs and alleviate the ongoing financial strain.

As a parent and 24/7 caregiver to a 6 year old who has a rare medically complex syndrome; it is impossible to hold down a job let alone a career for my spouse or I. Juniper has an extremely low seizure threshold, meaning

she gets seizures from common cold/flu viruses. She also has extremely long and dangerous status seizures which frequently last 30 mins-2 hours.

Along with status seizures, she has Wolf-Hirshorrn syndrome, reflux, hypotonic cerebral palsy, autism, microcephaly, upper airway restriction, unrepairable open palate, sensory processing disorder, hypotonia, gtube fed, and is unable to walk or talk. I am not asking for pity, as my child is the love of my life, and has so much to teach the world.

Due to her medical fragility, we were forced to give up our careers to provide adequate care for our child. I was a FT educator/social service provider; while my spouse was a FT lab technician. In my position, I was frequently bringing home germs and illnesses that would set off seizures and respiratory issues for Juniper. My spouse now works a PT entry level position in order to provide support when medical emergencies occur. There have been countless occasions when I've had to call him home to support seizure emergencies.

We searched for caregivers to support our family, however many were not interested in supporting us long term as it was only a "stepping stone" job for them. We went through 10 caregivers in the span of a year and a half. Through this experience I have had to manage the care workers, remote learning, PT/OT/SLP, and various medical specialists which is around 30 providers total to coordinate care, appointments and meetings. All the while managing Juniper's medications, tube feeds, seizure emergencies, choking scares, and using suction and oxygen during emergencies to try to avoid calling 911 to have another ill trained Paramedic and ER Dr who are unsuccessful at supporting my child's various medical needs, all during a deadly pandemic.

I am asking all of you to integrate a family centered model of care. For those of us who have children who have medically complex conditions, we are the best trained caregiver. My daughter deserves the consistency, love and stability of her parents. We notice when our nonverbal child has the slightest change in disposition that means a seizure is coming on, and get oxygen and the rescue meds. We can assess when our child who has an extremely high pain threshold has injured herself. We know how to safely support her through life as a crawler and wheel chair user.

Please support Oregon's most vulnerable children, and allow parents to manage their DSP/PSW care hours allocated through Medicaid and managed through the Child Intensive In home Services program of ODDS in order to be Paid Parent Caregivers. In May, after a long 4 year wait, Juniper was accepted into the CIIS program which due to the COVID-19 emergency started paying me to be their her caregiver.

This program has been a huge relief, as we had been struggling have been struggling against insurmountable odds in order to pay our bills, keep up with home repairs and adequately support our child. Unfortunately, the parent as paid caregiver program is set to end in January 2022. This will provide dire financial consequences and strains on families like ours. Please support my little love by allowing me to continue to support her fully, she has so much love to give.

I look forward to your support with including the Parent as Paid Caregiver program in the new Medicaid waiver 1115.

Kind Regards,
Emily Fern Dayton, MS

Kirk Foster, Owner of Wapato Shores Accessible Transportation
As the owner of Wapato Shores, my marching orders for my team was to protect the members that relied on us from Ride to Care from January 2015 on. That is not an exaggeration. My company grew dramatically under the Ride to Care program because of this model, but it came at great personal cost to me and to my family. I began

to lose the ability to maintain this role as my personal health suffered and I began having heart trouble as a result. My team would regularly be in tears due to the stress of trying to prevent failures. Many quit due to an inability to withstand the stress of protecting the members of vulnerable populations from Ride to Care. I finally gave up and donated my entire remaining 49 vehicle fleet to a non-profit to literally and arranged for them to hire my entire team to save my life per my cardiologist's orders. A combination of OHA policy and CCO inaction are the cause. Period. Providers cannot provide good service within the the current structure. There have been no constructive changes to improve the service structure since 2014 change destroyed it, despite all of the changes. This is because none of the structural changes have taken the needs of the members or the drivers or the providers into account. All changes are made from the OHA and CCO perspective. Ride Connection has solved the credentialing and issues of non-payment. The changes only help the CCO's internal problems. Other providers are closing, selling vehicles, many are evening buying box trucks and moving their drivers to packages and cargo because that is sustainable. Solving these problems is easy from an operational perspective. The problem is that no decision makers take the advice of those of us with experience. This is NOT a provider or driver issue

Ride to Care has been the model that is now being used. More members would use NEMT if the program hadn't already created an unreliable reputation. What are the qualifications for a NEMT company? CHA just uses the cab company here. There is no training required. I have a horror story and I'm not the only one. another example of this CCO outsourcing their obligations.

Barb M.

February 23, 2022
Topics discussed:

1. Medicaid redeterminations and HB 4035
2. Legislative Update
3. CCO Update
4. ODHS Update
5. Paid Family Caregiver Policy – follow up to January testimony
6. Advancing Consumer Experience Subcommittee

Public comment:

Charles Gallia
I worked with the Oregon Health Authority for several years and I'm aware that churn is a common research topic. You have publications that are on your website that talk about churn - who the populations are. Whenever a performance measure is calculated, there is a continuous eligibility criteria. That's applied to it, so you have the data about who it is that's being impacted.

One of my concerns is the kind of general approach that's being described as income being one of the issues that's related to the loss of coverage; actually, it's administration and administrative non-response as opposed to income. The people that you have data on have turned in their information and you know what their income is and that's the reason that's given, but largely it's administrative and the administrative challenge that is challenging for some of the individuals. Even with the existing kind of infrastructure to be able to be connected with and understand what the potential losses are there are a lot of folks who still think that they are covered when they're not, until they show up at an ER or for regular office visit.

Something that's beyond the existing system and even working with community partners in ways that I don't think is articulated in this bill – it is going to require a little bit different work with like peer support groups that you haven't connected with in the past and I also know that there are some of these things that could be

undertaken now to begin this outreach in a way because the OHA is already reimbursed for some of the disenrollment and the enrollment services that are supposed to be provided through this bill. So, it's kind of an observation and I know I've said a lot - but just to let you know that I think that they're seeing in in the works already that could be used to ameliorate what could be the most devastating change that Oregon's seen in its health care system in decades.

MAC members approved submitting a letter of support to ODDS to continue with the Paid Family Caregiver Policy. Two abstentions for this are Rachel Currans-Henry and Dave Inbody as they are employed at OHA and ODHS.

Prior to the MAC vote, Jackie Wetzel read a letter from Karun Virtue and the MAC heard public comment from 4 people.

All were in favor of sending the letter to ODDS. The MAC letter was addressed to the Director Office of Developmental Disability Services and the Interim Medicaid Director Oregon Health Authority. It is attached here.

