Oregon Health Plan

Section 1115 Annual Report

July/1/2021 – June/30/2022

Demonstration Year (DY): 20 (July/1/2021 – June/30/2022)

Oregon Health Authority

Table of contents

I. Introduction

A. Letter from the State Medicaid Director

During this reporting period Oregon's Medicaid system continued to be impacted by the COVID-19 Public Health Emergency and the Oregon Health Authority continued to work with our partners in the Medicaid system to meet our program goals as well as our statewide health equity goals.

The Oregon Health Authority (OHA) conducted an evaluation of the delivery system networks for Coordinated Care Organizations (CCO) and Dental Care Organizations (DCO), including time and distance analysis, DCO provider capacity analysis, provider accessibility, and a secret shopper analysis. OHA is sharing the resulting information with CCOs and will continue to monitor provider network reporting going forward.

Oregon's 2022 State Legislative session continued to focus on health equity and behavioral health issues, with a significant number of bills passing with new funding and program requirements. The Oregon Health Authority has begun to work with other state agencies as well as external partners to implement the new policies and programs.

Oregon's 1115 Medicaid Demonstration Waiver was approved in January 2017 to continue through June 30, 2022. In June of 2022 CMS extended that demonstration through September 30, 2022. This report covers the final year of the original demonstration but does not include the extension period. That period will be included in a subsequent quarterly report.

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

Medicaid Director

Dana Hittle, Interim Medicaid Director
503-991-3011 phone
503-945-5872 fax

Medicaid Deputy Director

Dana Hittle, Medicaid Deputy Director

503-991-3011 phone
503-945-5872 fax

Eligibility Policy Business Director
Vivian Levy, Eligibility Policy Business Director
503-519-3512 phone
503-945-5872 fax

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

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

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

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

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

II. Title

Oregon Health Plan
Section 1115 Annual Report
Reporting period: July/1/2021 – June/30/2022
Demonstration Year (DY): 20

III. Overview of the current year

This report includes the documentation of increased eligibility and enrollment due to the COVID-19 Public Health Emergency. It also includes the results of CCO network adequacy analyses, annual workforce development including Traditional Health Workers, the Transformation Quality Strategy (TQS) and Oregon's

2022 State Legislative Session. New developments during April through June of 2022 are reported here, as well as a summary of those included in previous quarterly reports.

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 been a challenge this year after completing a phased roll-out of a new, integrated eligibility system in March 2021. However, aggressive strategies have been taken to streamline and simplify work processes as well as implement system enhancements, and the state is now processing applications, renewals, and reported changes within required timeframes. Notably, Title XXI enrollment continues to increase at slightly higher-than-normal rates. This is partially because, as families with Title XIX children experience income increases that put children above the Title XXI income range, children are moved into Title XXI as the uppermost program available while their coverage remains active for the remainder of the public health emergency period.

2. Coordinated care organization enrollment

Total Coordinated Care Organization (CCO) enrollment for April 2022 – June 2022 grew by 1.4%, across all plan levels (CCOA, CCOB, CCOE, CCOG). Specific CCO membership growth ranged between 0.1% – 2.2%, with the exception of Trillium Community Health Plans in both the Portland metro tri-county area and the Lane County area. Trillium's metro tri-county CCO continued to experience greater enrollment growth at 10.5% as it continued to establish itself in this new market. Conversely, Trillium's Lane County CCO experienced a -0.4 decrease in enrollment.

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

DY20Q4 Member Growth Zone	CCO Service Areas
Greater than 5.00%	4
3.00%-4.99%	0
2.00%-2.99%	6
0.00%-1.99% Growth	34
Reduction in Enrollment	4

While CCO enrollment continued to increase April 2022 – June 2022, overall enrollment growth was lower than the previous quarter, and a whole percentage point lower than the same period in 2021. Please see the table below for a comparison of enrollment growth across all quarters.

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	DY20Q4 4/22-6/22

3.3%	3.9%	3.5%	2.4%	2.2%	2.4%	2.6%	1.4%

As noted in previous reports, on May 1, 2020, the Oregon Health Authority waived the requirement to limit each CCO's enrollment to the county limit(s) and grand total limit listed in its contract to mitigate enrollment challenges during the pandemic. This requirement was initially established for CCO contract year 2020, 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 –required adjustments above their 2021 contract limits in order to sustain auto-enrollment algorithms. New enrollment limits have been established for 2022. Between April 2022 and June 2022, one CCO required adjustment above its 2022 contract limit in three service areas in order to sustain auto-enrollment algorithms.

B. Benefits

The Pharmacy and Therapeutics Committee:

July- September 2021

There have been no changes for the time period specified (7/1/21-9/30/21).

Oct- Dec 2021

The P&T Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: Oncology Agents; Orphan Drugs; Targeted Immune Modulators; Multiple Sclerosis Oral Agents; Calcitonin Gene-Related Peptide (CGRP) Inhibitors; Hepatitis C, Direct-Acting Antiviral (DAA); Pulmonary Arterial Hypertension; Alzheimer's Disease; Evinacumab; Esketamine; Ravulizumab; Biologics for Rare Diseases; Gonadotropin-Releasing Hormone (GnRH) Modifiers; Growth Hormone; and Obeticholic acid.

The committee also recommended the following changes to the preferred drug list (PDL): make Combivent® Respimat® and Incruse® Ellipta® preferred; make Cosentyx® preferred; make Aimovig® preferred and Emgality® non-preferred; make branded Epclusa® non-preferred; make donepezil, rivastigmine, memantine, and Namzaric® preferred; make Vanalice™ non-preferred; and make tobramycin NaCl nebulized solution preferred and Kitabis® Pak and its generic alternative - tobramycin nebulizer solution - non-preferred.

Jan-March 2022

For the period of January 1 – March 31, 2022 the 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.

April 1 – June 30, 2022

The P&T Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: Oncology Agents; Orphan Drugs; Emergency Drug Coverage for Citizenship Waived Medical; Botulinum Toxins; Non-preferred Drugs; Drugs for Non-Funded Conditions; Direct-Acting Antivirals for Hep C; Sickle Cell Anemia Drugs; Fabry Disease; Vosoritide; Efgartigimod (Vyvgart™); Tetracyclines (Oral)-Quantity Limit; Attention Deficit Hyperactivity Disorder (ADHD) Safety Edit; Finerenone; Topical Agents for Inflammatory Skin Conditions; Targeted Immune Modulators for Severe Asthma and Atopic Dermatitis; Targeted Immune Modulators for Autoimmune Conditions; and remove PA requirement for Mycobacterium Agents.

The committee also recommended the following changes to the preferred drug list (PDL): designate sofosbuvir/velpatasvir/voxilaprevir (Vosevi®) non-preferred; efgartigimod (Vyvgart™) non-preferred; moxifloxacin preferred; Concerta® preferred; betamethasone-propylene glycol cream preferred; clobetasol propionate solution preferred; desoximetasone cream preferred; hydrocortisone cream preferred; and remove PDL coding for Sirturo® (bedaquiline).

Other benefit changes:

Extend post-partum coverage from 60 days after delivery to 12 months of coverage after delivery.

Health Evidence Review Commission (HERC) Annual Changes in Benefit Coverage
All changes in benefit coverage are posted publicly here: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

7/1/2021 through 9/30/2021:

- Health Evidence Review Commission: Errata to the February 1, 2021 Prioritized List were posted 8/9/2021.

10/1/2021 through 12/31/2021:

- Health Evidence Review Commission: The October 1, 2021 Prioritized List went into effect on 10/1/2021 and was reported in a Notification of Interim Changes. Errata to the October 1, 2021 List were published on 11/30/2021.

1/1/2022 through 3/31/2022:

- Health Evidence Review Commission: The January 1, 2022 Prioritized List went into effect on 1/1/2022 and was reported in a Notification of Interim Changes. Errata to the January 1, 2022 list were published on 1/10/22.

4/1/22 through 6/30/22:

- Health Evidence Review Commission: Errata to the January 1, 2022 list were published on 5/11/22.

C. Access to care (ANNUAL)

Federal and State regulations require each MCE to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. To support federal and State network adequacy requirements, the MCEs are contractually required to develop and submit DSN reports that consist of two components, an annual DSN Provider Narrative Report and quarterly DSN Provider Capacity

Reports, that crosswalk to the network standards in the MCEs' contracts with the State, the OHP CCO Health Plan Services Contract and the DCO Health Plan Services Contract.

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

- In urban areas, not exceeding 30 miles, 30 minutes.
- In rural areas, not exceeding 60 miles, 60 minutes.
- A minimum of 100 percent of members in each service area accessing care within the respective routine travel time or distance listed above.

The primary objectives of network adequacy activities were to:

- Evaluate provider network capacity, including compliance with standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN.
- Evaluate the network of Medicaid providers available both within and across MCE service areas for their ability to serve enrolled members in accordance with federal, State, and contractual standards for access to care.
- Assess the MCEs' primary care providers (PCPs) and primary care dentists (PCDs) for acceptance of new OHP members and appointment availability.

Coordinated Care Organization Provider Delivery System Networks

Results of the CCO DSN Provider Narrative Evaluation demonstrated the following:

- While most CCOs demonstrated effective collection and use of provider and member geocoding data to assist in network adequacy decisions and strategies, opportunities exist for several CCOs to improve data collection and monitoring activities.
- The most common opportunities identified related to data collection and monitoring activities included:
    - CCOs failing to submit necessary data, track all service categories, and provide sufficient explanations for efforts to remediate instances of noncompliance.
    - CCOs failing to utilize disease prevalence data to assist in network adequacy monitoring and decision making, focusing instead on one or two diseases (e.g., diabetes) that were already part of a different QI effort or providing insufficient explanation of any process used.
    - Some CCOs failing to implement a system of using provider performance metrics data to facilitate network adequacy decisions or not providing sufficient narrative responses and documentation to determine compliance with specific requirements.
- Approaches varied widely in method and frequency of timely access monitoring activities, with most relying heavily on the retrospective quarterly analysis of member grievance data.
- Most CCOs described significant investment in multiple forms of health information technology to facilitate coordination of care, interdisciplinary collaboration, coordination with community partners, and other essential functions.

Results of the DCO DSN Provider Narrative Evaluation demonstrated the following:

- While two DCOs demonstrated effective collection and use of provider and member geocoding data to assist in network adequacy decisions and strategies, opportunities exist for the remaining DCOs to improve time and distance analysis and/or reporting.
- Most DCOs reported using the membership eligibility data provided by OHA in combination with intake assessments and provider and/or member-supplied data to gather and maintain member population information. However, most DCOs reported using only member-supplied information to maintain disease information and did not report analyzing disease prevalence at a population level or using such data to facilitate network adequacy decision making.
- Most DCOs described significant investment in multiple forms of health information technology to facilitate coordination of care, coordination with community partners, and other essential functions.

Time and Distance Analysis

CCO-Specific Findings

The CCO service categories selected for overall compliance with the time and distance access standards were selected for the broadest and most fundamental types of services offered by individual practitioners and facilities. These included:

- PCPA
- Primary Care Provider, Pediatric (PCPP)
- Mental Health Provider, Adult (MHPA)
- Mental Health Provider, Pediatric (MHPP)
- Substance Use Disorder Provider, Adult (SUDPA)
- Substance Use Disorder Provider, Pediatric (SUDPP)
- Hospital (HOSP)
- Pharmacy (RX)
- Oral Health Provider, Adult (OHPA)
- Oral Health Provider, Pediatric (OHPP)
- Specialty Provider, Adult (SPA)
- Specialty Provider, Pediatric (SPP)

Additional service categories evaluated through the Time and Distance Analysis included: Federally Qualified Health Center (FQHC); Hospital, Acute Psychiatric Care (HPSY); Rural Health Centers (RHC); Urgent Care Center (UCC); Skilled Nursing Facility (SNF); and Indian Health Service and Tribal Health Services (IHS/THS).

Results of the CCO Time and Distance Analysis revealed the following:

- Most CCOs evaluated for compliance with time and distance access standards in both urban and rural settings demonstrated 100 percent of members had access to all selected service categories.
- With a few exceptions, most CCOs not achieving 100 percent compliance demonstrated at least 95 percent of members having access to the selected service categories.
- Specialists were monitored and reported as one group rather than individual provider type; this included obstetrics/gynecology providers, which created a barrier to adequately evaluating the adequacy of the specialty provider network.
- Gaps were identified in the reported provider networks suggesting the need to conduct an in-depth review of service categories in which the CCOs did not meet the time and distance standards, with the

goal of determining whether the failure of the CCO to meet the access standard(s) was a result of a lack of available providers or an inability to contract providers in the geographic area.
- We identified issues with provider data for four CCOs where the state-defined service and category were in conflict with the provider's federal taxonomy code associated with their NPI. These discrepancies led to the miscategorization of some individual providers and facilities and affected the reported time and distance findings for this service category, suggesting gaps in the quality of provider data.

One CCO (AllCare) failed to report time and distance data for multiple service categories evaluated, raising concerns about the adequacy of AllCare's provider network for these facilities and the services it provides, as well as AllCare's monitoring of its network.

DCO-Specific Findings

The DCO provider categories selected for overall compliance with the time and distance access standards were selected for the broadest and most fundamental types of services offered by individual practitioners and facilities. These included:

- Primary Care Dentist, Adult (PCDA)
- Primary Care Dentist, Pediatric (PCDP)
- Expanded Practice Dental Hygienist (EPDH)
- Oral Health Specialists (OHSP)

Results of the DCO Time and Distance Analysis revealed the following:
- Despite the DCOs not meeting 100 percent compliance with the state-established time and distance standards in the urban setting, four of the five DCOs demonstrated at least 99 percent of their members had access to all service categories.
- Gaps were identified in the reported provider networks suggesting the need to conduct an in-depth review of service categories in which the DCOs did not meet the time and distance standards, with the goal of determining whether the failure of the DCO to meet the access standard(s) was a result of a lack of available providers or an inability to contract providers in the geographic area.
- In most cases where the DCOs did not meet the time and distance access standards for an individual provider type (e.g., EPDH), the evaluation showed provider types offering similar services (e.g., preventive and primary dental services) were reasonably available to members.

DSN Provider Capacity Analysis Results

OHA conducted analyses of the quarterly DSN Provider Capacity Reports submitted by the MCEs to assess provider network changes quarterly and provide rapid feedback to the CCOs and DCOs regarding changes to the provider networks, concerns with the data submissions, and concerns with network composition.

Quality of DSN Provider Capacity Reporting: OHA evaluated the MCEs' ability to provide complete and accurate provider network data in the required format, including whether data values were present, the data were in valid formats, and the data provided valid values.

- Overall, data values were present for key data fields across most MCEs and data fields. For nearly all data fields, if a data value was present, the value was valid in both format and value for >99.9percent of cases.
- Common data fields missing across all CCOs included non-English languages spoken (primary), capacity (individual), PCPCH indicator, PCP assignment, and acceptance of new patients.

- Common data fields missing across all DCOs included non-English languages spoken (primary), PCD assignment, and acceptance of new patients.

Since Q1 2021, OHA has been working to update, streamline, and improve the reporting and quality of the data.

Provider Network Count: OHA evaluated the underlying infrastructure of the MCE's DSN, including whether or not health services are available to members through a sufficient supply and variety of providers.

Data reporting issues were identified, which raised concerns about the reliability of the CCOs' data and ability to effectively monitor the number, mix, and geographic distribution of the provider networks.

- In some cases, no data records were submitted by the CCOs or were submitted in such an array of categorization combinations that counts for certain service categories could not be reliably evaluated. AllCare and Yamhill CCO were excluded from the overall count due to not reporting data for multiple service categories.
- It was difficult to determine if a count of zero for any given provider type represented deficiency in the CCO's provider network or a provider data quality issue.
- These results highlight opportunities to improve the quality of provider data and collaboration amongst the CCOs and OHA to align network expectations and reporting requirements.

Provider Accessibility: OHA evaluated the degree to which contracted services are accessible to the MCE's member populations, including acceptance of new patients and access to non-English speaking providers.

- In general, OHA's analysis demonstrated new adult and pediatric members had access to PCPs across MCEs.
- No data were submitted by TCHP-North and TCHP-South for acceptance of new patients, suggesting a provider data quality issue.

While all MCEs reported numbers of providers with the ability to speak a non-English language, the data should be compared to the language needs of the member population.

Secret Shopper Results

Secret shopper telephone surveys were conducted among CCO-contracted PCPs and DCO-contracted dental care providers to collect information on new OHP members' access to services. Due to the nature of the secret shopper survey methodology and script, some survey respondents may not have answered all questions in the survey, which may impact generalization of the survey results.

Survey findings support specific opportunities for improving the quality of the CCOs' DSN Provider Capacity Report data and members' experiences contacting PCPs and scheduling a primary care appointment. Key findings from the CCO secret shopper survey included:

- Attempted to contact 2,653 cases, with an overall response rate of 50.1 percent (1,330 cases) across the CCOs.
- Among the non-responsive cases for all CCOs:
    - For 652 cases (49.3 percent), individuals answering the telephone reported that the location did not offer primary care services, and for an additional 73 cases (5.5 percent), individuals answering the telephone reported that the location was not a medical facility.
    - A total of 167 non-responsive cases (12.6 percent) involved call attempts where the individual answering the telephone (i.e., the survey respondent) indicated that the address for the sampled provider location did not exist, and 91 additional cases (6.9 percent) could not be contacted due to a disconnected phone number.

- Among all CCOs, 454 (34.1 percent) of the responsive cases reported that the provider location did not accept the CCO requested by the caller.
- Among all CCOs, 851 (97.1 percent) of responsive cases accepting the requested CCO reported that the provider location accepted OHP.
- Of the provider offices that could be reached, were accepting the requested CCO, and accepting OHP, 81.2 percent reported accepting new patients.
  Of the survey respondents that reported accepting the CCO, OHP, and new patients for either visit type, 48.8 percent were offered a potential appointment date.
- Among all CCOs, 174 (50.3 percent) were offered an appointment for a routine well-check visit, and163 (47.2 percent) were offered an appointment for a non-urgent symptomatic visit.
- The overall median wait time was 14.0 calendar days for a well-check visit among responsive cases accepting the CCO, OHP, and new patients. Median wait times ranged from one calendar day to23 calendar days.
- The overall median wait time was 8.0 calendar days for a non-urgent symptomatic visit among responsive provider locations accepting the CCO, OHP, and new patients. Median wait times ranged from same-day appointments (i.e., a wait time of zero calendar days) to 50 calendar days.

Survey findings support specific opportunities for improving the quality of the DCOs' DSN Provider Capacity Report data and members' experiences contacting dental providers and scheduling a primary dental care appointment. Key findings from the DCO secret shopper survey included:

- Attempted to contact 730 cases, with an overall response rate of 68.4 percent (499 cases) across the DCOs.
- Among the non-responsive cases for all DCOs:
  - For 22 cases (9.5 percent), individuals answering the telephone reported that the location did not offer dental care, and for an additional six cases (2.6 percent), individuals answering the telephone reported that the location was not a medical facility.
  - A total of 134 non-responsive cases (58.0 percent) involved call attempts where the individual answering the telephone (i.e., the survey respondent) indicated that the address for the sampled provider location did not exist, and six additional cases (2.6 percent) could not be contacted due to a disconnected phone number.
- Among all DCOs, 135 (27.1 percent) of the responsive cases reported that the provider location did not accept the DCO requested by the caller.
- Among all DCOs, 353 (97.0 percent) of responsive cases accepting the requested DCO reported that the provider location accepted OHP.
- Of the provider locations that reported accepting the DCO and OHP, respondents for 281 cases (79.6 percent) reported accepting new patients.
- Of the survey respondents that reported accepting the DCO, OHP, and new patients, 169 cases (60.1percent) were offered a potential appointment date for a routine dental cleaning.
- The overall median wait time was 28.0 calendar days for a routine cleaning among responsive provider locations accepting the DCO, OHP, and new patients. Median wait times ranged from 20.5 calendar days to 37.5 calendar days.

Statewide Workforce Development

During the reporting period, OHA focused on enhancing integration and utilization of Traditional Health Workers to ensure delivery of high quality, and culturally and linguistically appropriate care to improve health

outcomes. OEI focused on implementing the recommendations from the THW Commission including requiring CCOs to:

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

Tables 1 and 2 below captures the progress made towards increasing the number of certified Traditional Health Workers across various regions in Oregon.

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

THW Type	Greater Portland	Columbia Gorge	Willamette Valley	Oregon Coast	Central Oregon	Southern Oregon	Eastern Oregon
Community Health Workers (CHW)	209	55	162	71	68	113	84
Personal Health Navigator (PSN)	13	0	8	1	5	0	0
Peer Wellness Specialist	278	2	44	14	8	9	6
Peer Support Specialist	1174	25	707	216	196	454	169
Other THW	59	0	64	8	9	12	1
Total	**1733**	**82**	**985**	**310**	**286**	**588**	**260**

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

Please visit the THW website for a list of all active programs including name, location, and website.

Region	Active programs				In Development
	CHW	Peer Support	Peer Wellness	Birth Doula	
Greater Portland	4	9	2	2	4
Columbia Gorge	0	0	0	0	1

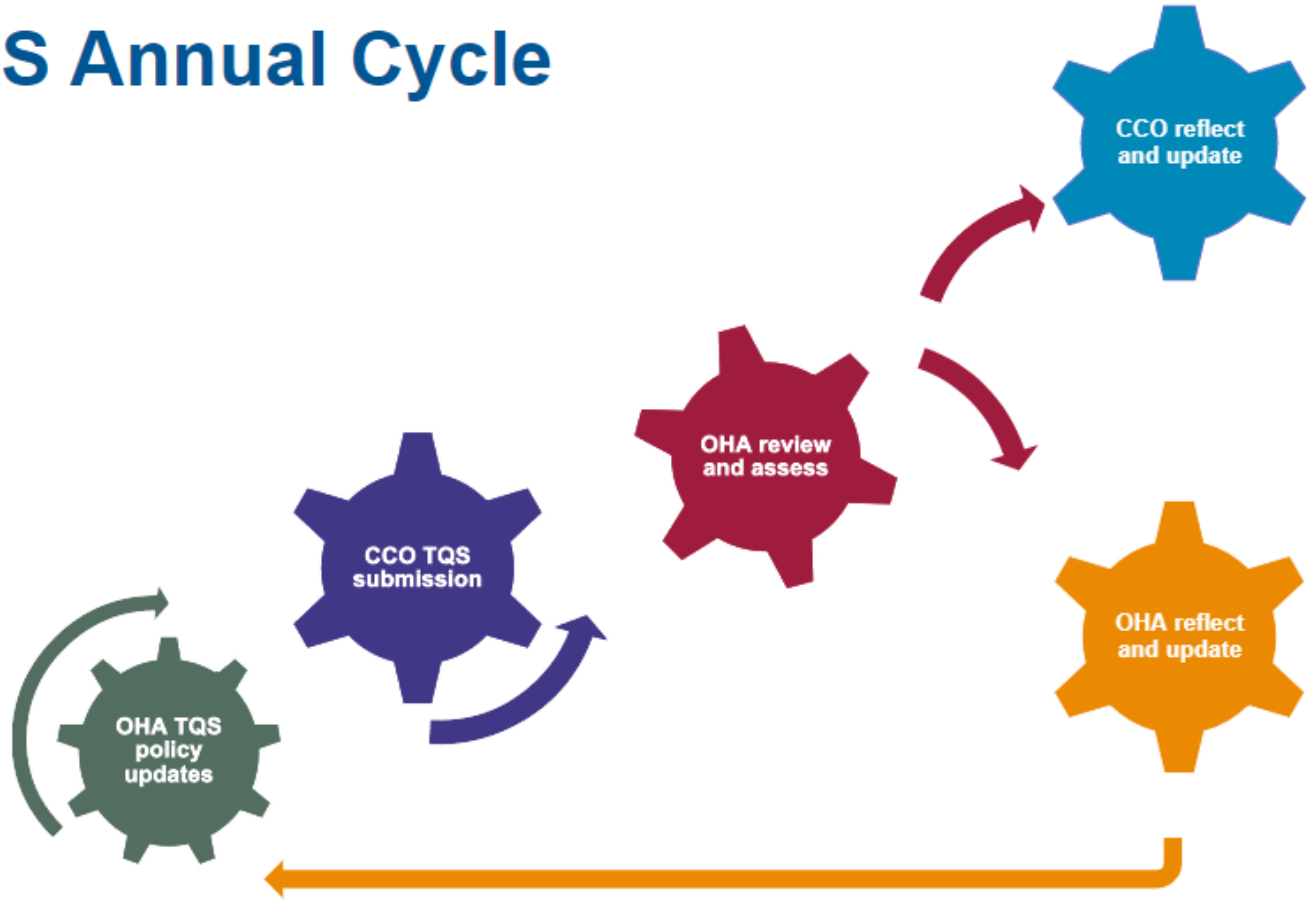
Willamette Valley	3	6	1	1	2
Oregon Coast	0	2	0	0	0
Central Oregon	1	1	0	0	0
Southern Oregon	1	4	0	0	0
Eastern Oregon	1	1	0	0	1
Total	10	22	3	3	8

D. Quality of care (ANNUAL)

Transformation Quality Strategy (TQS)

Each year since 2018, CCOs are required to submit the Transformation and Quality Strategy (TQS) incorporating all components of the Quality Assessment and Performance Improvement (QAPI) program to ensure a robust quality program that supports the strategic goals of OHA. The TQS goals are to support the safe and high-quality care for all members under CCOs by ensuring the quality and transformation plan adequately covers federal requirements, pushes health transformation forward, and continues the path towards the triple aim (better care, better health, lower cost). Annually, CCOs receive from OHA TQS guidance which includes: TQS guidance document, FAQs, template that is required for TQS submission and TQS project examples. The guidance is updated annually to reflect any policy direction changes in the OHA quality strategy and TQS component areas and incorporates edits as a result of the TQS assessment from the prior year. The updates are made to support moving the CCOs forward in performance in ensuring quality and transformation in the health care delivery in Oregon.

TQS Annual Cycle



TQS Assessment Review Timeline

- October: Guidance documents posted, including scoring criteria
- October–March: Technical assistance webinars and office hours
- March: CCOs submit TQS to OHA
- April-May: OHA component subject matter expert review
- June: Individual CCO scores and written assessment shared with CCO
- June-July: Individual CCO assessment calls
- August: Post CCO submissions and written assessments to website

The TQS template and CCO TQS submissions can be accessed on OHA's Transformation and Quality Strategy Technical Assistance website. In addition to the guidance materials, OHA provides annual technical assistance (TA) on TQS requirements and written assessments of progress for each CCO's TQS. The TQS assessments include pre-defined assessment components and scoring determined by whether each component was: fully relevant, fully detailed, and feasible (3 points); somewhat relevant, somewhat to very limited detail and feasibility (2 points); or very limited relevance, very limited to not detailed and feasible (1 point).

2022 TQS scoring results summary

- Range (out of 144 points possible) = 73.4–132 points = 51–91.7%
  - Average = 120.23 points = 83.5%
- Average CCO score increased 5.9 percentage points

Projects statistics

- Range = 8–16
- Average = 12
- % projects continued average = 54% of projects continued from prior year (median = 45%)
  - Decrease from average of 77% continued last year

Figure 1: CCO score by TQS component

	Advanced	AllCare	CHA	CPCCO	EOCCO	Health Sha	IHN	JCC	PS-Central	PS-Gorge	PS-Lane	PS-M/P	Trillium-Nc	Trillium-So	Umpqua	Yamhill	Avg CCO score
Access: Cultural Consideration	7	4.5	8	9	8	8	6	9	9	9	9	9	9	9	4	9	7.91
Access: Quality and Adequacy	9	5	9	7	4.7	7	6	9	9	9	9	9	9	9	5.6	9	7.83
Access: Timely	8	3	5	6	5	4	9	8	9	9	9	9	9	9	4	9	7.19
BHI	8	9	9	9	9	9	9	9	9	9	9	9	8	8	7	7	8.56
CLAS Standards	3	9	8	8	7.25	9	6	6	9	9	9	9	6	6	3	9	7.27
Grievances and Appeals	9	8	9	9	4	9	9	9	9	9	9	9	9	9	4.5	9	8.34
Health Equity: Cultural Respor	5	8	8	7	9	8.5	9	9	9	9	9	9	6	6	3	9	7.72
Health Equity: Data	7	8.5	9	9	9	9	6	9	9	9	9	9	9	9	3	9	8.28
OHI	9	9	8	9	9	8	6	9	7	7	7	7	7	7	5	8	7.63
PCPCH Enrollment	4	9	9	9	6	6	9	9	9	9	9	9	9	9	8	9	8.25
PCPCH Tiers	5	9	9	9	6	6	9	9	9	9	9	9	9	9	8	9	8.31
SPMI	8	8	9	7	8	8	9	9	9	9	9	9	7	7	4	9	8.06
SDOH-E	9	5.5	9	8	8	9	8	4	9	9	9	9	7	8	2.8	7	7.58
SHCN FBDE	0	6	5	5	3	6	4	8	4	4	4	4	8	8	4	7	5.00
SHCN Non-duals	8	0	6	3	0	7	5	8	4	4	4	4	8	8	4.5	5	4.91
Utilization Review	6	9	8.5	6	6.2	8	8	6	9	9	9	9	7	7	3	7.7	7.40
TOTAL SCORE	105	110.5	128.5	120	102.2	121.5	118	130	132	132	132	132	127	128	73.4	131.7	120.23
Percent of total possible	72.9%	76.7%	89.2%	83.3%	70.9%	84.4%	81.9%	90.3%	91.7%	91.7%	91.7%	91.7%	88.2%	88.9%	51.0%	91.5%	83.5%
Prior year %	79.6%	74.4%	88.1%	80.9%	79.6%	84.1%	75.6%	83.3%	81.1%	81.1%	81.1%	81.1%	63.1%	64.6%	67.4%	75.9%	77.6%

Statewide Performance Improvement Project (PIP)

In the time period for this annual report, the CCOs undertook two distinct areas for statewide PIPs: 1) integration statewide PIP 2) substance use disorder PIP. For each of these PIPs the CCOs were involved in different stages of quality improvement efforts that will be described further.