PUBLIC COMMENT

Razzano Joey W
I can tell you that I am both a parent of a child experiencing complex medical issues who was qualified on the children in-home intensive services waiver as well as the Oregon representative for the International Rett Syndrome Foundation and also on the board for the Northwest Rett Syndrome Association. I have met one family that did apply for the waiver and did not get approved and I have several families who also asked me from several other states. I'm considering moving to Oregon for you know, I've heard it's good, there for families like mine. And I have to continually tell them if you depend on any type of supports specifically California has in home support services and IHS S does pay parents to be caregivers. I have to tell them if you depend on that income, you will not get it in Oregon. It's just been a hard and fast rule and that literally prevents them from moving here, I can also tell you that I agree completely with the testimony that was just read that the divorce rate among families is between 80 and 90%. I have personally experienced and seen it happen time and time again. I can also tell you that changing an 18-year-old poopy diaper is not natural and even though we do have the supports in place, both under 18 as well as over 18. Finding good care in your home, consistent good care is all that really does is it allows you to actually work outside the home when what you would really be doing what you'd really want to be doing is staying home with your child. If you had the choice, instead of living in poverty so now we are in a public health emergency where many of the families. I represent are finally getting some financial relief. And I have to caution them and say you know this is just while COVID is so this terrible thing has given us this silver lining. I would support the letter that supports paid family caregivers 100% and I'd be happy to give you multiple instances where I know, people who this would help them either stay out of poverty or stay married or both.

Gabriel Triplett
I talked to a mom who had to move to California in order to keep her family whole because as a single mom, she could not work an alternative job and take care of her child. That meant, she needed to leave all of her natural supports behind. A big thank you to Joey for sharing your comment. Emily Fern also says thank you to Karun Virtue who articulated so much of our providing 24/7 caregiving for our child who has disabilities and chronic complex medical conditions. The permanent parent paid caregiver program is essential to support the diverse needs of vulnerable communities.

Kelsey Smith

I just wanted to point out that in addition to it being the eternal struggle to find personal support workers for our kiddos. The way that we're supposed to use those were actually disallowed to have a job and use those hours in order to go to a job so it is virtually impossible to work while we have these kids with disabilities. And so I guess that would just reiterate what everybody else is saying which is this is the most important thing to so many of us for our future and the future of our kids and I just wanted to say one more thing in the last you know 2 years since this pandemic started my quadriplegic medically fragile child has actually never been healthier and the reason for that is that because we can't find caregivers we don't have a parade of caregivers coming through our house, which means that we're able to better monitor you know who's coming in, what kind of germs are coming in everything about it has actually been better for us being able to be paid caregivers being able to closely monitor the people coming into our house in order to make sure that we can ensure his health and safety has been really life changing fronts. It's the first time he has gone more than a couple months without being hospitalized for a long term. So, to us, at least in in our experience, it is saving the state a lot of money not having to be hospitalized as often. So, thank you.

Jenny Hoyt submitted comment via chat:
The letter support was beautifully written and really encapsulated the struggles. We face in this journey as parents of disabled kids. Thank you for taking the time.

Metrics and Scoring Committee

The committee met once in this quarter.

March 18, 2022
There was no oral public testimony.
Written public testimony:

- Carly Hood-Ronick MPA, MPH Executive Director of Project Access NOW (PANOW)
  - In support of the social needs screening metric concept
- Samantha Shepherd, Executive Director of CCO Oregon
  - From Social Determinants of Health and Health Equity Workgroup Behavioral Health, Dental and Oral Health Workgroups
    - In support of adopting a social needs screening metric into the CCO quality metric set.
  - From the Behavioral Health Workgroup
    - To recommend transitioning SBIRT measurement to move beyond screening and referral to a measurement of engagement in Substance Use Disorder treatment services.
  - From the Dental and Oral Health Workgroup
    - In support of the inclusion of the oral evaluation for adults with diabetes to the 2019 CCO metrics set and to recommend that the Preventive dental service utilization for adults measure be added to the 2020 set.

Health Plan Quality Metrics Committee (HPQMC)
The committee met once in this quarter.

March 29, 2022
There was no oral public testimony.
Written public testimony:

- Carly Hood-Ronick MPA, MPH Executive Director of Project Access NOW (PANOW)
  - In support of the social needs screening metric concept
- Gary Plant, MD, FAA, Madras Medical Group

- In support of a social needs screening metric that is focused on the community level and not at the primary care clinic level. The CCO measure should include assessment at community level both for needs and resources. The state and community also need to dedicate resources to address those needs identified in the assessment.

- Matthew Mitchell, Data Analytics Manager, Central City Concern. Member of OHA's SDOH measure concept workgroup and member of the screening tool subcommittee.
  - In support of the social needs screening metric concept
- Samantha Shepherd, Executive Director of CCO Oregon
  - From Social Determinants of Health and Health Equity Workgroup Behavioral Health, Dental and Oral Health Workgroups
    - In support of adopting a social needs screening metric into the CCO quality metric set.
  - From the Behavioral Health Workgroup
    - To recommend transitioning SBIRT measurement to move beyond screening and referral to a measurement of engagement in Substance Use Disorder treatment services.
  - From the Dental and Oral Health Workgroup
    - In support of the inclusion of the oral evaluation for adults with diabetes to the 2019 CCO metrics set and to recommend that the Preventive dental service utilization for adults measure be added to the 2020 set.

Oregon Health Policy Board

Public comments relating to the Oregon Health Authority's (OHA) 1115 Wavier Renewal Application were shared at the January 2022 OHPB meeting; no public comments were shared at the February and March 2022 OHPB meetings. The January comments and meeting agenda are provided below.

OHPB January 2, 2022
Meeting Agenda & 1115 Waiver Public Comments

1. Welcome, Roll Call and Minutes Approval
2. OHA Director's Update
3. Oregon Health Reform Roadmap
4. Cost Growth Target Program Update
5. Public Comment (non-1115 Waiver Topics)
6. OHA 1115 Medicaid Waiver Updates
7. 1115 Waiver Public Comment

Annie Valtierra Sanchez gave comment - My name is Annie Valtierra Sanchez , I am the Director of Regional Health Equity Coalition in Southern Oregon, So healthy, and I am here on behalf of the other RHECs. Dear Chairs and members of the Oregon Health Policy Board. I'm here to clarify the stance of Regional Health Equity Coalitions with regards to the concepts in their 1115 Medicaid waiver application. Specifically, this group wants to be clear that we strongly support and are advocating for the Community Investment Collaboratives model. We the RHEC participated in writing House Bill 3353 to help carry forward the vision and goals in the bill. We also participated in a waiver workgroup related to focus equity investments concept, we also develop a set of principles to guide that process. And previously, we, as we stated to the Oregon Health Policy Board here back in August 2021, it is our hope that all waiver concepts will be aligned with the principles which also reflect the asks in House Bill 3353, which prioritize target investments and efforts to populations and communities who have been most impacted by historic and contemporary injustice and health inequities. Shift power and decision-making authority to community voice, create opportunity, opportunities to build sustainable infrastructure systems and programs that recognize reconcile and rectify historical and

contemporary and justices support community leadership, development, build and rebuild trust between health systems and communities. We know that it cannot be done in silos. So, we are calling to action, OHA, our allies and partners, our CCO partners to join us in advocating for this necessary and fundamental shift. Especially as that they trust the wisdom of communities that they are meant to serve in join us in this effort. We are also calling to action OHPB members. If parody and delivery of services and health equity are a priority for you all. Please help support this effort to shift power and resources to communities through your positions of leadership. Thank you.