In September 2021, CCOs submitted through external quality review (EQR) for the integration statewide PIP. All CCOs met validation standards for the design stage of the *Mental Health Service Access Monitoring* PIP. The development of the topic occurred collaboratively between OHA, community, partners and CCOs from March 2021 through August 2021. CCOs will be reporting interventions through EQR on July 31, 2022 reporting and reported in subsequent 1115 reporting. [Insert data here]

In April 2021, CMS approved Oregon's SUD 1115 waiver with the inclusion of a SUD statewide PIP. The SUD statewide PIP topic design work began in March 2022 through July 2022. Design discussions included collaborative meetings across OHA and with CCOs at the Quality Health Outcomes Committee (QHOC) meetings. During regularly bi-weekly meetings review of gaps, data and needs assisted OHA and CCOs, in determining scope of topics to pursue. Additionally, a survey was conducted in April 2022 to further solicit feedback from CCOs as well as SUD subject matter experts on preferred topic areas to determine metric viability of the top topic areas. Survey response results are below:

- Survey responses: OHA =4, CCOs = 16, Other = 14.
- 1st Choice selection by survey respondents' results:
- 50% Access to Care for OUD/SUD
- 14% Adolescent OUD/SUD services
- 31% Initiation Engagement and Treatment (IET)

- 5% Medication Assisted Treatment
- 0 Prenatal/post-partum member and OUD/SUD

Access to care for OUD/SUD services and Initiation, Engagement, and Treatment (IET) were the two potential topics that rated with the highest levels of interest from respondents and were further discussed and reviewed for SUD PIP viability.

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

CCO PIP

CCOs conduct two CCO specific PIPs, selected by the CCO and met to serve as rapid-cycle projects. These two PIPs vary across CCOs and may also take on the style of a focus study. The list for CCO specific PIPs can be found here: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/PIPs%20Summary_2021Q3.pdf

Quality Strategy

In accordance with 42 CFR §438.340, OHA implemented a written quality strategy for assessing and improving the quality of health care and services furnished by the MCEs to Oregon Medicaid members under the Oregon managed care program.

OHA's mission is helping people and communities achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality affordable health care. The OHA's quality strategy identifies goals and objectives, using the Institute of Healthcare Improvement Triple Aim framework, intended to achieve better care, better health, and reduce the cost of care. The table below outlines the OHA Quality Strategy Goals and Objectives.

Triple Aim	OHA Goals	Objectives and Strategies to Achieve Goals
Improving the member experience of care	1. Improve the behavioral health system and address barriers to access to and integration of care	• Integrate behavioral, physical, and oral health to allow members to receive the right care at the right time and in the right place • Focus on behavioral health (mental health and substance use disorder) services • Assure needs of children with serious behavioral health needs

		are addressed as a priority
	2. Increase value and pay for performance	• Reward providers' delivery of patient-centered and high-quality care • Reward health plan and system performance • Ensure consideration of health disparities • Align payment reforms with other State and federal efforts
Improving the health of Oregonians	3. Focus on social determinants of health and health equity	• Build stronger relationships between the CCOs and other sectors • Align outcomes between health care and other social systems to improve health equity • Encourage a greater investment in prevention and addressing social factors that impact health
Reducing costs of health care	4. Maintain sustainable cost growth and ensure financial transparency	• Continue to operate with a sustainable budget • Address the major cost drivers in the system • Ensure ongoing transparency and accountability

Oregon Health Authority

- OHA has developed a comprehensive program to transform the health care delivery system and improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services. To ensure health plan accountability and improve health outcomes, OHA works collaboratively with various stakeholders, committees, and oversight bodies:

- Oregon Health Policy Board—develops strategic direction of health system transformation.
- OHA Quality Council—monitors clinical quality performance, health system transformation, and QI.
- Medicaid Advisory Committee—advises OHA on the policies, procedures, and operation of OHP.
- Health Systems Division Quality Assurance Department—monitors the CCOs and DCOs for contract compliance, EQR, and quality assurance (QA) elements (complaints, fraud, waste, abuse).
- Quality Management Committee—provides overall structure for OHP quality governance to monitor and improve quality initiatives.
- Health delivery system (partnership committees with delivery system and OHA)
- Quality and Health Outcomes Committee—monitors clinical quality performance with improvement strategy development and implementation.
- Health Evidence Review Committee—reviews and develops evidence-based practices for all MCEs (including FFS).
- CCO Operations Collaborative and Contracts and Compliance Workgroup—monitors compliance with CCO contract requirements and provides guidance on the operational implementation of requirements.

OHA used monthly, quarterly, and annual reporting from its external quality review organization (EQRO) and MCEs to monitor its success in meeting the key goals/measures of the quality strategy. OHA continued to make progress on implementing its quality initiatives through ongoing monitoring, assessments of progress toward meeting strategic goals, and evaluating the relevance of its quality strategy. OHA conducted the following activities to support progress in implementing the quality strategy.

- OHA regularly monitored the effectiveness of the MCEs in achieving the goals above through EQR activities and reports. OHA has contracted with HSAG to perform both mandatory and optional activities for OHP: compliance monitoring and corrective action follow-up evaluation, Performance Measure Validation, validation of PIPs, DSN adequacy evaluations, Mental Health Parity evaluations, Encounter Data Validation, and technical assistance (TA) to the OHA and MCEs.

- OHA annually defines a set of performance measures for the CCOs to monitor progress in improving care, making quality care accessible, eliminating health disparities, and curbing the rising costs of health care. These measures assess performance across several domains including prevention and early detection of physical, mental health (MH), substance use disorder (SUD), and oral health conditions; chronic disease and special health care needs; and acute, episodic, and procedural care. In collaboration with the health care community, measures are reviewed and selected each year to support the measurement, tracking, and improvement of performance and outcomes. Measures fall into two primary categories:

- CCO incentive measures through which the CCOs are eligible to receive payments based on their performance each year.

- State quality measures used by OHA to report to CMS as part of Oregon's Section 1115 Medicaid waiver.

- OHA and the EQRO continued to work with the MCEs to implement and evaluate PIP progress, testing and refining interventions through QI activities designed to facilitate more efficient and long-term sustained improvement.

OHA began reviewing and revising its quality strategy in support of its Section 1115 renewal. In addition, OHA also focused on the following initiatives to help improve quality efforts.

Network Adequacy Workgroup

Beginning in 2020, OHA convened an internal workgroup to develop minimum quantitative network adequacy standards to ensure there are no gaps in access to and availability of services for OHP members enrolled in an MCE. The network adequacy workgroup is carrying out a data analysis of claims and member demographic data to understand member needs and compare to the supply of providers and network capacity. The analysis will be used to establish access standards, develop geomaps, and tools for ongoing monitoring of network adequacy. To date, the group has worked with MCEs to improve the quality of the data being reported to OHA and has revised reporting instructions and templates to address data quality issues. After a review of states' standards and CMS standards, the group has revised the existing time and distance standard and will continue to refine the time and distance requirements based on the results of the data analysis and ongoing monitoring.

Grievance and Appeals System Evaluation and Updates

In 2020, to address the findings related to appeals and grievances, OHA evaluated and approved CCO appeal and grievance policies, procedures, and member notice templates. OHA also evaluated quarterly grievance and appeals data submitted by CCOs ensuring the data were accurate and complete. OHA reviewed a sample of NOABDs and respective PA documentation to ensure the notices were compliant with all regulatory requirements. Upon completion of the grievance and appeals system evaluations, OHA provided each CCO with evaluation results identifying areas requiring corrective action. To address findings, CCOs were required to submit an improvement plan for OHA approval. In addition, OHA issued guidance to reiterate CCO contract and State rule requirements regarding verbal requests for appeal, grievance, and hearing processes.

In 2021, OHA identified a need to revise the member notice templates (Notice of Adverse Benefit Determination and the Notice of Appeal Resolution) to update the required information to be in compliance with regulatory requirements. OHA convened a workgroup and worked closely with MCEs to revise the member notice templates. Between July 2021 and June 2022, the CCOs revised their member notice templates and updated their systems to implement new notices that are compliant with all regulatory requirements.

NEMT Quality Assurance Monitoring Report

In the July 2020 - June 2021 Annual Report, OHA highlighted that it established a quarterly NEMT reporting requirement for MCEs in order to monitor the quality of NEMT services provided to OHP members across all service areas. The quarterly NEMT reports are required to include information related to service delivery events, network availability, call-center, and reimbursement information. In the July 2021 - June 2022 reporting period, OHA convened all CCOs to review their data, understand their NEMT benefit, and identify challenges and opportunities for improvement to the NEMT program. OHA is in the process of compiling all input and will convene all CCOs to discuss NEMT challenges and identify opportunities to work together to address system level issues.

E. Complaints, grievances, and hearings

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 fourth quarter (April 1, 2022, through June 30, 2022), the Oregon Health Authority (OHA) received 212 hearing requests related to the denial of medical, dental, and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 187 were from CCO-enrolled members and 24 were from FFS members.

202 cases were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. In every quarter there is an overlap of processed cases with those received. For instance, cases processed and resolved in April of 2022 may be cases OHA received as far back as February and March of 2022.

OHA dismissed 93 cases that were determined to be not hearable cases. Of the not-hearable cases, 75 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 109 cases that were determined to be hearable, 22 were approved prior to hearing. Members withdrew from 41 cases after an informal conference with an OHA Hearing Representative. 25 cases went to hearing, where an administrative law judge upheld the OHA or CCO decision and 16 cases were dismissed for the members failure to appear. The Administrative Law judge reversed the decision in four cases and set aside one case during this quarter.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	**22**	**10%**
Client withdrew request after pre-hearing conference	**41**	**20%**
Dismissed by OHA as not hearable	**93**	**46%**
Decision affirmed*	**25**	**12%**
Client failed to appear*	**16**	**8%**
Dismissed as non-timely	**0**	**0%**
Dismissed because of non-jurisdiction	**0**	**0%**

Decision reversed*	**4**	**2%**
Set Aside*	**1**	**0%**
Total	**202**	

*** Resolution after an administrative hearing.**

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

CCO and FFS Complaints

The information provided in the charts below is a compilation of data from the current 16 coordinated care organizations (CCO) and fee-for-service (FFS) data. The annual reporting period covers July 1, 2021 through June 30, 2022.

Trends

	Jul – Sep 2021	**Oct – Dec 2021**	**Jan – Mar 2022**	**Apr – Jun 2022**
Total complaints received	4,415	4,152	4,262	4,398
Total average enrollment	1,394,117	1,427,347	1,452,054	1,475,164
Rate per 1,000 members	3.17	2.91	2.94	2.98

Barriers

The number of complaints reported for the past four quarters remained relatively steady with an overall decrease in the average number of complaints of .58%. The Access to Care category continues to have the highest number of complaints. Access to Care complaints increased 3.6% over the first quarter of 2022 with a 5.13% increase over the average of the past four quarters. The IP category shows a 1.6% increase over the first quarter of 2022. Overall, there was a 1.7% decrease over the average number of complaints in the past four quarters for the IP category. Quality of Care (QC) continues to be the third highest category of complaints however this category is showing a 7.65% decrease over the first quarter of 2022. Overall, the QC category shows a 4.7% decrease over the average in the past four quarters. FFS data shows the highest number of complaints are Billing issues, with Access to Care issues being the next highest category.

Interventions

CCOs – 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. One CCO reports their new NEMT brokerage company is holding town halls with members, providers, and stakeholders. CCOs indicate the nationwide staffing shortage continues to be problematic with NEMT drivers as well as staffing in provider offices. Some CCOs report they are continuing to focus on a variety of dental provider issues. CCOs continue to report they have established committees and taskforces specifically to address provider capacity within their networks. Some CCOs are reporting they are improving their auditing processes to ensure providers

are providing appropriate, timely services to members. CCOs continue to report they are increasing 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 Apr – May second quarter of 2022 was 233. An additional 604 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 114 complaints from members enrolled in Dental Care Organizations. 7044 informational calls were received asking for a variety of information, such as information about their coverage, CCO enrollment, request ID cards, etc.

Statewide rolling 12-month Complaints totals

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

Complaint category	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022	Apr – Jun 2022
Access to care	1,566	1,395	1,559	1,618
Client billing issues	394	390	381	416
Consumer rights	288	475	344	436
Interaction with provider or plan	1,451	1,210	1,256	1,277
Quality of care	539	538	549	510
Quality of service	177	144	173	141
Other	0	0	0	0
Grand Total	4,415	4,152	4,262	4,398

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 over the past four quarters. 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 the second quarter of 2022, 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)	**Jul – Sep 2021**	**Oct – Dec 2021**	**Jan – Mar 2022**	**Apr – Jun 2022**
a) Denial or limited authorization of a requested service.	27,636	26,931	26,862	28,669
b) Single PHP service area, denial to obtain services outside the PHP panel	897	820	835	680
c) Termination, suspension, or reduction of previously authorized covered services	224	153	109	126
d) Failure to act within the timeframes provided in § 438.408(b)	7	3	9	9
e) Failure to provide services in a timely manner, as defined by the State	59	84	82	101
f) Denial of payment, at the time of any action affecting the claim.	46,204	63,703	54,606	52,775
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	75,027	91,694	82,503	82,360
Number per 1000 members	66.6	79.5	70.03	68.43

CCO Appeals

The table below shows the number of appeals the CCOs received over the past four quarters. In the second 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	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022	Apr – Jun 2022
a) Denial or limited authorization of a requested service.	1,116	1,041	1,072	1,193
b) Single PHP service area, denial to obtain services outside the PHP panel.	29	23	34	22
c) Termination, suspension, or reduction of previously authorized covered services.	5	10	2	5
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.	0	1	0	0
f) Denial of payment, at the time of any action affecting the claim.	245	222	244	331
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	1,395	1,297	1,352	1,551
Number per 1000 members	1.24	1.12	1.15	1.29
Number overturned at plan level	388	444	401	524
Appeal decisions pending	0	10	8	0
Overturn rate at plan level	27.8%	34.2%	29.7%	33.78%

F. CCO activities

1. New plans

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

One of the previously existing plans – Trillium Community Health Plan – had applied to continue in its historical Lane County service area and to expand into Clackamas, Multnomah, and Washington Counties (the Tri-County). OHA denied Trillium a notice to proceed in the Tri-County and gave until June 30, 2020, for Trillium to demonstrate a sufficient provider network in the Tri-County or that service area would be removed

from its contract. On August 14, 2020, OHA approved Trillium's expansion into the Tri-County, effective September 1, 2020. This expansion was subject to a Corrective Action Plan (CAP) effective March 5, 2021; the CAP was closed on May 31, 2022.

2. Provider networks
All significant changes are reported in other sections.

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 (Dental Care Organizations) contracts where capitation rates are developed separately.

OHA met with CCOs from May to August 2021 to discuss the CY2022 rate development process. At the end of the process, OHA delivered the final CY22 rate packages to CCOs in early August 2020 and met with each CCO, individually, to discuss their rates and request feedback. In addition, OHA also hosted a Dental Rates Workgroup meeting to further discuss the CY2022 Dental rates with the Dental Care Organizations (DCO). The CY2022 CCO and DCO capitation rates were submitted to CMS October 1, 2021 and are posted on our website: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/OHP-Rates.aspx

At the end of 2021, OHA underwent a procurement process to hire a new Actuarial Firm to develop the Capitation Rates. The procurement closed in mid-January 2022. 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 continues to monitor the COVID-19 pandemic closely and working with CCOs in a partnership in maintaining our healthcare system.