Christian Moller-Anderson gave comment - Hello, my name is Christian Molloy Anderson and I serve as the Executive Director for Smile for Kids. Thank you for the opportunity to share some feedback about the 1115 Waiver, renewal application. And a special thanks to Dr. Santa for your earlier question about EPSDT as well for kids as an Oregon based private 501 c3 nonprofit organization that funds orthodontic treatment for our Medicaid youth in all of Oregon's 36 counties. We have existed since 2004 Because Oregon excludes OHP kids from any orthodontic treatment unless there's a cleft palate or cranial facial syndrome involved. We are disappointed that OHA has requested that CMS renew the state's authority to restrict coverage for treatment services identified during EPSDT screenings to those services that are consistent with a prioritized list of health services for individuals above age one. We think this waiver is unnecessary for OHA to achieve its programmatic goals and we're especially concerned about its impact on children with handicapping malocclusions. In all other states, the Medicaid program covers medically necessary orthodontic services for children who have this severe and life altering condition. And having malocclusion can interfere with eating, speaking, sleeping, smiling and normal social relating. It can affect both the physical and social emotional development of children. Its impact can be felt over a lifetime in the loss of achievements in education, possibilities of employment and a reduction in overall health and wellness including mental health. Hundreds, perhaps 1000s of Oregon's most vulnerable children are currently denied access to critical and medically necessary care that should be covered as part of the EPSDT benefit. A smile for kids does its best to fill this gap. But we have resources to serve only about 60 new applicants each year and usually have around 200 active kids during non-COVID times in braces. We have filed more detailed written comments, but the bottom line is that we urge OHA to reconsider its request to waive these EPSDT requirements. Thank you very much.

Josh Balloch gave comment - Hi, my name is Josh Balloch. I'm the Vice President of Government Affairs for AllCare Health. Thank you for the opportunity to testify today. AllCare Health is very supportive of many of the parts of the waiver including the increase of overall enrollment in CCOs, keeping healthcare continuity for members as they transition from different care settings in an attempt to create flexibility and invest upstream and creating metrics to ensure those investments happen. But there are still concerns around the draft waiver when it creates to create new health care silos that does not properly align with a bipartisan supportive bill of HB 3353. Regions across Oregon are extremely complex and often priority populations have different needs in the same region. An example would be a Spanish speaking community in Jackson County is very different and has very different barriers than the Spanish speaking community in Brookings, which is only 60 miles away. The new silos that are proposed in the new waiver are said to be empowering community. But there's no definition of what the community is and regions are not defined, membership is not defined, because of this lack of clarity there is going to be gaps where communities are missed, and creating silos and health equity separated from the whole system will make these gaps even more pronounced. Equally concerning are how these new groups will actually submit to the OHA for grant dollars. There are two major concerns for this one since this significantly weakens local control and HB 3353 was designed to hold both CCOs and the OHA accountable. How can these new entities hold OHA accountable if they are beholden to the DOJ for grants? Finally, this new silo of handing out grants sets back five years what CCOs and the committee and the CCOs community advisory councils have been doing. Because CCOs have never had a true global budget, our councils have been stuck giving out grants as opposed to giving multiyear funding for community projects. AllCare Health community advisory councils highlighted many of these multiyear projects they would have loved to have funded, but the but we're not able to do and they would think that HB 3353 would make it more sustainable. I

know that I've run out of time, but I do want to make sure that as we're moving forward that that there's more efforts to actually closed the gap. And that as you are incorporating these comments into the process, that the Oregon Health Authority does a much better job of actually bringing in people to actually say, are we are we actually getting what we're trying to do as you're making changes to the actual final waiver that you end up proposing? I would also strongly encourage concluding community advisory councils, especially considering a large part of their membership is made up of actual Oregon Health Plan users. Thank you for the opportunity to testify today.

Meghan Moyer gave comment - Hello, my name is Megan Moyer. I'm the Public Policy Director for Disability Rights of Oregon. I would like to say that Disability Rights of Oregon finds many of the new ambitious ideas in this waiver to be exciting and we are very supportive. But we continue to have very serious concerns about how OHA uses quality or quality adjusted life years in how it has prioritized its list as well as we do not support the continued waiver of EPSDT. I have had many conversations with DHS related to quality, and frankly feel like I'm not getting a clear answer about how it's used today. But it is very clear that the quality score was at the heart of much of the scoring that was done at least up until 2013, possibly to 2017. I was also clarified that quality was not. We did not rescore all those scores may that were done before 2013, which was the overwhelming majority of conditions and treatments were scored using a quality adjusted life year model and is still ranked without score today. Quality adjusted life years is a deeply discriminatory measurement that devalues the life of people with disabilities. It treats people who have chronic disease and disability as if their life is worth a fraction of what the life of a healthy person is. It is not based on science; it does not have any value. Outside of the opinions of healthcare professionals have what they believe the quality of life is for somebody with a disability. The health professions are well documented as being discriminatory and biased against people with disabilities. And yet it is still a score that has been incorporated and at the heart of our prioritized list. Disability Rights of Oregon is asking that we disavow the quality adjusted life year and re score using a non-bias matrix. The prioritized list so that people with disabilities are not disproportionately impacted at by the prioritized list. Thank you