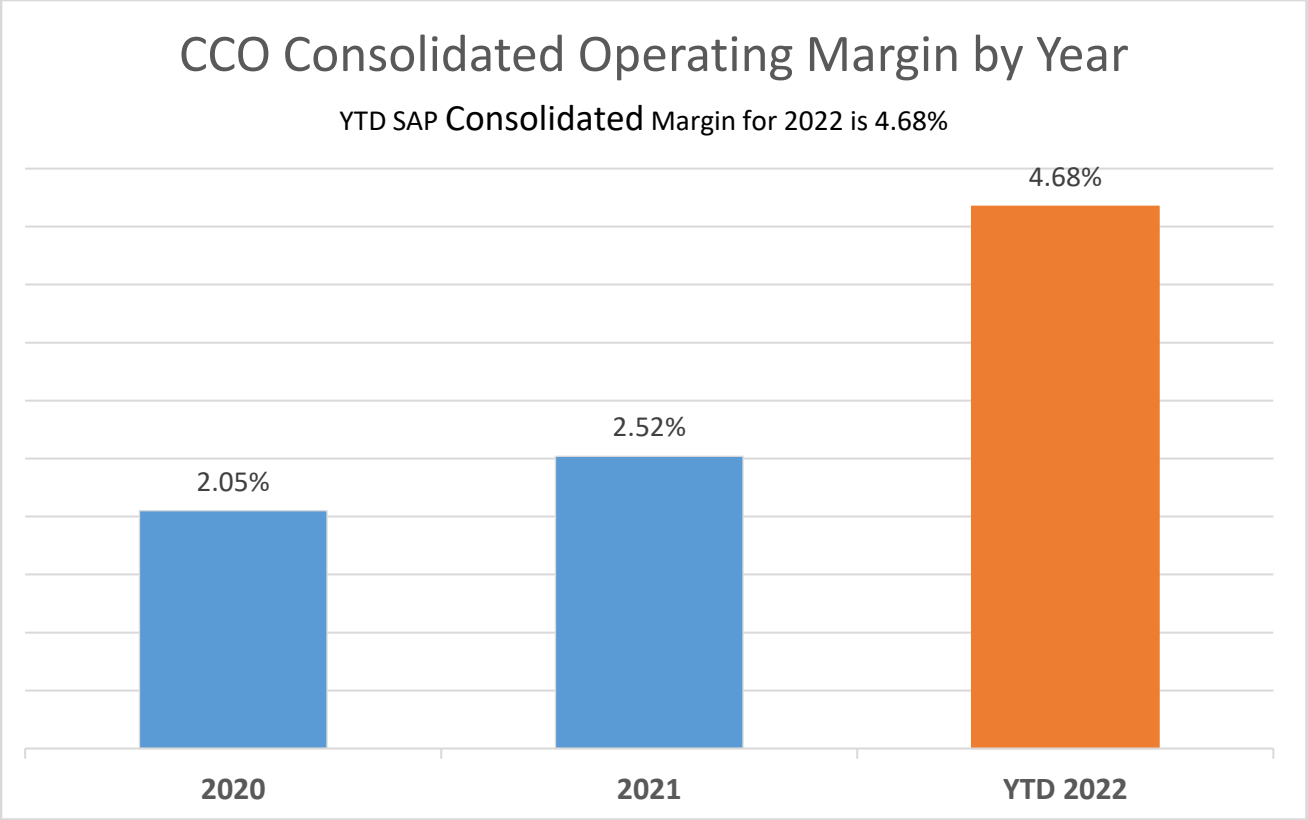
4. Enrollment/disenrollment
All significant changes are reported in other sections.

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
In 2021, the CCOs were required to file their financial statements based on Statutory Accounting Principles (SAP). This change from Generally Accepted Accounting Standards (GAAS) and recognizes that CCOs are structured and operate more similar to the registered insurers that are also required to file on SAP through the National Association of Insurance Commissioners (NAIC). The NAIC statements also provide an analysis of the MSR, which will be reported for the 2021 calendar year, as well as the first three months of 2022, January – March.

This change, while important for the long-term analysis of CCO operations, also means that the historical comparative data is only available since the second quarter of 2020.

CCOs achieved a statewide operating margin of 2.52% through the twelve months ending December 31, 2021. This is a strong margin for the year, coming off of a year with an overall margin of 2.01% for the reporting year of 2020 and taking into consideration a second year of a Public Health Emergency caused by COVID-19. For the first three months of 2022, the reported operating margin is 4.68%.



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.

Calendar year 2021 was the CCO's first full years' worth of reporting to NAIC. The NAIC statements provide an analysis of the MSR, which will be reported for the 2021 calendar year, as well as the first three months of 2022, January – March.

Through the calendar year 2021, spending on Member Services using the SAP standards was at 87.41%. Administrative costs of 9.88% were also reported for the 2021 calendar year. For the first three months of 2022, Member Service expenses using SAP standards, the average MLR was 84.81%, a reduction of 2.6% from the prior calendar year. The Administrative costs averaged 10.3%, an increase of 0.42% from the prior calendar year.

The Risk Based Capital (RBC) Formula was developed as an additional tool to assist with financial analysis of insurance companies. The purpose of the formula is to establish a minimum capital requirement based on the types of risks to which a company is exposed. The RBC formula developed for Health Insurance providers reflect the risks associated with the economic environments of these companies.

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

Under the RBC system, regulators have the authority and statutory mandate to take preventive and corrective measures that vary depending on the capital deficiency indicated by the RBC result. These preventive and corrective measures are designed to provide for early regulatory intervention to correct problems before insolvencies become inevitable, thereby minimizing the number and adverse impact of insolvencies. An RBC ratio of 200% is the minimum surplus level needed for a health insurer to avoid regulatory action.

The reporting period ended December 31, 2021 was the second year that RBC was measured for the CCOs. The 2021 calculation of RBC resulted in all CCOs calculating an RBC greater than 200%, and above the regulatory action level.

For additional CCO financial information and audited financials are posted publicly here: http://www.oregon.gov/oha/FOD/Pages/CCO-Financial.aspx

7. Corrective action plans

During the year, one CCO continued to be on a CAP and another CCO's CAP was closed.

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

• *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:* May 31, 2022
• *Action sought:* Development and implementation of a plan for correcting the issues identified by OHA; submission of monthly reports to OHA for a period of at least six months.
• *Progress during year:* The areas for improvement identified in the CAP are network development, health equity and language access, community engagement, and intensive care coordination. OHA's review of Trillium's progress reports for the first two quarters of the year indicated significant progress in nearly all areas of the CAP. By the end of the third quarter, all areas of the CAP were closed except for one element of "community engagement". The remaining element was closed in the fourth quarter, resulting in closure of the CAP.

8. One-percent withhold

This annual report is for data from July 1, 2021 through June 30, 2022.

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of January 2021 through December 2021.

All CCOs except for three 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 February, March, April, May, and 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.

One third CCO did not meet the Administrative Performance (AP) standard for the month of September, October, and December 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 significant activities are reported in other sections.

G. Health Information Technology

Medicaid Electronic Health Record (EHR) Incentive Program

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

CCO Health IT Roadmap & Data Reporting

Per the CCO 2.0 Contract, CCOs are required to draft and maintain an OHA-approved health information technology (HIT) Roadmap describing how they use/will use HIT to achieve outcomes including population health management and value-based payment (VBP) arrangements, and how they will support physical, behavioral, and oral health providers with EHR adoption and health information exchange (HIE) for care coordination and hospital event notifications (as well as CCO use of hospital event notifications). CCOs submit their Updated HIT Roadmaps to OHA annually on March 15th for review and approval starting in 2021.

Between July and December of 2020, OHA developed an Updated HIT Roadmap template to help streamline CCO responses and reduce burden. CCOs used this template to complete their Updated HIT Roadmaps and submit to OHA March 2021. In June 2021, OHA completed an initial review of the Updated HIT Roadmaps and has approved some, while requesting additional information from CCOs on others. OHA anticipates that all CCOs will have an approved Roadmap by October 2021.

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

HIT Commons

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

EDie and the Collective Platform (formerly known as PreManage)

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

Oregon Health Authority

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

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

Recent highlights:

- As of July 9, 2021, COVID-19 positive case data from OHA's Oregon Pandemic Emergency Response Application (Opera), the state's COVID-19 case investigation system, is being shared with all users of the Collective Platform. A flag is visible on a patient's record if they had a confirmed positive COVID-19 test result in the last 42 days. This information is also included in EDie notifications across 63 Oregon hospitals. More information about this initiative is available here. See the COVID-19 Data Sharing Initiative section below for more information on COVID-19 data sharing.

- OHA, HIT Commons, and Collective Medical partnered to bring statewide COVID-19 vaccination information from the state's ALERT Immunization registry into EDIE/the Collective platform. As of April 2021, population reports are available via the platform for all CCO and health plan users, which allow for quickly assessing members who have received no vaccine, as well as identifying the manufacturer and dose of vaccines that have been administered.

- The HIT Commons EDIE Steering Committee met on June 25, 2021. Topics of discussion included product and support updates from Collective Medical, EDIE/Collective Platform use cases under development, ED utilization dashboards and updates on the HIT Commons/OHA effort to re-energize Assertive Community Treatment (ACT) team utilization of the Collective Platform. Materials from that meeting are available here. The Committee's next meeting is August 27, 2021.

- OHA is collaborating with partners on several initiatives to share COVID-19 data in support of response and recovery efforts. • OHA is now sharing COVID-19 positive case data to users of EDie and the Collective platform, and to clinical and health plan/CCO users of Reliance eHealth Collaborative's Community Health Record. • COVID vaccine data reports are now shared weekly with CCOs for their members. Additionally, COVID-19 vaccine data are flowing into EDie/the Collective platform and to the Reliance HIE. Collective platform COVID Vaccine Population Reports allow for quickly identifying members who have received no vaccine, as well as identifying the manufacturer and dose of vaccines that have been administered. Updates on Health IT Policy and Efforts, Oregon Health Authority (August 2021) Page 7 of 8 • Oregon efforts to integrate Public Health COVID-19 data into HIT and HIE will be

discussed and assessed at monthly meetings of the Public Health Data Sharing Workgroup, convened by HIT Commons in partnership with OHA.

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

Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative

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

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

Direct Secure Messaging Flat File Directory

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

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

Health IT Stakeholder Groups

Health IT Oversight Council (HITOC)

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

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

Highlights from HITOC's meetings this past year:

August 2020:

- Received an update about COVID impacts on OHA and the implications for OHA's HIT work
- Heard updates from Oregon HIT organizations supporting COVID needs, including HIT Commons, Reliance eHealth Collaborative, OHA's COVID Wraparound
- HITOC members provided updates and highlights about COVID's impact on HIT including successes and challenges, lessons learned, and needs and priorities
- Considered preliminary COVID-related implications for the Strategic Plan Update, including HITOC goals, workplan, and priorities
- Received an update on legislative and regulatory changes including HB 4212: race, ethnicity, language, and disability reporting requirements; state Legislative update; and CMS/ONC Interoperability Final Rules

October and December 2020: meetings canceled

February 2021:

- Received an update about COVID impacts on OHA and the implications for OHA's HIT work
- Heard updates from Oregon HIT organizations supporting COVID needs, including HIT Commons, Reliance eHealth Collaborative, OHA's COVID Wraparound
- HITOC members provided updates and highlights about COVID's impact on HIT including successes and challenges, lessons learned, and needs and priorities
- Considered preliminary COVID-related implications for the Strategic Plan Update, including HITOC goals, workplan, and priorities
- Received an update on legislative and regulatory changes including HB 4212: race, ethnicity, language, and disability reporting requirements; state Legislative update; and CMS/ONC Interoperability Final Rules

April 2021:

- Updates on OHA activities related to telehealth. Explored the tribal and rural perspectives with HITOC members sharing their experiences.
- Oregon's Office of Broadband presented on their current and upcoming activities, as well as the state and federal funding opportunities.
- Updates on COVID data sharing around positive cases and vaccine status was discussed.
- OHA updated HITOC on REALD data collection activities.

June 2021: meeting canceled

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

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

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

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

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

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

ONC Information Blocking and CMS Interoperability Final Rules

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

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

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

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

Health Information Exchange (HIE) Onboarding Program

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

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

Community Information Exchange (CIE)

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

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

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

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

offered by CCOs and health plans. OHA developed a flyer and presented at multiple community forums to educate and show support.

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

H. Metrics development

July 1, 2021 – June 30, 2022

1. Kindergarten Readiness

This developmental work comprises a multi-year measurement strategy:

1) Adopt two metrics for the 2020 CCO incentive measure set (complete):
    i. Well-child visits for children 3-6 years old
    ii. 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 launched).
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)

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

The strategy moved forward in the last year:

- In July 2021 the Metrics & Scoring Committee voted to add the third component of the four-part measurement strategy (a CCO-level measure to improve the social-emotional health of young children) to the 2022 CCO Quality Incentive Program.

In September 2021, the Committee further voted to include the three kindergarten readiness measures that have been developed thus far in the Challenge Pool for measurement year 2022, potentially worth additional quality incentive payments if CCOs achieve these measures.

- In Fall 2021 and into 2022, the partnership team of Children's Institute, OPIP, and OHA worked on making final updates to the specifications for the social-emotional health measure. The partnership team also met on a quarterly basis to continue momentum for the overall measurement strategy and plans to support implementation of the social-emotional health measure, and its eventual conversion to a child-level measure in measurement year 2025.
- In this last year, OHA's Transformation Center began work on a technical assistance plan related to the social-emotional health measure. This included conducting two needs assessments calls with CCOs, which led to the launch of a year-long learning collaborative beginning in May 2022. Information on the Learning Collaborative and other supports for the measure offered through OHA's Transformation Center are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Emotional-Health-Metric.aspx.
- In May 2022 the Metrics & Scoring Committee voted to continue the inclusion of the first three components of the multi-year-measure strategy in the Quality Incentive Program metrics set for measurement year 2023.

2. SDOH/Health-related Social Needs Measure

The draft measure was piloted in the summer of 2021. Between July and September 2021, the OHA team and consultants reviewed the measure and results of the pilot with interested parties and Tribes. Discussions of the measure took place at these meetings: July 22 CCO Metrics TAG, September 10 Tribal Advisory Council, and September 22 Medicaid Advisory Council. In addition, OHA sought further input from the Integrated Care for Kids (InCK) team and the Oregon Primary Care Association. In the fall of 2021, findings from the pilot test and additional input from stakeholders was incorporated into the measure specifications. In early 2022, OHA held focus groups with Medicaid members to seek input on the measure. In spring of 2022, several public meetings 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. 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. Finally, in May 2022 the Metrics & Scoring Committee voted to include the measure in the 2023 CCO incentive measure set. Over the next year OHA's Transformation Center will provide technical assistance to support CCO work related to the measure.

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

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. In July 2020, the Metrics and Scoring Committee, after much discussion, ultimately did not select the measure the workgroup developed to be included in the 2021 CCO incentive measure set. 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.

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

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.

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.

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 remains pending.

Cal. et. al v. Azar.

Oregon was a co-plaintiff in litigation challenging CMS's Rule revision that 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. CMS's Rule revision was enjoined in *California et al. v. Azar*, 501 F.Supp.3d 830 (N.D. Cal. 2020). Defendants appealed the district court's ruling, but the appeal was held in abeyance (in an administrative stay) after an NPRM proposed to reverse the

rule revision. CMS's final rule reversing the rule revision was published in the Federal Register in May 2022. The appeal was subsequently dismissed on June 27, 2022.