Colleen Reuland gave comment - Hi, I'm Colleen Reuland the Director of the Oregon Pediatric Improvement Partnership. We are extremely supportive of the elements of the waiver focus on addressing structural racism and children within OHA health equity definition. A key component for children in Medicaid and CHIP is the intentional inclusion of disability. For children with special health care needs the Oregon Health Plan is the safety net for their medical, behavioral, oral and care coordination needs. In Oregon 145,000 publicly insured children so that's more than one in four have medical complexity. We hear from parents and young adults consistently and persistently about how their access to and care coordination needs continue to be unmet. We have significant concerns about the waiver proposal related to incentivizing equitable care. Measures that are incentivized have been shown to be a critical tool to focus on specific populations for which improvements are desperately needed. The current proposal will result in no metrics that will incentivize equitable quality care for children with special health care needs. And the very program meant to ensure these children's needs are met. The upstream metrics proposed although critical and addressing some of the historical and equity and social challenges faced do not contain metrics focused on children with disabilities. The etiology of disabilities with children is different than adults, and that the majority are not caused by lifestyle or life circumstances that could be addressed by upstream efforts. The current proposal calls for downstream metrics to only be chosen from the CMS core set. In the set, there are no metrics for children and youth with special health care needs. There are no metrics for focus on care coordination and complex health management. And the metrics included focus on behavioral health, do not measure integrated behavioral health or dyadic behavioral health. The metrics program must be designed in a way that ensures equitable access to high quality care for children youth with special healthcare needs. And therefore, we strongly recommend reconsideration of the waiver language related to downstream metrics. Thank you for your time.

Richard Gibson MD PhD gave comment - Good morning. I'm Richard Gibson, Physician Informaticist with Comagine Health. We appreciate the opportunity to support the renewal of Oregon's Medicaid waiver to improve health equity. Comagine Health is a national nonprofit healthcare consulting organization. We've been working collaboratively with patients, providers, payers and community-based organizations for 40 years. In Oregon, to provide care management and quality improvement services as well as cost and quality data management Comagine Health supports continuous enrollment of adults and children in the Oregon Health Plan. We partner with OHA to monitor health outcomes for Medicaid beneficiaries. We have maintained an all-payer claims database since 2010. In Oregon that allows us to track cost quality and utilization indicators in the commercial Medicare and Medicaid markets are all payer claims database can follow individuals over the years even if they change insurance companies or markets. Enrollment data show that individuals are moving from OHP to self-pay and back. Such churn increases health risk individuals, and the loss of claims diminishes the completeness of quality and cost data can imagine health supports expanding funding of community-based organizations and traditional health workers to address health inequity. Community based organizations frequently rely on grant funding to deliver services a model insufficient to support sustainable infrastructure needed to scale command health assist these organizations to engage with the emerging community health information exchange in Oregon. We helped them build infrastructure and standardized workflow for referral to evidence based self-management programs they provide and receive payment from Medicare and Medicaid. Thank you for the opportunity to support Oregon Health Authority and its Medicaid waiver application.

IV. Progress toward demonstration goals

A. Improvement strategies

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

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

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

Patient-Centered Primary Care Homes

As of March 30, 2022, 637 primary care practices were recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Eighty-three PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model.

Due to the impact of COVID-19 on primary care practices in Oregon, the PCPCH program has been conducting all site visits virtually since August 2020. In January and February, the PCPCH program suspended all site visits due to the COVID-19 surge caused by the omicron variant; six site visits this quarter. Site visits include verification that the practice is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address barriers.

In fall 2022 the PCPCH program will convene an advisory committee to make recommendations on the next iteration of the PCPCH standards to ensure the program supports a primary care system that addresses community-identified needs, especially the needs of those who experience systemic racism, barriers in

accessing care, and health inequities. The committee work will be informed by information receiving during listening sessions the PCPCH program conducted with over 30 community-based organizations, primary care practices and those experiencing health inequities. The PCPCH program began recruitment for the advisory committee during this quarter and will make final appointments in June 2022.

Certified Community Behavioral Health Clinics

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

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

During this demonstration period, Oregon continued to pay a daily rate to participating clinics, using the selected the Prospective Payment System (PPS-1) model and through federal legislation was granted an extension to participate for additional years. The rate for each CCBHC is unique to each organization and was developed based on analysis of cost reports submitted to OHA during the planning grant. Among the key successes for 2022:

- Updated cost reports were submitted to CMS for Demonstration Year 4
- Updated federal metrics were submitted to SAMHSA for Demonstration Year 4
- Continued meeting with other demonstration states as program expands nationally
- OHA continues to advise CCBHC national council as a leader of primary care integration in service delivery
- OHA's CCBHC billing/Medicaid specialist is in the process of re-basing CCBHC rates
- OHA is in the process of re-certifying all clinics according to state and federal criteria for first on-site visits post-pandemic

Tribal Care Coordination

The State of Oregon and the nine Federally-recognized Tribes are the first in the nation to advance tribal care coordination via the 100% FMAP Savings and Reinvestment Program. This program allows the state to claim 100% federal match for services that would otherwise be paid at the usual federal/state match percentage, for services received outside of an IHS or tribal 638 facility for AI/AN Medicaid beneficiaries. To be eligible for 100% federal match, the care received outside of the IHS/tribal facility must be requested and coordinated by the IHS/tribal facility.

The claiming of 100% federal match is made possible by CMS guidance contained in State Health Official Letter SHO #16-002 (2/26/16). The disbursement of these savings to the tribes is allowed per Governor Brown's letter to the tribes on 9/7/16. Services eligible for this program include any covered Medicaid services. These services are typically covered at 100% FMAP when provided at IHS/tribal facilities, but SHO #16-002 allows 100% funding for services outside of IHS/tribal facilities as long as the care is coordinated by the IHS/tribal facility. The state then claims the enhanced federal match, subtracts a small administrative fee, and returns the difference to the IHS/tribal health program that coordinated the care. As of November 2021, seven tribes participate in the 100% FMAP Savings and Reinvestment Program.

To further assist in efforts to expand coordination of care for tribal members, the Oregon Health Authority has contracted with CareOregon to provide care coordination services for the roughly 28,000 AI/AN people enrolled in the Oregon Health Plan who are fee for service patients. CareOregon's model of care coordination

was led and developed by the tribes during discussions taking place in 2016. The tribes requested establishment of a program that focused on culturally-responsive health care and took into account the unique nature of the AI/AN health care delivery system. During the first 11 months of the program 766 members enrolled in the program, and 1,336 calls were received by CareOregon's call center. 140 of these tribal members were enrolled in one of Oregon's nine federally recognized tribes; 346 individuals were enrolled in an out of state tribe. CareOregon reports high rates of member satisfaction with the program, which has been renewed for a fourth year.

In July 2021, OHA received approval of a State Plan Amendment to allow tribes and the urban Indian health program to form Indian Managed Care Entities (IMCEs). Once operations start, these IMCEs will provide tribal care coordination services to approximately 15,000 of the 20,000 fee for service AI/AN Oregon Health Plan members. We have submitted our IMCE operational readiness review and IMCE contract to CMS for review and approval. At this time the readiness review has been approved by CMS. We are still awaiting approval of the IMCE contract.

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

Comprehensive Primary Care Plus (CPC+)

The Transformation Center manages the Medicaid fee-for-service implementation of CPC+, which concluded at the end of December. OHA is closing out the program, including reconciling 2020 performance-based payments (PBIP) with quality and utilization measure results. Participating practices will receive reports including quality and utilization data and paid amounts for 2020 and preliminary amounts for 2021.

Value-Based Payment Innovations and Technical Assistance

The Transformation Center kicked off the OHA CCO VBP work group during this period. Work group members will share best practices of their CCO's VBP development and implementation and receive targeted technical assistance. The focus of the first meeting was to introduce work group goals and build relationships to foster a healthy and productive learning environment. Topics proposed for future meetings, identified from a CCO survey conducted at the end of last year, include:

- Review of CCO VBP contract deliverables
- Development of VBP performance targets and benchmarks
- VB approaches to developing risk-sharing models
- Risk adjustment methods
- Attribution models
- Models to address Oregon's VBP care delivery areas

Value-based Payment Compact

The Oregon Value-based Payment Compact represents a collaborative partnership to advance the adoption of VBPs across the state. As part of Oregon's legislatively mandated initiative to contain growth in health care costs, payers and providers are working together to advance payment reform and move to VBP. The Oregon VBP Compact is a voluntary commitment by payers and providers to participate in and spread VBPs, meeting specified targets and timelines over the next four years. This effort will increase the impact of the CCO VBP work by spreading VBPs across other payers. The compact, jointly sponsored by the Oregon Health Authority and the Oregon Health Leadership Council, already has 47 signatories, covering 73 percent of the people in Oregon. Signatories include commercial, Medicaid and Medicare Advantage payers.

The VBP Compact Work Group, charged with ensuring the Oregon VBP Compact is successfully implemented, met in January and March. The work group further refined the strategies to address challenges to VBP adoption and began discussions of organizational accountability for each strategy.

Primary Care Payment Reform Collaborative

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

The collaborative's Implementation and Technical Assistance Workgroup finalized recommendations to the collaborative for payment models to sustainably support and integrate traditional health workers, and recommendations to the VBP Compact Workgroup for primary care VBP models. The VBP Compact Workgroup requested the collaborative develop a primary care payment model incorporating the recommendations.

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

Statewide Performance Improvement Project

No significant updates during this reporting period.

Roadmap to Oral Health

- Certification rules for school dental sealant programs (Oregon Administrative Rules 333-028-0300 through 333-028-0350) were permanently amended effective January 28, 2022. In response to the COVID-19 pandemic, the certification rules needed to include specific guidelines to safely provide dental sealant services in a school setting. Two technical assistance webinars were conducted with school dental sealant programs:
  - February 3, 2022 – provided an overview of the certification rule changes and the newly developed OHA Infection Prevention and Control Guidelines.
  - March 17, 2022 – provided an update to the OHA Infection Prevention and Control Guidelines in response to changes in masking requirements effective March 12, 2022.
- Oregon Metrics & Scoring Committee selected an oral health metric for the 2022 challenge pool that coordinated care organizations are financially incentivized to reach: members receiving preventive dental or oral health services, ages 1-5 (kindergarten readiness) and 6-14.
- The Transformation Center re-launched the reducing childhood caries affinity group after taking a several month hiatus to allow health system partners to prioritize needs brought about by the Delta and Omicron waves of COVID-19. Four regional coordinated care organizations in the state, as well as the statewide care coordinator for the fee-for-service program, are engaged in learning quality improvement science and implementing those lessons to increase the rate of application of topical fluoride varnish in primary care settings.

Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources

Sustainable Relationships for Community Health (SRCH) program

In 2022, all four (4) SRCH grantees submitted interim reporting for work accomplished 7/1/2021-12/31/2021 and new 6-month action plans for 1/1/2022-6/30/2022. In general, all SRCH teams were challenged by

Oregon Health Authority

COVID-19 pandemic impacts on program delivery (in-person and virtual), health care and social service workforce fatigue, staffing challenges and staff turnover and adjustments were made for each SRCH team in their new 6-month action plan. In addition, OHA-PHD staff are recovering from the pandemic response, adjusting to the arrival of new limited duration staff while usual PHD staff are still working on the response efforts. There are also Statewide contracting delays due to the pandemic which affects the OHA-PHD timeline to provide contractual funds to SRCH grantees and technical assistance contractors for SRCH grantees. Despite these numerous, ongoing challenges, SRCH grantees made some progress toward project goals which are outlined below.

SRCH team success and challenges:

The *Central Oregon* team will shortly launch a Tomando Control cohort in with the support of a new Spanish speaking leader/coach. In addition, the team worked with a creative agency (contractor) on program promotion to adapt website content to plain language and plan to translate into Spanish. The team also continues to work on refining CRM tool to manage outreach in all three counties of Central Oregon. The Central Oregon team has opted not to continue with the CDC Umbrella Hub arrangement established in 2020 between Crook County PH and Deschutes County PH, but will work to join Oregon Wellness Network (OWN) which will allow more support for coordinated training and resources for Central Oregon partners.

Confederated Tribe of Siletz Indians Due to low participation in the three-touch campaign and Diabetes management pilot, (CTSI) team has shifted focus from Diabetes Self-Management Education (DSMES) to Diabetes Prevention Program (National DPP). CTSI began planning and roll-out of the Food RX program among the Siletz tribal members. Technical assistance from Comagine Health is supporting CTSI with planning and connecting to similar efforts among the Navajo tribal areas.

The *RHEHub (Regional Health Education Hub*)/IHN-CCO team has focused in on creating a sustainability roadmap for the systems and structure needed to support National DPP and other self-management education efforts. Comagine Health is contracted to provide facilitation and support among the RHEHub members to develop the roadmap and then present the roadmap to all partners in June, 2022. OHA-PHD does not plan to fund RHEHub beyond 2022.

The *Tillamook County* team is focusing on supporting hiring of CHWs for the partner organizations, providing education and resources for existing network of CHWs and will begin supporting collaborative weekly and monthly check-ins for the CHW network. In addition, Tillamook team is in conversations and planning to integrate CHW activities with UniteUs platform which is already being utilized for other community-clinical linkage activity in the area.

Healthier Together Oregon

OHA continued implementation of Healthier Together Oregon, the State Health Improvement Plan. During this reporting period, a guidance committee for the PartnerSHIP held a retreat to build their 2022 work plan. They identified three goals: 1) establish an engaged and active PartnerSHIP, 2) expand knowledge and use of HTO by health equity partners around the state, and 3) establish the PartnerSHIP as an accountability partner for advancement of prioritized strategies.