L. Public forums

Health Evidence Review Commission

August 12, 2021

This testimony concerned coverage of PET scans for breast cancer.

Ms. Holli Thomas offered testimony about PET scans. She said she has metastatic breast cancer that is now in remission. Ms. Thomas reports that she recently was able to have a PET scan paid for and will need another scan at some point. She pointed out that she had no tumors so her lymph nodes were not enlarged; there was nothing a CT or MRI would show. However, the PET scan showed cancer in one of the lymph nodes under her left arm. She said that the PET scan saved her life.

This testimony concerned electrolysis for transgender services.

Ms. Petra Wilson stated she is a transgender woman with OHP health insurance. She urged the Commission to consider the World Professional Association for Transgender Health (WPATH) letter about electrolysis published on July 15, 2016. That letter was written by Dr. Jamison Green who, at the time, was the immediate past-president and chair of the WPATH Ethics Committee.

HERC Value-based Benefits Subcommittee

August 12, 2021

This testimony concerned breast cancer index.

Max Salganik, Associate Director of Medical Affairs for Biotheranostics, testified that the breast cancer index's (BCI's) role is to inform extended endocrine therapy. He agreed with including both node negative and node positive patients based on NCCN recommendations. All of their studies have had a mix of node negative and positive patients. BCI could be used for identifying very low risk patients who could avoid chemotherapy, but he was not requesting coverage for such an indication.

This testimony concerned PET scans in breast cancer.

Ms. Holli Thomas said she is a breast cancer patient and expressed her support for the newly revised proposed guideline. She questioned the use of the word "tumor" in the staff recommended guideline but agreed with the general staff recommended changes.

This testimony concerned Cologuard.

Leslie Dennis, Quality Director for Adventist Health: Ms. Dennis testified about Cologuard as an option for colorectal cancer screening. Hawaii and California Medicaid cover this test, but not Oregon Medicaid. Adventist is requesting inclusion of all options to increase CRC screening. During the pandemic, she said Adventist has had a high return rate of mailed Cologuard tests and are increasing their colorectal cancer screening rates. She also said they were using Cologuard to reduce the number of colonoscopies that can be done due to COVID-19. Dennis noted that Adventist is seeing a higher return rate for Cologuard as compared to FIT. Cologuard also has a 3-year testing interval rather than a 1-year interval of FIT. Cologuard has an outreach program which is why she feels there is an increased return rate.

Melissa Wood, Exact Sciences, testified that patient follow up and adherence is more challenging in the Medicaid population compared to other populations. However, Cologuard has seen a greater than 50% return rate nationwide in Medicaid populations. She said that flex sigmoidoscopy is not being used anymore. FIT has low return rate, which gets lower over each year in the 10-year screening cycle. Cologuard is 92% sensitive for early-stage cancer. Cologuard has no longitudinal data on reducing CDC incidence or mortality. In Oregon, the only patients not covered for Cologuard are underserved patients.

This testimony concerned smoking cessation and elective surgery.

Tamara Fountain, ophthalmologist in Chicago and President of the American Academy of Ophthalmology (AAO), requested coverage of cataract surgery regardless of smoking status. Cataracts can lead to blindness and surgery is the only definitive treatment for cataracts. The AAO supports the HERC staff recommendation. There is no evidence that smoking status impacts cataract surgery outcomes. Current guidelines do not address smoking cessation prior to this surgery. The Centers for Medicare and Medicaid Services (CMS) local coverage determination does not include any smoking cessation prior to cataract surgery.

Nisha Nagarkatti-Gude, ophthalmologist in Portland, board member of the Oregon Academy of Ophthalmology, agreed with the staff recommendation to exclude cataract and other bloodless surgeries. Cataract surgery is not always elective. Cataracts affect ability to drive, work, take medication, or perform other activities of life. Unlike other surgeries, cataract surgery does not have the risks of many complications. It involves a very small incision and no sutures. No adverse events have been seen in healing with smoking. Active smoking status and use of anesthesia is a concern, but most patients have little to no anesthesia for cataract surgery.

This testimony concerned rhinoplasty and septoplasty.

Dr. Richard Kohl testified regarding lack of coverage for deviated septum repair for his daughter, who is an OHP patient. He discussed the impact of deviated septum on her physical and mental health. Staff offered to conduct research to see whether a change to the List may be appropriate and offered to connect him with appropriate resources to deal with individual circumstances.

This testimony concerned electrolysis for transgender services.

Ms. Petra Wilson testified she was a transgender woman on the Oregon Health Plan who is requesting coverage for electrolysis for facial hair. The current exceptions process requires severe psychosocial comorbidities for coverage of facial feminization, which acts as an inducement to present that kind of behavior in order to receive care. Ms. Wilson requested clarification of when electrolysis is covered around surgical sites and stated that it should be covered for the top of breasts and between the breasts as well as for facial hair. Does this include around the surgical site or just at the incision? She cited a 2016 statement from the World Professional Association of Transgender Health (WPATH) which says that the WPATH 7.0 guideline intended to recommend electrolysis for facial hair as medically necessary.

HERC Evidence-based Guidelines Subcommittee

September 9, 2021

This testimony concerned high-frequency chest wall oscillation devices.

Joey Razzano introduced herself as the Oregon representative for the International Rett Syndrome Foundation and said she is speaking on behalf of the Northwest Rett Syndrome Association. She disclosed that she is employed by the Oregon Health Authority but is speaking on behalf of her developmentally

disabled daughter. She said that studies for conditions such as Rett Syndrome will always be too small to be considered for these kinds of policy decisions. She described her personal experience of intensive hospital care every winter and how "vest therapy" can be a cost-effective alternative to emergency room use. Manual chest physiotherapy is not effective or safe for someone who is as medically complex as her daughter. She asked the subcommittee to expand the coverage recommendation to include conditions such as her daughter's.

Gary Hansen, Director of Scientific Affairs for RespirTech (manufacturer of devices), thanked the subcommittee for their thorough review of the evidence that was submitted by RespirTech. He is disappointed with the narrowness of the criteria and said he is hopeful that the subcommittee will be open to accepting future evidence that RespirTech is working to produce.

Shani Noel, Director of Market Access for Hillrom (manufacturer of devices, began her testimony by discussing her employer's recent publication of the budget impact of the vest for managing airway clearance in patients with complex neurological disorders. She presented the Hillrom study findings, disclosing that she is a co-author, and said that there were significant cost reductions associated with high-frequency chest wall oscillation. The cost analysis also demonstrates that use of this device is cost effective for patients with complex neurological disease.

This testimony concerned PANDAS/PANS/pediatric autoimmune encephalitis.

Kym McCornack, outreach coordinator for Northwest PANDAS PANS Network, ceded her time to Dr. Dritan Agalliu.

Dritan Agalliu, Columbia University Associate Professor in the Department of Neurology, began his testimony by questioning the expertise and literature that was used to inform the report and presentation. He said he has worked in PANDAS and PANS for 10 years and many of his studies are not cited or discussed and described two of his group's basic science papers. He has mice models that study the mechanisms of these diseases and that strep infections elicit an immune response that targets the brain, which can lead to neuropsychiatric symptoms. He described other studies that are under review that show that PANS patients have a cytokine profile in their blood indicative of inflammation. He said these children have abnormal immunity and that azithromycin reduces obsessive compulsiveness in these children, as does cognitive therapy.

Sarah Lemley, Director of the Northwest PANDAS PANS Network began her testimony by describing her 12-year-old daughter who has PANDAS and whose condition was reversed by azithromycin and steroids. Lemley stated that in 2019, a house bill was passed to promote awareness for PANDAS/PANS and the declaration stated that treatments may include antibiotics, steroids, IVIG, therapy, and other modalities as needed. Lemley said this report dismisses work done by NIMH and the legislative work in other states. She said adopting this guidance would be irresponsible for Oregon children and that expertise from national experts and bodies are needed.

Deborah Miller described her 12-year-old son who has not been able to get treatment for his PANDAS condition. She said he is a victim of the broken health care system because he does not have access to the treatments he requires. The IVIG treatment that has been recommended for him is every 4 to 6 weeks at a cost of $50,000. She urged the subcommittee to make treatments accessible for children like her son.

Meggan Bennett described her 11-year-old son with PANDAS, saying he is receiving social security benefits because of his symptoms. He has not improved on antibiotics, steroids, or tonsillectomy and is unable to take psychiatric medication. His pediatrician has recommended IVIG but her family is unable to

afford the treatment. She described her son before he got sick and how their family has been experiencing this since he was 6 years old. She pays out of pocket for many treatments that insurance doesn't cover, including hyperbaric infusions and supplements.

Jennifer Matson described how her 14-year-old son was diagnosed with PANDAS when was 12, developing psychiatric and compulsive symptoms. Physicians in the hospital would not consider a PANDAS diagnosis so she sought a Chicago pediatrician who treated many PANDAS and PANS children. Her son had his tonsils and adenoids removed and her employer paid for IVIG treatments. Today, her son is free of PANDAS symptoms. She said that her insurance company paid over $30,000 to acutely hospitalize her son but the IVIG only cost $12,000. His medical care has been about $1,200 per year since he received IVIG.

Paul Ryan, President of PACE Foundation discussed the national standard of care for PANDAS and PANS, presenting a slide of a map that showed national locations of centers of excellence across the country, some of which were created with assistance from the NIMH. The standard of care includes the treatments that are under consideration in the draft coverage guidance report. Eight states have authorized insurance coverage for such medical treatments. The subcommittee should join the recent legislative expansions by recommending these treatments, as any other decision would deny Oregon families the same treatment protocols that are available elsewhere.

Rachel Prusak, Oregon House Representative introduced herself and stated she is the Chair of the House Healthcare Committee as well as a family nurse practitioner. She supports evidence-based decisions regarding PANDAS and PANS treatment. After working with advocates on this issue and hopes that the subcommittee can consider this discussion more broadly than just the evidence. During legislative session, she was looking forward to HERC's deliberation of this topic. She said that while side effects exist for any of these treatments, that practitioners must weigh the risk and benefit of such interventions. She concluded by stating it is vital to increase access to care for Oregon families who experience these conditions.

Diana Pohlman, Director of PANDAS Network, founded the network in 2009 because of her two children who had PANDAS at the age of 7. Repeated strep infections led her to discover PANDAS and the IVIG protocol and within one year of treatment, her son was fine and is now a young adult and successful. Her daughter also recovered in a relatively short amount of time. She didn't understand a lot of the research presented today but hopes that the conversation can be broader than just the evidence. She has spoken to thousands of families over 14 years, and IVIG is important to families.

Health Evidence Review Commission (HERC)

October 7, 2021

There was no public comment at this meeting.

November 18, 2021

This testimony concerned Expanded Carrier Screening (ECS):

Devki Nagar, Myriad Genetics laboratory, testified. She said her lab provides expanded carrier screening. Ms. Nagar said the American College of Medical Genetics and Genomics published a practice resource to update their carrier screening guidance, given the recognition that their 2004 and 2008 guidelines predated data that has shown that an ethnicity focused approach to carrier screening no longer provides equitable screening, given the diversity of the US population and especially Medicaid programs. She expressed her excitement to see the policy proposed today as it will allow more providers to align carrier screening approaches or to choose a more limited approach based upon their personal preferences and values. Given how expanded carrier screening can really ensure more equitable carrier screening, she applauds the

committee's proposed policy to allow access to ECS for Oregon Medicaid beneficiaries and providers who elect to utilize this more equitable approach.

This testimony concerned Whole Gene Sequencing (WGS):

Leslie Rogers offered testimony on behalf of the rare disease community. He spoke about his personal experiences with diagnosing his child and the hardships endured by his and many other families. He said the delays in getting the correct diagnosis led to his child being bedridden and suction dependent for life. He implored the Commission to make WGS widely available.

Dr. John Fox, a pediatrician and epidemiologist, offered testimony. He stated he is an employee of Illumina which manufactures devices that do genomic sequencing. He said there are as many as 15 times as many kids who would have one of the 7,000 diagnosed and even more undiagnosed genetic disorders, who wouldn't be captured because they're not critically ill and not hospitalized in the NICU or PICU. He said he is thankful that the Commission has decided to cover this rapid whole genome sequencing in the inpatient setting and exploring for kids over age one and also in the outpatient setting. He said the typical sequence in the outpatient setting is to do a chromosomal microarray under specific conditions. In the 20% of kids you test, they have a positive result, you're done. You have a chromosomal abnormality that's detectable on chromosomal microarray. In the 80% of kids who don't have a finding a non-chromosomal microarray, then the typical standard of care is to go on and do a whole exome sequencing which is about the cost of a whole genome sequencing. Establishing a diagnosis earlier on, it makes sense to look at whole genome sequencing as the standard of care

This testimony concerned Handicapping Malocclusion:

Dr. Manu Chaudhry, President of Capital Dental Care, spoke. He has experience as a provider and a plan manager in California when they enacted a plan to cover this condition for Medicaid. He said he is not against increasing the benefit to include components of handicapping malocclusion and as a clinician, he agrees that the benefits should be expanded. However, handicapping malocclusion is not well defined. With this type of subjectivity, he feels that it's very important and critical that these qualifiers should be well defined prior to advancing with approval through the HERC. He said the best approach would be to postpone the implementation until January of 2024.

This testimony concerned Continuous Glucose Monitoring (CGM):

Renee Taylor, Director of Medical Science at Dexcom, which is a manufacturer of continuous glucose monitoring (CGM), gave testimony. She said she wanted to call attention some important evidence that was not fully considered in the MED review for CGM that was presented at last month's subcommittee meeting. Specifically, there was evidence omitted which supports coverage of CGM for persons with type two diabetes on intensive insulin, meaning use of three or more daily injections of insulin or an insulin pump. She said it should be noted that this subgroup represents less than 15% of the broader type two diabetes population. She said a clinically significant reduction in A1C is defined by the FDA as 0.3%. A JAMA study showed CGM met a 0.6% mean reduction in A1C and a 50% reduction in the rate of severe hypoglycemic events. The ADA 2021 practice guidelines now strongly recommend the use of therapeutic CGM in all persons with diabetes using intensive insulin. Medicare covers therapeutic CGM for beneficiaries using intensive insulin. She said all local, regional, and national private payers serving Oregon residents, including Kaiser, MODA regions, Providence, Aetna and Cigna cover their members with type one and type two diabetes using intensive insulin.

October 7, 2021
This testimony concerned Cranial Electrical Stimulation:

Josh Briley, PhD, Science and Education Director for EPI (manufacturer), clinical psychologist: Dr. Briley testified regarding his experience using Alpha Stim to treat thousands of patients. He noted that the HERC staff literature reviewed included only a small portion of the literature on Alpha Stim. He personally has seen clinically significant improvement in depression, anxiety, and insomnia. User surveys show very significant improvement in symptoms as well. Alpha Stim is very safe, side effect rate is <1% and are mild and self-limiting. This technology is also less expensive than extensive therapy and has fewer side effects than medications. It also works faster than therapy.