Internally to OHA, the core group was revised in response to the strategies prioritized by the PartnerSHIP. The core group is a cross-division work group within OHA that provides backbone support for HTO. The core group serves as the hub of coordination, staff support and information sharing across six major functions: guided vision and strategy, Support aligned activities, establish shared measurement practices, build public will, advance policy, and mobilize funding. The group will be developing and prioritizing a work plan to build more supports within OHA for implementation.

Finally, in response to the prioritized strategy of increasing affordable housing that is co-located with active transportation, OHA convened other state agencies who have shared work in the space of affordable housing, active transportation, and health equity. The first meeting was held in March to assess readiness for engagement, with representation from Oregon Department of Transportation, Oregon Housing and Community Services, Department of Land Conservation and Development and Department of Environmental Quality.

Innovator Agents

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

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

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

Specific areas in which IAs have increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources are included below.

State Health Improvement Health Plan statewide work to eliminate health inequities:
An Innovator agent (IA) joined the newly revamped OHA State Health Improvement Plan (SHIP) Core Group. The SHIP is an important vehicle for driving community-based and public health resources towards improving social and structural determinants of health and equity. The OHA SHIP Core Group steers the coordination, staff support, and information for streams of work related to development and implementation. As part of this work, the Core Group supports aligned activities with resources across the state also focused on addressing social and structural determinants of health and equity, which in turn provides simplified cross-county efforts to improve community health. The OHA SHIP Core Group's focus on collaboration is transformative work that is critical to reaching the OHA goal of eliminating health inequities by 2030.

Advancing Traditional Health Worker payment models within Coordinated Care Organizations: An IA has started staffing OHA's contract with an outside consultant focusing on a Traditional Health Worker payment guidance document and technical assistance. The goal of this work it to support to Oregon Coordinated Care Organizations (CCOs) in integrating and developing payment models for Traditional Health Workers

(THWs). In addition to CCOs, the audience for this work will include other value-based payment (VBP) initiatives including, though not limited to, the Primary Care Payment Reform Collaborative (PCPRC). The PCPRC continues to advocate for the integration of THWs in primary care through payment strategies including VBP. In addition to payment, successful integration of THWs requires provider and staff education about their role and how to best utilize them to address patient needs. Although integrating THWs may require infrastructure and workflow changes, the practice has the potential to ultimately simplify administration and result in more effective care that incorporates community-based and public health resources.

Integrating pharmacy access across Local Public Health Authorities and Coordinated Care Organizations and advancing language access within pharmacies:
An IA worked with Local Public Health Authorities (LPHAs) and Medicaid Consumers to better understand and communicate to OHA and a Coordinated Care Organization (CCO) service area the significant barriers to accessing pharmacy needs. The IA coordinated the attendance of OHA pharmacy leads at a the CCO's regional community meeting, which includes LPHA attendance, to share and coordinate streamlined approaches to removing barriers to pharmacy access. As a result of this meeting and continued collaboration, to-date, more OHP members are knowledgeable about Oregon's efforts to support translation in local pharmacies and map pharmacy desserts. Further, CCOs and the LPHA have developed clearer guidance for members on how to access prescriptions. Finally, the local CCOs have made efforts to remove barriers to access (e.g., call-in pharmacy options, offering 90-supplies for some medications). This attention to pharmacy access considers community resources and aims to ultimately improve access to needed health care for CCO members.

IAs ensured safety and health equity across the state of Oregon. SB698 required every pharmacy to provide written translation and oral interpretation for anyone with limited English proficiency (LEP) to receive their prescription instructions in both their language of choice (14 languages are legally required to be translated) and in English. The IAs have ensured this information has been shared amongst providers, OHP members, and with pharmacies across the state. This is a more effective model of care that ensures OHP members receive the correct instructions about their medication. IAs have worked with community partners, representatives from Refugee Assistance programs and CCOs to ensure these new standards are made available through every pharmacy in Oregon.

Cross-sector community led COVID response and recovery efforts: IAs meet with Executive Leadership of CCOs multiple times per month. The information presented to the leaders by the IA includes COVID-19 information at the state, regional and county level; including vaccination rates and strategies to increase CCO membership vaccination rates. At community level, IA present information to Community Advisory Committees (CACs)for CCOs. Because CACs are made up of OHP members, community partners and stakeholders, presentations are focused on COVID updates for their county/region, and developments within OHA or other state departments, as well as resources and learning opportunities. Ultimately, the COVID-related information IAs share with CCO leadership and CACs contributes to more effective COVID response and recovery, because it supports coordinated cross-sector efforts. For example, , an IA through participating with COVID-Response partners at the community level was able to provide a group of 5 school district administrators and school nurses in one county with timely information and strategies around childhood COVID vaccine best practices to assist with planning for the 5-11-year-old vaccine rollout. That Innovator Agent participated in and contributed to a Vaccination Strategy workgroup hosted by one of CCOs with the delivery network and LPHA on a monthly basis. By connecting local partners with CCOs and OHA and carrying current COVID-19 related information to the community level, IAs helped to assure universal communication and coordinated planning

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

Emergency preparedness and Social Determinants of Health Innovation: In an innovative approach to addressing Social Determinants of Health due to Oregon's risk of wildfires, the state legislature set aside state general funds for air filtration devises in counties most at risk of wildfires and for Oregon Health Plan members most at risk of adverse health effects from smoke inhalation. Innovator Agents (IA) worked with Oregon Health Authority (OHA), Coordinated Care Organizations (CCOs), local Americans with Disabilities Act (ADA) offices, and community partners to plan the distribution of air filtration devices (SB 762) using the CCO model and coordinated care within CCOs. The group developed and used an equity-driven approach to identify members to receive the devices.

Integrating dental care coordination: The IA hosted a panel discussion on the topic of dental care access with OHA, the CCO, local Health Council, Community Advisory Council (CAC) and dental care organizations (DCOs) aimed at discussing ways to simplify the care coordination process between members, CCOs and DCOs.

Aligning community Maternal Child Health program and Coordinated Care Organizations: An IA worked with Local Public Health Authorities (LPHAs) in a CCO region to help align Maternal Child Health (MCH) programs at the community level and at the CCO level. Through this process the IA developed a graphic demonstrating MCH programs across the three-county region, to help the CCO better understand MCH programs at the community level and align with existing internal MCH services. This graphic along with the connection made between CCOs and LPHAs by the IA, is informing a new collaborative contractual process between a CCO and three LPHAs.