Jay Halaj, PhD, Senior Consultant for Allevia Health (manufacturer): Dr. Halaj testified that the Portland VA and other VAs cover Alpha Stim. Hundreds of practitioners use this device and thousands of patients are using it. After about 20 minutes of using the device, patients have a response and are able to push through barriers in processing trauma. It brings on a sense of calm and reduces arousal. Device use can avoid costly emergency visits for situations like panic attacks. It's also especially useful in addition treatment as a non-chemical way to reduce anxiety and insomnia from treatment in that population.

This testimony concerned Minimally Invasive Lumbar Decompression for Spinal Stenosis:

Vishal Khemlani, MD, anesthesiologist, Vertos Medical affiliate (manufacturer): Dr. Khemlani gave a brief presentation of the MILD procedure and said he has done over 150 procedures. His presentation gave an overview of the procedure's effectiveness and included patient success stories.

Paul Konovodoff, Director for Market Access, Vertos Medical (manufacturer): Mr. Konovodoff began his testimony by addressing cost of the MILD procedure, stating the procedure has a Medicare cost of $4,000 for an ambulatory surgical center, or $6200 for hospitals charges and $600-700 cost for the physician fee. He said that the MILD procedure is covered for 92 million lives, including many commercial lives. He said 41,000 procedures have been done nationwide and 1500 certified providers are currently doing this procedure, 15 or 20 of which are in Oregon. Ohio and Illinois Medicaid have recently added coverage. MILD has been FDA approved since 2005.

This testimony concerned Vitiligo:

Drs. Julie Dhossche and Sara Leitenberger, OHSU pediatric dermatology: Dr. Dhossche began the brief invited presentation by declaring no conflicts of interest. She gave an overview on vitiligo, current therapies for repigmentation, and maintenance therapies.

November 18, 2021
This testimony concerned Expanded Carrier Screening:

Peggy Flanigan, parent: Ms. Flanigan testified she is a carrier of the fragile X gene and was unaware of her carrier status when her daughter was born in the 1980s. Her daughter is also a carrier. There are effects for female carriers as well as for boys affected by fragile X. She wanted to bring awareness to screening for rare genetic disorders. She testified that discovering her carrier status influenced her decision to not have additional children.

Taylor Kane, Executive Director of Remember the Girls: Ms. Kane testified she is a carrier of a rare genetic disorder. Knowledge of her carrier status has empowered her in terms of reproductive planning. She wanted to stress that learning of one's carrier status is not overwhelming, rather it is empowering.

Ashley Svenson, genetic counselor with Myriad Genetics (manufacturer): Ms. Svenson expressed support for the proposed changes which align with ACMG's recommendation. Ms. Svenson said these changes will help to eliminate racial bias in testing.

Yael Weinstein, genetic counselor in Springfield, Oregon: Ms. Weinstein testified that expanded carrier screening is the only approach that allows adequate screening for patients. Not using the expanded carrier screening approach gives the patient a false-negative result. In her experience, she educates couples on their results. She can offer consults by phone. In many cases, she sees patients who have only a partial carrier screening and then needs to do additional testing. Her clinic uses a panel of 176 genes. Many screens use 14-20 conditions. In her opinion, Oregon has the resources to offer and counsel for expanded carrier screening. 80% of children born with genetic conditions have no family history. She also noted that the labs have genetic counselors available to assist patients/families. She will send information on the specific panels she uses in her practice to HERC staff to distribute to members.

Samantha Coover, parent: Ms. Coover testified she has a son with fragile X syndrome, but she was never offered prenatal screening. Expanded carrier screening could have helped her by allowing her to get early interventions in place for her child from infancy.

Mike Flanigan, parent: Mr. Flanigan testified that expanded carrier screening will reach so many more patients. Genetic counseling is now more available than ever due to telehealth and other advances developed during the pandemic.

Haywood Brown, OB/GYN and Medical Director for ACCESS (carrier screening advocacy group): Dr. Brown testified that an expansion in screening is a very powerful tool. He agreed with the GAP recommendation and felt it is more equitable coverage.

This testimony concerned Whole Genome Sequencing:

John Fox, pediatrician, former medical director of a Michigan state health plan in Michigan, and current employee of Illumina (manufacturer): Dr. Fox testified that there is a large unmet need in both the inpatient and outpatient setting. He said that whole exome is similar in cost to whole genome sequencing. Michigan found clinical utility in WGS as it changes management in 95% of patients as well as changes reproductive decisions. Without WGS, microarray testing is generally done first, which adds cost. Michigan decided to add coverage for WGS as it is overall less expensive. In his health plan, the cost of WGS was $5,100 versus $4,900 for whole exome sequencing.

This testimony concerned Handicapping Malocclusion:

Christian Moller-Anderson, Executive Director for Smile for Kids (orthodontics non-profit): Mr. Moller-Anderson testified that state Medicaid programs are required to cover dental treatment, including handicapping malocclusion. There is a massive barrier to health for low-income populations with non-coverage, which goes against OHA's triple aim. Without equitable access to orthodontic care, low-income kids have deleterious health outcomes.

Manu Chaudhry, dentist, and President of Capital Dental Care: Dr. Chaudhry testified that he initially supported moving this forward at the OHAP meeting. However, he has since revised his position on this

issue. Dental disease that is caused by handicapping malocclusion is worsened when treatment is applied and there is a lack of pristine hygiene post-treatment. He recommended against adding this as a benefit currently and felt cost could be better spent to address and prevent inequities in oral health.

HERC Evidence-based Guidelines Subcommittee

December 2, 2021

This testimony concerned High-Frequency Chest Wall Oscillation Devices:

Gary Hansen, Director of Scientific Affairs for RespirTech (manufacturer of devices): Hansen thanked the subcommittee for their work on the revised report but has concerns about ambiguous language in Section D of the second paragraph of the revised draft report's box language, including use of the term "standard of care." He suggested alternative language of "failure" of chest physiotherapy and positive expiratory pressure devices (PEPs) to make the box language clearer.

This testimony concerned PANDAS/PANS:

Christina Cronin-Vejar: Ms. Cronin-Vejar ceded her time to Dr. Earl Harley.
Deborah Miller: Ms. Miller ceded her time to Dr. Harley.
Kym McCornack: Ms. McCornack ceded her time to Dr. Beth Latimer.
Ivan Vejar: Mr. Vejar ceded his time to Dr. Beth Latimer.
Diana Pohlman: Ms. Pohlman ceded her time to Dr. Harley.

Rachel Morse, parent: Ms. Morse began her testimony by thanking the subcommittee. She is the mother of two PANDAS/PANS patients. She said that these families have PTSD scores like combat veterans. She said the lack of data for this condition is because of the minor age of the patients. She warns that testing protocols can add to long wait times and prevent timely access to care. Morse asked for an emergency task force to be formed and a multidisciplinary clinic to be established. She said that long COVID is a form of PANS by definition.

Paul Ryan, PACE Foundation (PANDAS/PANS advocacy group): Mr. Ryan said his group is involved with clinics around the country, and his group includes IVIG as a standard of care. He said that Option 1 should be expanded to include infectious disease doctors and cited Dr. Daines as one such medical expert. He said his concern about requiring subspecialists and requiring pre- and post-testing is something that a mature multidisciplinary clinic is capable of but has concerns that Oregon will need educational programs to facilitate awareness of these conditions.

Sarah Lemley, Director of the Northwest PANDAS PANS Network: Ms. Lemley said she has no conflicts. She said she was concerned with requiring two subspecialists as outlined in Option 1. She said there is a lack of expertise and support for PANDAS/PANS within these specialties and said that out of the two local children's hospitals that have such specialists, one will not see PANDAS/PANS patients due to the controversial nature of the disorders. Lemley identified other Oregon hospitals and departments that will not take OHP, diagnose or treat PANDAS/PANS patients, or which have a long wait time. She asked the subcommittee to remove the two-physician subspecialist requirement as it would only increase the burden of accessing care for vulnerable families.

Earl Harley, MD, Professor of Otolaryngology and Pediatrics at Georgetown University: Dr. Harley began his testimony by describing his 28-year practice and association with Dr. Beth Latimer in working on PANDAS/PANS research. He would like the subcommittee to consider tonsillectomy and adenoidectomy as treatment options of PANDAS/PANS. Tonsillectomy is very controversial in the world of PANDAS/PANS

as well as the field of pediatrics. He cited a 2018 red book recommendation against tonsillectomy or any PANDAS/PANS treatments by the American Academy of Pediatrics. He has seen almost 300 PANDAS/PANS patients, half of whom received tonsillectomy, and has done CME conferences on the topic of these disorders. Harley said he has an ongoing trial funded by the PANDAS PANS Network that is looking at tonsil tissue samples and conducting various analyses. His theory is that strep infection is one of many triggers of the disorder, and that almost any bacteria can trigger this disorder, many of which are found in the tonsils and in the gut microbiome. He said he is continuing this research in the current pilot study and is conducting other retrospective analyses. He recommended tonsillectomy, treating the gut microbiome, and having access to IVIG as treatment options for PANDAS/PANS. He said tonsillectomies are safe and should be considered for select children.

Sarah Zeman, parent: Ms. Zeman introduced herself as a former disability attorney and parent of a child likely affected by PANS. She said she has no conflicts. Zeman said she supports increasing access to IVIG with only one physician consultation and recommendation, not two, as she said that places unnecessary burdens on families and currently treating providers. She said her family's trauma and burdens are exponential and echoed earlier testimony that her family has PTSD. Zeman attempted to secure care for her gravely ill child and said that Oregon is a doctor desert. Doctors in Oregon tend to lack awareness of PANS and refuse to treat PANS. She said while we wait for national treatment standards that access to care should not be made burdensome on overtaxed and traumatized families.

Beth Latimer, MD, d/b/a Latimer Neurology Center: Dr. Latimer began her testimony by describing her 20-year practice in pediatric neurology. She said she agrees that current published studies for PANDAS/PANS have not been done well, citing limitations of inherent bias, not enough differential between intervention and placebo groups, and not enough children enrolled in the studies. She said the American Academy of Apheresis approves of treating PANDAS/PANS. Latimer said that symptoms of OCD, depression, suicidality, and sleep deprivation were outlined in two international studies as a result of low REM sleep in these affected children. She said the subcommittee's recommendation of two subspecialists agreeing on IVIG might be possible if these providers were in the same hospital but that it is too burdensome for families to make two separate consultations. She also expressed concern that requiring less-invasive therapies may exacerbate symptoms of suicidality, such as the use of SSRIs. Parents are desperate for a treatment option for their children. She said it is more cost effective to treat these children than treating their symptoms. Access to care is a financial burden. She said of the 25% of children that received IVIG in her clinic and showed no improvement; she would consider those children as candidates for tonsillectomy.

Oregon State House Representative Rachel Prusak: Representative Prusak began her testimony by thanking the subcommittee. She stated her concern of watching her community members not having access to care. She said she was a 20-year family nurse practitioner and that we need to improve access to care for the community to decrease suffering. Requiring two subspecialists may be harmful and other types of providers, such as nurse practitioners, should be considered. She said that her own adult patients face at least six months wait times to see a specialist, and assumes it is worse for the pediatric population. She understands requiring one subspecialist. She is working to strengthen Oregon's investments to solve these problems.

Health Evidence Review Commission (HERC)

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.

HERC Evidence-based Guidelines Subcommittee
April 7, 2022
This testimony concerned PANDAS/PANS:

Sarah Lemley, Director of the Northwest PANDAS PANS Network: Ms. Lemley said she has no conflicts. She thanked the subcommittee for their deliberations on this topic. She urged the committee to adopt Option 2 and said that Option 1 imposes cumbersome barriers for families who are already stretched thin. Requiring one pediatric subspecialist would align Oregon with most other states in allowing a treatment pathway for IVIG.

Paul Ryan, PACE Foundation (PANDAS/PANS advocacy group): Mr. Ryan said he has no conflicts. He urged the subcommittee to vote for Option 2 and to expand the provider type eligible to treat this population to include rheumatologists and infectious disease specialists. He thanked the committee for their time.

Christina Cronin-Vejar, parent: Ms. Cronin-Vejar said she has no conflicts. She described her child's disease and treatment history, including tonsillectomy. She said her family considered IVIG but could not afford the treatment. She said there is a significant lack of providers who know about PANDAS/PANS and even fewer who are comfortable treating this population. She urged the subcommittee to vote for Option 2 and said these children deserve appropriate medical treatment.

Kym McCornack, parent: Ms. McCornack thanked the subcommittee. She described her daughter's disease and treatment history, including accessing IVIG and subsequent symptom remission. She urged the subcommittee to listen to the family experiences and vote for Option 2.
This testimony concerned bariatric procedures:

Greg Showell: Mr. Showell said he is a registered nurse and a bariatric program coordinator in Corvallis. He said these bariatric interventions are needed and lowering the BMI to 30 expands access to care. He said the bariatric surgery candidates undergo a rigorous screening process to ensure that patients are good candidates for these procedures.

Derek Rogalsky: Dr. Rolgalsky is a bariatric surgery in Coos Bay and states he has no conflicts. He said he performs his procedures at an MBSAQIP-accredited center. He agrees that bariatric surgery should be expanded to adolescents. He had minor comments regarding the scope statement. He encouraged the study designs to be expanded beyond RCTs to include prospective cohort studies. He briefly summarized the evidence profiles of various bariatric procedures.

Health Evidence Review Commission (HERC)
May 19, 2022
This testimony concerned equine therapy:

Leia Hughey, PhD, who testified at VbBS earlier in the day, said she had her concerns addressed at that meeting and had nothing further to add.

This testimony concerned freespira:

Monica Frederick, an employee of Freespira. Ms. Frederick clarified that Freespira is not a smartphone app but is an FDA cleared class to medical device that is supported by health coaching and data analytics. Also, it

treats panic disorders and post-traumatic stress disorder (PTSD), rather than substance use disorder. She said that as of April 1, CMS established a HCPCS code for this application.

Robert Cuyler, PhD, an employee of Freespira and a clinical psychologist. Dr. Cuyler gave a very brief walkthrough of the intervention and the components.

Joe Perekupka, CEO of Freespira highlighted a 35% overall reduction of medical costs within the Medicaid marketplace with this device.

This testimony concerned Y90 liver directed therapy:

Mike Cusnir MD, of Mount Sinai in Miami, testified about treatment for metastatic colon cancer and liver disease.

HERC Value-based Benefits Subcommittee
May 19, 2022
This testimony concerned Freespira:

Monica Frederick, an employee of Freespira, testified that Freespira is a digital therapeutic device with FDA approval. Freespira is for the treatment of panic disorder and post-traumatic stress disorder (PTSD), not opioid use. It is not a smartphone app. She said that HCPCS A9291 was published in April 2022: "Prescription digital behavioral therapy, FDA cleared, per course of treatment", and this code would be appropriate to use with Freespira. Bob Cuyler, PhD, Clinical Psychologist and Chief Clinical Officer of Freespira testified about how the device addresses respiratory dysfunction related to panic and PTSD. The device is used at home and monitored by a health coach at the company. The typical treatment protocol is twice daily use for 28 days. He noted that there is an extensive public literature on this intervention and multiple peer-reviewed studies find clinically significant symptom reduction in >70% of patients. Other studies have found a savings of 35% in medical spending in the one-year period after treatment, mainly due to reduced medical visits. He noted the device has a high response rate in Medicaid populations. Joe Perekupka, CEO of Freespira, testified about how the device can help symptoms, address social determinants of health, and help patients gain access to care.