Leading with data and program best practices to identify reasons for underutilization of services: An IA joined the newly form OHA workgroup that is focusing on underutilization of the *Cover all Kids* program. Recent data has demonstrated that children in this program had significant underutilization of services, specifically mental health services. The IA is serving an active role in identifying barriers in accessing and utilizing care, through direct connections with CCOs to better understand underlining causes of this issue. The health equity and cultural sensitivity approach brought forth by the IA has been instrumental to the workgroup; additionally, it has been helpful for other workgroup members to learn about CCO health equity strategies, shared by the IA. Findings from this workgroup will help inform OHP and system wide strategies to help us in reaching the OHA goal of eliminating health inequities by 2030.

Advancing childhood immunizations through Coordinated Care Organizations and OHA Immunization Program:
An IA participates in a monthly Immunization workgroup for one CCO. Recently the workgroup (made up of CCO staff and contracted providers) voiced concerns about children not attending their Well Child Visits, thus being behind on childhood immunizations. The IA provided connection to the OHA Immunization program for communication and outreach resources and provided connection to another OHA committee to voice concerns that were negatively impacting the CCO's ability to meet a quality metric. The IA continues to bring COVID-19 updates to the workgroup, related to approval status of the 6 month- 5 years old COVID-19 vaccine. Additionally, the IA participates and contributes to best practices around increasing COVID-19 vaccination rates to a vaccination workgroup focused on equity and strategy, that is hosted by an LPHA.

An IA has worked over this past quarter with the OHA PH Division Immunization Section to resolve some information gaps/inaccuracies in the information that CCOs were receiving about childhood vaccinations. The IA began that work as an advocate for one of CCOs, but in the process of quality improvement, it was determined that the data glitch was affecting data for all CCOs. The problem was able to be corrected and updated accurate data then distributed to all CCOs. An IA worked with the OHA PH Division Immunization Section to identify solutions for missing COVID-19 Vaccination data on residents in a border county in Oregon

who may have been vaccinated in Washington State. In doing so, the IA was able to support larger conversations between states about Immunization Data Registry interoperability/file transfers and encourage a national solution to this challenge for those who travel across state lines for clinical services which involve administration of any vaccination.

Reducing barriers to access for populations facing transitions: An IA continued work with an OHA team preparing our next 1115 CMS Waiver. Based on feedback from a variety of system partners, we have been able to create a focused concept paper in the Waiver proposal that addresses medical coverage, care/case management and SDOH services and supports for individuals and populations in transitions from one setting to another. The defined populations are those in federal, state, and local corrections systems transitioning to the community, those youth in OYA custody, children with special health care needs transitioning to adulthood, foster youth transitioning to adulthood and those populations affected by climate change events/emergency events (like wildfires or heat emergencies).

Reducing barriers to timely enrollment into Coordinated Care Organizations: IAs have supported work related to internal processes which contain delays for determining OHP eligibility and enrolling eligible individuals into the CCO in their area. There is currently a "gap" of several days-2 weeks where eligible individuals are in an open card/FFS status in our state process. That gap is a barrier for members to receive care and for CCOs to be able to reach out to support that member in addressing needs. Convening the right OHA and ODHS leaders and assuring leadership support to request the resources necessary to accomplish this change will help those on OHP access needed services more quickly. This connects to both the implementation of Healthier Oregon (effective July 1, 2022) and the proposals in our 1115 CMS Waiver.

Supporting with Social Determinants of Health non-urgent 911 calls: An IA served in an advisory capacity with an initiative proposed by the Portland Fire Department to create a pre-transport response system called the Community Health Assessment and Response Team or CHART. Care Oregon recently awarded a grant to Portland Fire and CHART for implementation. Projections include significant savings to Medicaid and CCOs by CHART responding to non-urgent 911 calls. The CHART team has the skills, training, and supervision to do appropriate assessment of an individual and providing some care/case management and SDOH supports instead of transporting unnecessarily to an ED/hospital setting.

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

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

Health-Related Services

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

Staff published new HRS guidance on health information technology (HIT) and traditional health workers, and HRS reporting guidance to support changes to the Exhibit L annual submission template. In continued collaboration with OHA's consultant, the Oregon Rural Practice-based Research Network (ORPRN), staff hosted a companion webinar to the published HRS guidance on HIT. All HRS guidance documents for CCOs and external partners are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx

To improve future use of and support potential increases to HRS spending, staff continued to work with the ORPRN on direct CCO TA.

In Lieu of Services
Starting in 2022, CCOs may offer in-lieu-of-services (ILOS), which aim to address gaps for which HRS is not the appropriate mechanism. ILOS are services determined by the state to be medically appropriate and cost-effective substitutes for covered services or settings under the State Medicaid Plan. ILOS must meet requirements outlined in 42 CFR 438.3(e)(2). CCOs are not required to offer ILOS to members. A member cannot be required to use the alternative service or setting. ILOS supports health system transformation through key services, such as the Diabetes Prevention Program and traditional health care workers and enables covered services to be provided in non-traditional settings.

In collaboration with OHA's consultant, the Oregon Rural Practice-based Research Network (ORPRN), staff published the ILOS brief, ILOS coding resource guide, and FAQ. Staff also published a comparison document to help CCOs accurately implement and report on ILOS, HRS and SHARE Initiative efforts.

Lever 6: Testing, accelerating and spreading effective delivery system and payment innovations through peer-to-peer learning, the spread of best practices, and innovation through the Transformation Center

Transformation Center activities

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

Behavioral health integration
The center is working with the Health Systems Division to identify and address barriers to behavioral health integration for primary care practices seeking to employ unlicensed providers, including peer support specialists.

Population health
Community advisory council activities
The center continued to host peer-to-peer meetings with community advisory council (CAC) coordinators (topics included how CCOs are structuring CAC meetings to meet CCO 2.0 requirements, and how CCOs are involving their CACs in the community health assessment process). As part of a learning series on the social determinants of health and equity, the center held learning sessions for CAC members on the following topics: reviewing spending requests using an equity lens, understanding community health assessment health disparities data, and strategies to address community health improvement plan priorities focused on the social determinants of health and equity. The center also sent out the first e-newsletter to CAC members in English and Spanish.

Community health assessment (CHA) and community health improvement plan (CHP)
The center reviewed CCOs' CHA/CHP submissions, as well as CHA/CHP improvement plans to address gaps in meeting CHA/CHP requirements, and provided feedback to CCOs.

The center hosted the first session in a new operations-focused CHA/CHP learning collaborative for CCOs and their collaborative CHA/CHP partners. This session focused on resourcing CHA and CHP work. The collaborative will include five additional sessions and will run through June 2023. The center also updated CHA/CHP guidance for CCOs and plans to hold CHA/CHP office hours for CCOs in April and May.