This testimony concerned equine therapy:

Leia Hughey, a licensed clinical psychologist who owns an equine facility where she treats families/children with mental health issues, testified about one CCO discontinuing coverage for equine therapy, which she said is evidence-based practice. Children with better insurance can access this treatment, so it is discriminatory for OHP patients.

This testimony concerned visual field testing:

Julie Falardeau, ophthalmologist, OHSU: Dr. Falardeau testified that visual field testing is a diagnostic tool for a variety of conditions, such as tumor progression or localizing residual field deficits. The ability to objectively quantify visual deficits is very important and she relies very heavily on this tool to answer diagnostic questions.

This testimony concerned PANDAS/PANS:

Sarah Lemley, Executive Director of the NW PANDAS/PANS Network and mother of a child with PANDAS: Ms. Lemley testified that there is a lack of expertise in these conditions in Oregon. She said the Commission needs to rely on the expertise of national experts. She listed Oregon and national experts who agreed with current recommendations, including psychiatrists and neurologists. Per Ms. Lemley, IVIG is approved for

PANDAS by several commercial insurers. Bethany Godlewski, CEBP staff, clarified that that research reflected in the coverage guidance failed to find payer policies supporting coverage by commercial insurers.

Cristina Cronin-Vejar, mother of a patient with PANDAS/PANS: Ms. Cronin-Vejar testified of her daughter's symptoms, which were relieved partially by antibiotics, NSAIDs, tonsillectomy, SSRIs, and other treatments. However, she noted that her daughter has never returned to her baseline self after these therapies. Her daughter has difficultly with school. Not having access to IVIG is very distressing to her family.

Deborah Miller, the mother of patient with PANDAS: Ms. Miller urged adoption of proposed coverage, stating that her child needs IVIG therapy.

Dan Twibell, PACE foundation and father of a PANDAS child: Mr. Twibell testified that PACE is a non-profit organization dedicated to increasing awareness and treatment for PANDAS/PANS. PACE recommends that the EbGS recommendation be adopted by VbBS and HERC.

HERC Evidence-based Guidelines Subcommittee
June 2, 2022
This testimony concerned High-frequency Chest Wall Oscillation Devices:

Gary Hansen, Ph. D., Director of Scientific Affairs for Respirtech (manufacturer): Dr. Hansen testified that the prevalence of bronchiectasis in the Medicaid population is higher than a broader non-Medicaid population, and that coverage should be extended to a subset of bronchiectasis patients.

Alan Barker, MD, OHSU pulmonologist: Dr. Barker testified that he has been involved in patient care, clinical care, and teaching in the field of bronchiectasis for 35 years. He has received honoraria in the past from a company who manufactured a device and has published many papers on this topic in the academic literature. He agreed that bronchiectasis is not a rare disease, like cystic fibrosis. He stated that it is difficult to study a device with appropriate shams. He also stated that chest physiotherapy (PT) has been part of airway clearance for decades and is already an accepted management tool. He also stated that it has been about two decades since chest PT has been considered the gold standard, and today it is hardly ever done in Oregon and the United States; instead, directed coughing, positive expiratory pressure devices, and the oscillation devices are typically used for non-cystic fibrosis bronchiectasis.

Aaron Trimble, MD, OHSU pulmonologist and appointed ad hoc expert: Trimble stated he had equity concerns with the proposed recommendation to exclude coverage for patients with non-cystic fibrosis bronchiectasis. He urged the subcommittee to provide a coverage pathway for a subset of patients with bronchiectasis. Prior infection of tuberculosis is a significant risk factor developing bronchiectasis later in life and many of these patients often have language or cultural barriers to care. Trimble stated that relying on these patients to access these devices via the exceptions process is unrealistic.

July 16, 2021
Written public comment is available on the MSC webpage and includes the following:

- Representative Andrea Salinas, Representative Rachel Prusak, Representative Rob Nosse, Representative Tawna Sanchez, Senator Kate Lieber, and Senator Deb Patterson of the Oregon Legislature provided joint public comment in support of continuing to include the (1) emergency department utilization for members with mental illness and (2) cigarette smoking prevalence measures in the CCO Quality Incentive Program.
- Jennifer Little, Director - Klamath County Public Health, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

- Glenn Gailis, MD, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Ralph Eccles, DO, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Jessica Guernsey, Public Health Director - Multnomah County Health Department, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Margo Lalich, Interim Public Health Director - Clatsop County Department of Public Health, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Julia Hesse, Health Promotion Specialist – Clatsop County Department of Public Health, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Merritt Driscoll, Executive Director – Blue Zones Project-Healthy Klamath, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Karen Ard, Tobacco Prevention and Education Program Coordinator – Deschutes County Health Services, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Donna Mills, Executive Director, Central Oregon Health Council, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Armando Jimenez, Program Manager Tobacco Prevention & Education Program - Clackamas County Public Health Division provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Elena Rivera, Senior Health Policy and Program Advisor - Children's Institute, and Colleen Reuland, Director - Oregon Pediatric Improvement Partnership, provided a joint letter in support of the social-emotional health measure that is part of the multi-3-year multi-measure health aspects of kindergarten readiness measurement strategy previously endorsed by MSC.
- Melinda Davis, Associate Director - Oregon Rural Practice-based Research Network and Associate Professor, OHSU Department of Family Medicine & School of Public Health; John Muench, Professor – OHSU Department of Family Medicine & School of Public Health; Nancy Elder, Director - Oregon Rural Practice-based Research Network and Professor – OHSU Family Medicine; Brigit Adamus Hatch, Assistant Professor – OHSU Department of Family Medicine; Susan Lowe, Patient Advisor/Advocate - ANTECEDENT Advisory Board Member; Kyle Higgins, Behavioral Health Consultant, - South Waterfront Family Medicine Clinic OHSU; and, Josh Haynes, Vice President - Cresa Patient Advisor/Advocate ANTECEDENT Advisory Board provided joint letters in support of continuing to include the screening, brief intervention, & referral to treatment measure in the CCO Quality Incentive Program.
- Jay Rosenbloom, MD, Resa Bradeen, MD, Deborah Rumsey, Executive Director and Julie Harris, Director of Population Health (Children's Health Alliance and Children's Health Foundation) provided testimony on the pandemic and impact on benchmarks set for the program.

In addition to the written public comment above, MSC also heard oral comment as below:
• Melinda Davis, Associate Director - Oregon Rural Practice-based Research Network spoke to written testimony in support of continuing to include the screening, brief intervention, & referral to treatment measure in the CCO Quality Incentive Program.
• Jennifer Little, Director, Public Health, Klamath Public Health, spoke to written testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

• Glenn Gailis, MD, family physician in Klamath Falls, spoke to written testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
• Julie Harris, Director of Population Health - Children's Health Alliance, spoke to submitted written testimony and encouraged MSC to extend benchmark reconsideration factors into the decisions regarding targets for childhood immunization status and immunizations for adolescents measures in the future.
• James McCormack – OHSU, provided testimony in support of continuing to include the screening, brief intervention, & referral to treatment measure in the CCO Quality Incentive Program.
• Jessica Guernsey, Public Health Director - Multnomah County Health Department, spoke to written testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
• Michelle Glass, Policy & Advocacy Coordinator - SO Health-E (Southern Oregon Regional Health Equity Coalition), provided testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
• Miriam Herrmann, Manager, Strategic Provider Partnerships – Trillium CCO, provided testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
• Jacqueline Moreno – Lane County Public Health, provided testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
• Nadia LeMay, Tobacco Prevention & Education Coordinator – Crook County Health Department, provided testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
• Rebecca Pearson, Vice-chair - Jackson County Community Advisory Council for AllCare CCO and Rogue Action Center, provided testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

August 20, 2021
Written public comment is available on the MSC webpage and includes the following:
• Tara Jegtvig, Director of Finance & Human Resources, Northwest Medical Homes, LLC, regarding 2021 benchmarks and requesting pay-for-reporting
• April Hansey, Clinic Administrator, South Hilyard Clinic regarding 2021 benchmarks and requesting pay-for-reporting
• Megan Fields, Administrator, River Road Medical Group, regarding 2021 benchmarks and requesting pay-for-reporting
• David Huntley, Epidemiologist, supporting continuation of the Cigarette Smoking Prevalence measure in the program (pertinent to last meeting)

In addition to the written public comment above, MSC also heard oral comment from the following:
• Julie Harris, Children's Health Alliance, regarding preventative care in primary care setting
• Robin Moody, Executive Director, Dental3, regarding

September 17, 2021
Written public comment is available on the MSC webpage and includes the following:

- Cat Livingston, MD, MPH Medical Director Health Share of Oregon, in support of majority of changes proposed to the 2021 benchmarks and also to postpone 2022/2023 benchmarks.
- Marshall Greene, M.S. Director of Value Improvement, Mosaic Medical, supporting a "pay-for reporting" approach for 2021 reporting.
- Andrew Luther, MD Jennifer Lind Medical Director, Jackson Care Connect CEO, Jackson Care Connect regarding 2021 benchmarks
- Children's Health Alliance and Children's Health Foundation regarding 2021 benchmarks and challenge pool measure pool selection

- Central Oregon Health Council's Operations Quality Incentive Measure (QIM) Workgroup regarding 2021 benchmarks.
- Avery T. Horton, Jr. Citizen, Voter, Taxpayer, regarding correct dosages at pharmacy and quality checks.
- Erin Fair Taylor, Vice President of Medicaid Programs, PacificSource Community Solutions regarding the 2021 benchmarks.
- Advantage Dental, Capitol Dental, CareOregon Dental, ODS, Willamette Dental Group regarding the 2021 benchmarks.

In addition to the written public comment above, MSC also heard oral comment from the following:

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

October 15, 2021
This was a joint committee meeting between HPQMC and Metrics and Scoring (MSC).
There was no written or oral public testimony.

November 19, 2021

- Kati Sánchez**,** Oregon Rural Practice-based Research Network (ORPRN)

Re: In support of move of Screening, Brief, Intervention and Referral for Treatment (SBIRT) from reporting-only measure to incentive benchmark measure

- Melinda Davis, Oregon Rural Practice-based Research Network (ORPRN)

Re: In support of move of Screening, Brief, Intervention and Referral for Treatment (SBIRT) from reporting-only measure to incentive benchmark measure

December meeting was cancelled
There was no January meeting.
There was no February meeting.

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.

April 15, 2022
There was no public testimony

May 20, 2022

Oral Testimony

- Colleen Reuland, Oregon Pediatric Improvement Partnership
  - Re: In support of including Kindergarten Readiness Social Emotional Health Measure in the incentive measure set and challenge pool for 2023.

Written Testimony

- Chanel Smith, Cascade Health Alliance
  - Re: Draft 2023 CCO Incentive Measures
  - Meaningful Language Access
  - Kindergarten Readiness
  - SDOH Screening and Referral Measure

June 24, 2022

Oral Testimony

- Elena Rivera, Children's Institute
  - Re: In support of including Kindergarten Readiness Social Emotional Health Measure in the challenge pool for 2023.

Written Testimony

- Jim Rickards, Yamhill CCO
  - Re: Reducing 2022 benchmarks due to the COVID-19 Pandemic
- Mathew Sinnott of, Jackson Care Connect
  - Re: Reducing 2022 benchmarks due to the COVID-19 Pandemic

Health Plan Quality Metrics Committee

July 27, 2021

There was no public comment for this meeting.

August 24, 2021

This meeting was cancelled.

September 24, 2021

There was no public comment for this meeting.

October 15, 2021

This was a joint committee meeting between HPQMC and Metrics and Scoring (MSC).
There was no written or oral public testimony.

November 30, 2021

There was no written or oral public testimony.

December meeting was cancelled

There was no January meeting.

There was no February meeting.

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.

April 26, 2022
There was no public testimony.

There was no May meeting.

There was no June meeting.

Medicaid Advisory Committee

The Medicaid Advisory Committee is a federally mandated body that advises the State Medicaid Director and the Oregon Health Policy Board on the policies, procedures, and operation of Oregon's Medicaid program through a consumer and community lens. The MAC met seven times between 7/1/2021 and 6/30/2022; details of public comment along with agenda topics are summarized below.

September 22, 2021, Meeting:
The committee received the following public comments:
1. Beth Englander from the Oregon Law Center shared concerns about how health-related services (HRS) are run in general. Beth stated that there is a lack of fairness across the state in how people can access flexible services (Beth clarified that her comments are related to flexible services, which are HRS for individual needs). It is difficult for individuals to find out what flexible services exist. Some members also do not know how to request them and if they get denied, there is no recourse for OHP members to challenge the decision. An example of this is a person with congestive heart failure being denied an air conditioner even though they live in an area that gets very hot. There is also no data on how many requests come in for flexible services to each CCO, how many are rejected and the reasons why requests are rejected.
2. Heather Jefferis, Executive Director of the Oregon Council for Behavioral Health expressed her thanks for the analysis of the behavioral health sector. Heather also asked what the roadmap is to integrate the recommendations into the waiver.
Committee members discussed the following topics:

- 1115 Waiver Interim Evaluation Findings
- Agency Updates for OHA and OHDS
- 1115 Waiver Renewal

- SDOH Screening Measure
- Ombuds Program Quarterly Report
- Consumer Voice Subcommittee Report and Recommendations

October 27, 2021, Meeting
Committee members discussed the following topics:

- Agency Updates for OHA and OHDS
- REALD Requirements
- Waiver Renewal Update

There was no public comment

December 15, 2021, Meeting
Committee members discussed the following topics:

- Agency Updates for OHA and ODHS
- 1115 Waiver Application Public Comment Forum
- REALD Implementation
- OHPB Committee Membership Workgroup Findings
- Office of Health Information Technology Strategic Plan and Community Information Exchange

The committee received the following public comments:
1. Sarah Spansail, Chair, Jackson County Community Advisory Council "Thank you so much Jackie and Hello, Medicaid Advisory Committee members. My name is Sarah Spansail. I live in Medford and I am the chair of the Jackson County Community Advisory Council with Allcare. While we support the extra focus on HealthEquity and other positive changes in the waiver, like children staying insured until the age of 6.
I'm here today to speak in opposition to the draft waiver as written. House Bill 3353 is seen as a way to increase the accountability of CCOs especially when it comes to supporting and serving those who are typically underserved. It's a way to continue to build on the community relationships we've already established, enabling us to create more sustainable and long-term projects in order to create real community transformation.
Unfortunately, the draft presented is siloing out dollars into a new undefined entity with no specific geographic or membership makeup. And while I understand some community partners were engaged in the drafting of the waiver and many of the changes in it are positive, it is disappointing that the community advisory councils were not invited to participate more deeply in the internal process and offer feedback. Our councils have been working hard to support the health of our communities for more than 7 years and have invested over $ 1.2 million dollars in that effort. We've accomplished this through a collaborative process that ensures our OHP members, representatives like myself and others have an equal voice to our community partners. Our request to this community is that the draft 1115 waiver is changed to reflect House Bill 3353 as it is written and secondly as these changes are made to the waiver, OHA should work with our community advisory councils on these internal processes as we are important stakeholders.
The flexibility and sustainability of these funds are critical to supporting otherwise underfunded programs that focus on the most vulnerable and underserved people in our communities, so please change the waiver and ensure that our community advisory committees are partners in that process. I appreciate your time. Thank you."
2. Patti Maloney, Soundview Medical Supply "My name is Patti Maloney, I work with Soundview Medical Supply. We are an incontinence supplier, and we do a lot of business with beneficiaries who have CareOregon, OHP and the managed care programs. I will be writing something up, but I wanted to put in a comment. Because when you're putting in the waivers and there's a lot of talk about opening up care, the care inequity and, allowing people, the eligibility to be longer periods of time.
But we're really concerned about is the continued care and within the continued care is those can continued care requirements, especially during COVID, the 1135 waiver was very vague and it's pretty simple. It does say that sufficient health care items and services are available to meet the needs of individuals enrolled which is something that you had up on the OHA website, that also includes that providers you know who give these

services are in good faith get reimbursed. I'd like to drill down a little bit on that and talk about those requirements for the continued care. We work with customers or beneficiaries that have permanent lifelong conditions and there was never anything in the language for the waivers about not being able to go to the doctor, the Telehealth was something that was talked about. But when you're talking about a population that is mentally or physically disabled, they really have to rely on somebody else to do those things for them. The pandemic had things shut down. Certain things, their care providers could not bring them to appointments or have the ability to have a Telehealth appointment. Uhm. We were unable to get these continued care requirements as renewals; they're considered prescriptions. Uhm doctors whose offices were closed so one of the things that I wanted to, and I will address. It is and I know you want to keep things under the 2 minutes. Oh, you're muted do you want me to stop? It's just really they're looking at the requirements for the continued care and I think that falls right into you know the health equity. Thank you."