Social Determinants of Health Measurement Workgroup
The proposed SDOH measure concept is "Rate of social needs screening in the total member population using any qualifying data source". This work is moving into the approval phase between March and June, with the following activities: (1) OHA staff presenting an educational webinar on the metric to the Oregon Health Policy Board; (2) Health Plan Quality Metrics Committee considering adding the measure to the core measure set; and (3) the Metrics and Scoring Committee deciding whether to add the measure to the CCO's 2023 incentive measure set.

Supporting Health for All through REinvestment: the SHARE Initiative
The SHARE Initiative comes from a legislative requirement for CCOs to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity.

The Transformation Center finalized and posted 2022 SHARE reporting templates and guidance: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx. CCOs' 2021 SHARE spending plans were also posted at this link. Technical assistance for CCOs included one learning collaborative session focused on calculating return on investment, facilitated by ORPRN.

CCO incentive metrics technical assistance
Kindergarten readiness

- **Preventive dental** – The Transformation Center restarted its two-year learning collaborative to increase rates of topical fluoride varnish applied in primary care and improve overall performance on the preventive dental care metric. Four CCOs and the care coordination contractor for the fee-for-service program are engaged in the work. The learning collaborative met three times, and the Transformation Center led two sets of office hours between sessions to help the entities develop their quality improvement efforts.
- **System-level social emotional health** – This is a new CCO incentive metric for 2022. In the first year, it will include four components: data review, asset map, community partner engagement and action plan. In year four it will transition to a child-level metric. The Transformation Center hosted two webinars focused on asset mapping and behavioral health services for children (infant to five years). The center has also contracted with a consultant who will begin facilitating a 12-month learning collaborative.

Screening, brief intervention and referral to treatment (SBIRT)
The Transformation Center is partnering with ORPRN to offer TA to primary care clinics in support of the SBIRT metric. The TA is a three-year study funded through the Agency for Healthcare Quality and Research (AHQR). The project is designed to address unhealthy alcohol use, chronic pain management and opioid prescribing in primary care. Moving forward, the TA is also addressing ramifications COVID-19 may have on SBIRT workflows and concerns about a rise in unhealthy alcohol and drug use concurrent with the physical distancing needed to suppress COVID-19. The recruitment phase was expanded to neighboring states and extended through February 2022. Sixty-two clinics have been recruited, which makes Oregon one of the highest-participating states nationally.

Cross-cutting supports
Care coordination (CC) and intensive CC learning collaborative

The Transformation Center is hosting a monthly learning collaborative throughout 2022 to support CCOs and other organizations who provide care coordination to OHP members with the delivery of effective care coordination and intensive care coordination. The three sessions this quarter were attended by about 100 people per session. Participants included representatives of all CCOs as well as multiple county mental health agencies and several delivery systems that serve OHP members. Learning collaborative content is based on information collected from participants in late 2021; the highest priority for participants is clarification of Oregon administrative rules related to care coordination and CCO contract requirements related to care coordination.

COVID-19 vaccines: virtual learning series for providers
The Transformation Center started meeting with the OHA Vaccine Planning Unit & COVID-19 Response & Recovery Unit to plan a new learning series for providers in support of COVID-19 vaccine rollout for the 6-month to four-year old populations.

COVID-19: Vaccines and equity
The Transformation Center is partnering with the Oregon Academy of Family Physicians, Boost Oregon, and Oregon Rural Practice-based Research Network (ORPRN) to bring culturally and linguistically robust vaccine education to rural communities and communities of color. This project focuses on equity and motivational interviewing for providers, who will then become voices in their own communities to speak to vaccines and other emerging issues. OHA released an interest form for clinicians to participate in this project.

Boost Oregon will provide speaker training, culturally appropriate messaging, slide decks and supplemental materials about COVID-19 vaccination to participating providers. Providers chosen will then give up to three 1–2-hour presentations. Presentations will be held at community gatherings, such as church events, community events and online events. Providers will receive no-cost CME credits for the training and stipends for giving community presentations. Material development and recruitment planning has begun.

Statewide CCO learning collaborative for the Quality and Health Outcomes Committee
The Transformation Center coordinated a statewide CCO learning collaborative session that focused on how CCOs are integrating and paying for traditional health workers (THWs), and THW programs and services, to support improved quality and health outcomes. The session included a review of the evidence about THWs and health care quality and presentations from two CCOs about how they're integrating and paying for THWs. All evaluation respondents (six) rated the session as valuable for supporting their work.

Transformation and quality strategy (TQS) technical assistance
OHA held monthly TQS office hours for CCOs in preparation for the annual submissions that were due in March.

B. Lower cost (ANNUAL)

C. Better care and Better health (ANNUAL)

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports
Attached separately

2. State reported enrollment table

Enrollment	January/2022	February/2022	March/2022
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,200,047	1,213,976	1,223,698
Title XXI funded State Plan	122,297	127,932	127,399
Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member months	% Change from previous quarter	% Change from previous year
Expansion	**Title XIX**	PLM children FPL > 170%	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%	56,510	152,160	3.89%	26.41%
Optional	**Title XIX**	PLM women FPL 133-170%	N/A	N/A	N/A	N/A
	Title XXI	SCHIP FPL < 170%	135,957	364,778	1.95%	19.16%
Mandatory	**Title XIX**	Other OHP Plus	186,606	535,706	1.47%	7.03%
		MAGI adults/children	949,580	2,722,417	0.89%	7.15%
		MAGI pregnant women	15,847	41,649	29.11%	48.94%
		QUARTER TOTAL	1,344,500			

** Due to retroactive eligibility changes, the numbers should be considered preliminary*

OHP eligible and managed care enrollment

		Coordinated Care				Dental Care	Mental Health
OHP eligible*		**CCOA****	**CCOB****	**CCOE****	**CCOG****	**DCO**	**MHO**
January	Total	1,344,500	1,344,500	189	14,307	65,437	N/A
February	Total	1,344,500	1,344,500	183	13,962	66,107	N/A
March	Total	1,344,500	1,344,500	187	13,905	66,220	N/A
Quarter average	Total average number	1,344,500	1,344,500	186	14,058	65,921	

** Total OHP eligibles include TANF, GA, PLM-Adults, PLM-Children, MAGI Adults/Children, MAGI Pregnant Women, OAA, ABAD, CHIP, FC, and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.*

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

B. Complaints and grievances

Attached separately.

C. CCO appeals and hearings

Attached separately.

D. Neutrality reports

Attached separately.