January 26, 2022, Meeting
Committee members discussed the following topics:

- 1115 Waiver Renewal – MAC letter of support
- Quarterly Ombuds Program Report and NEMT Update
- 2022 MAC Workplan Discussion
- Medicaid Redeterminations and Migration to the Marketplace
- Agency Updates for OHA/ODHS

The committee received the following public comments:
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 parents 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 wheelchair 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 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 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

Committee members discussed the following topics:

- Medicaid redeterminations and HB 4035
- Legislative Update
- Agency Updates from OHA/ODHS
- Paid Family Caregiver Policy – follow up to January testimony

- Advancing Consumer Experience Subcommittee

The committee received the following public comments:

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.

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 *(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.

April 27, 2022 Meeting
Topics covered:

- Ombuds quarterly report
- Compensation for state committees and boards (HB 2992)
- Advancing Consumer Experience – subcommittee update and charter review
- Unwinding the Public Health Emergency (PHE), HB 3035
- Coverage changes for handicapping malocclusion
- APD 1115 Demonstration request

There were 16 pieces of written testimony submitted to the MAC for this meeting. Most of the letters came from individuals advocating for continuation of the federal exception CMS granted to Oregon to allow the state to pay parents to care for their minor children with disabilities. Written testimony also included a letter from the Oregon Developmental Disabilities Coalition opposing continuation of this program. In addition, during the meeting, three additional individuals provided oral testimony in support of the continuation.

June 25, 2022 Meeting
Committee members discussed the following topics:

- Oregon Health Plan Quality Strategy
- Denial language updates
- Update on paid parent caregiver policy
- Bridge Program Taskforce
- PHE unwinding update
- 1115 Waiver update
- Long-term supports and services update
- Regional listening sessions – Joint Task Force on Universal Healthcare

There was no public testimony.

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 June 30, 2022, 636 practices were recognized as Patient-Centered Primary Care Homes (PCPCHs). This is approximately three-quarters of all primary care practices in Oregon. Ninety-seven PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model. Ninety-two percent of Coordinated Care Organization (CCO) members receive care at recognized PCPCH – this is over 1.1 million lives.

The PCPCH program continued to conduct verification site visits virtually due to the impact of the COVID-19 pandemic. Site visits include verification that the practice is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address barriers. The PCPCH program completed 73 virtual site visits in this reporting year.

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 in February 2022 and made committee appointments in June 2022.

Tribal Care Coordination

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

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

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

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

In July 2021, OHA received approval of a State Plan Amendment (SPA) to allow tribes and the urban Indian health program to form Indian Managed Care Entities (IMCEs). Per SPA OR 21-0008, IMCEs will provide care coordination under the Primary Care Case Management model. One Indian Managed Care Entity will begin offering care coordination services beginning September 1, 2022 to fee for service American Indian/Alaska Native Oregon Health Plan members. Two additional IMCEs are expected to begin services by early 2023. Once operations start, these IMCEs will provide tribal care coordination services to approximately 15,000 of the 22,000 fee for service AI/AN Oregon Health Plan members.

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

Comprehensive Primary Care Plus (CPC+)

The Transformation Center managed the Medicaid fee-for-service implementation of CPC+, which concluded at the end of December. Per-member, per-month (PMPM) care management fees and performance-based payments (PBIP) were key components of the CPC+ payment model. OHA prospectively paid the PBIP at 50% of eligible. Track 2 alternative comprehensive primary care payment launched in January 2021. The quarterly hybrid payment includes a prospectively paid PMPM payment and a corresponding FFS claims reduction on payments for specific claims submitted during the program year. Track 2 practices selected their hybrid payment ratio for CMS in the fall of 2020, and OHA used the same payment ratio. OHA calculated PBIP for 2020 and reconciled the prospectively paid payments. The majority of participating practices outperformed the 50% prospective payment and earned additional PBIP.

Value-based payment (VBP) innovations and technical assistance (TA)

The Transformation Center launched and continued work with the OHA CCO VBP work group. The work group shared accomplishments and lessons learned. OHA staff reported on possible methodologies for calculating a CCO's VBP percentage to align with requirements in the current CCO 2.0 contract, and work group members offered their questions and preferences. OHA staff also shared progress on the state's VBP

compact, a voluntary agreement into which payers across the health care system entered to encourage VBP arrangements.

OHA published a VBP resource library. Resources covers a wide range VBP topics, including risk stratification, attribution, evidence-based care and workflows, performance measurement, promoting health equity and emerging trends. The library also includes sections on each of the five care delivery areas required in CCO contract (hospital, maternity, behavioral health, oral health, and children's health).

CCOs completed three important VBP contract deliverables. They submitted Patient-Centered Primary Care Home and care delivery area VBP data and responded to the VBP pre-interview questionnaire. Subsequently, they participated in 90-minute interviews with OHA's contractor for VBP evaluation, the Center for Health Systems Effectiveness (CHSE). The data, questionnaire and interviews provide OHA with rich sources of information to monitor CCO progress toward VBP goals and assess needs for technical assistance. The information collected informs CHSE's evaluation of OHA's VBP roadmap implementation and becomes the basis of reports on best practices for VBP to share among CCOs and other parts of the health system.

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, approved *Paying for Value in Health Care: A Roadmap for Implementing the Oregon Value-Based Payment Compact*. The roadmap includes an analysis of barriers to VBP implementation, strategies to address these barriers and milestones and indicators of success. The roadmap details the following strategies.

- Develop a short menu of VBP models for use in Oregon that is developed by and reflects the priorities of key stakeholders and allows for greater model alignment.
- Design the VBP models on the short menu to promote health equity, as well as to mitigate adverse impacts on populations experiencing health inequities by 1) employing payment model design features and measures to protect against stinting; 2) ensuring payments are sufficient to cover the cost of infrastructure changes to support health equity (for example, traditional health workers and changes to IT systems to track equity); 3) providing additional supports (for example, technical assistance and infrastructure payments) for providers serving populations experiencing health inequities; and 4) ensuring new upside or downside risks will not exacerbate existing inequities.
- Publish a dynamic web-based VBP toolkit to 1) promote shared vision, process and understanding between providers and payers regarding VBP; 2) provide tools and educational resources to support provider and plan readiness to engage in or advance their VBP participation, across a continuum of

adoption; 3) promote alignment of models and methods in support of VBP adoption; and 4) define the short menu of VBP models.

- Consider targeted strategies to address provider concerns about financial risk.
- Maximize data, program, and policy alignment to remove barriers to VBP adoption.
- Explore foundational principles for attributing individuals to providers for the purposes of developing budget-based VBP models.

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.

The collaborative's VBP Payment Model Development Workgroup further developed the primary care VBP model and made the following decisions:

- The workgroup strongly recommends that practices be certified as PCPCHs before engaging in VBP models and that payers incentivize PCPCH certification for practices they contract with.
- All primary care practices will be invited to participate in the payment model within three years at whatever schedule payers/provider decide.
- The workgroup will develop the list of covered services to include in prospective payment at the CPT code level with a common code list.

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

Roadmap to Oral Health

During the period from July 2021-June 2022, OHA joined 13 other states as part of CMS's Advancing Prevention and Reducing Childhood Caries in Medicaid and CHIP Affinity Group. The project's aim is to reduce childhood caries by spreading the practice of having primary care providers apply topical fluoride varnish as part of well child visits. Additionally, the project seeks to improve referrals to dental homes. Several coordinated care organizations have engaged with their providers in this voluntary quality improvement effort, which will continue with CMS technical assistance support through March 2023.

The 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.

Using resources from the HRSA Oral Health Workforce Grant, OHA's Primary Care Office has been facilitating the partnership of Curry Health Network and Capitol Dental to bring teledentistry services to southern Curry County. Curry county is an isolated, rural county on the southern Oregon coast and one of the most underserved areas of the state for dental care. Once operationalized, this project will bring comprehensive oral health services to Medicaid patients in the region.

The OHA Public Health Division's Oral Health unit supported Medicaid programs with training and technical assistance. The unit held multiple clinical trainings to dental hygienists and assistants for school dental sealant programs during the period. They also provided technical assistance regarding infection prevention and control for COVID-19, 2021 and 2022 CCO incentive metrics, and health equity approaches to school dental sealant programs. A majority of the children these programs serve are covered by Medicaid.

The Oral Health unit promulgated rules to support changes to dental sealant programs brought about because of the COVID-19 PHE. They also continually updated related infection prevention and control guidelines as the PHE evolved.

OHA's Health Evidence Review Committee approved Handicapping Malocclusion as a benefit to implement on January 1, 2023. OHA continues to consult with external partners and state dental and Medicaid directors to gather prevalence data, approval workflow, network adequacy, and clinical guidelines for offering this benefit.

Under the dental director's leadership, OHA launched an oral health workforce learning collaborative to understand better the challenges facing Medicaid managed care entities' ability to contract with or hire adequate numbers of oral health professionals and staff.

Dental Director update

During this time period, OHA welcomed and said goodbye to a dental director. Recruiting a new dental director is a priority for OHA, and the agency taken the time for an initial, internal process to establish how OHA will best position a future Dental Director for success before posting the position again.

Based on this assessment, OHA will move the dental director position into our agency's Health Systems Division as a leadership position within the Medicaid Section.

The dental director will continue to provide overall oral health strategic direction within in agency, and direct leadership support for our oral health work across our public health programs, health policy and analytics division, and beyond.

OHA is working on the final updates to the position description in recognition of these organizational changes. In addition, the agency is working with the Department of Administrative Services to address any needed classification changes and prepare for posting this position.

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

Sustainable Relationships for Community Health program

Activities: Sustainable Relationships for Community Health (SRCH) is a grant funded opportunity for community and clinical partners to address chronic disease health disparities in the local community. This

multi-sector approach to advance healthcare transformation in the state, provides space for teams of local public health authorities, Coordinated Care Organizations (CCOs), clinical partners and community-based organizations, to determine and build together shared health systems change goals and infrastructure, to be sustained and spread beyond the grant period.

To adapt to the COVID-19 pandemic, OHA released a flexible SRCH funding model as an opportunity to apply lessons learned from the COVID-19 pandemic to chronic disease prevention and management efforts and focus these efforts on addressing disparate health and social impacts experienced by communities in Oregon who are affected by higher incidences of chronic disease and COVID-19 The successes and learning from the Sustainable Relationships for Community Health (SRCH) grant teams in FY21 led OHA-HPCDP to direct this year's funding for SRCH toward a sub-set of the teams implementing diabetes prevention and management projects, further focusing the funding opportunity. Four (4) of the SRCH teams received funding and technical assistance from OHA-HPCDP from July 1, 2021 to June 30, 2022.

OHA-HPCDP and contractors provided technical assistance to support innovations in chronic disease disparities prevention and management to SRCH teams per their request. The technical assistance included: practice facilitation from Comagine Health for workflow development, EHR and other tool development and support for general collaborative/partner development and facilitation as well as support from OHSU-HSDHC to pilot a Diabetes Self-Management Education and Support cohort with the Confederated Tribes of Siletz Indians.

Progress and Findings:

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

The *Confederated Tribes of Siletz Indians (CTSI) SRCH team* piloted a virtual Diabetes Self-Management Education and Support (DSMES) Native cohort with the OHSU-Harold Schnitzer Diabetes Health Center. This work includes tribal adaptations to the DSMES curriculum, establishing a closed loop referral between Siletz Tribal Health and OHSU, and piloting a Tribal DSMES cohort. CTSI determined that while collaboration with OHSU-HSDHC was successful, there was more client and clinic readiness to address prediabetes via the National Diabetes Prevention program and have the program be Native-led. The technical assistance from Comagine Health supported CTSI with planning and connecting to similar efforts among the Navajo tribal areas as well as conducting National DPP assessment to assess readiness to begin offering National DPP cohorts in next fiscal year. In Q4, The Confederated Tribes of Siletz Indians completed their readiness assessment DPP assessment and trained 11 tribal members as DPP lifestyle coaches, and will be launching a tribal DPP cohort in July 2022

The *Central Oregon SRCH Team* fully transitioned from using Compass Platform and EPIC EHR to Welld for program data management and billing for the National Diabetes Prevention Program. With the Welld platform being live, the Central Oregon SRCH team worked to partner with other entities to deliver National DPP and bill for the program. Their work also included training and onboarding of new lifestyle coaches to using Welld for new National DPP cohorts. Progress in Q3 and Q4 slowed due to staffing turnover and lack of capacity. The Central Oregon team is assessing how to maintain services with staffing changes and plans to continue SRCH work to address prediabetes and diabetes in the next fiscal year.

The *RHEHub (Regional Health Education Hub*)/IHN-CCO team created a sustainability roadmap for the systems and structure needed to support National DPP and other self-management education efforts. Comagine Health provided facilitation and support among the RHEHub members to develop the roadmap. In Q4, the RHEHub team finalized their Program Roadmap and presented the roadmap to the RHEHub Steering Committee for feedback. The team used National DPP as the example to create the Program Roadmap and the process, and the team will be using it in the upcoming SRCH year. This will allow the RHEHub team to identify regional needs (e.g., coordination, additional funding, referral pathways, etc.) and support regional partners to align and work together to deliver national DPP and other evidence-based health education programs.

The *Tillamook County* team focused on supporting long-term sustainability of the CHW position(s) in medical and non-medical settings across the county. They created a comprehensive CHW job description for Tillamook Community Health Centers that provides pathways for internal promotion and growth as well as an entrance point for those in the community to become a CHW. This process included delays in approval and posting the new CHW position, part of which is due to limited current staff availability as a result of COVID-19 response In Q4, The Tillamook SRCH team received approval for the CHW job description with all entities (e.g., county, the union, board of commissioners). Due to the delays in receiving approval, the Tillamook SRCH team was unable to launch a National DPP cohort with the CHW providing National DPP and billing for services with OHP Medicaid, but anticipates supporting this in the new fiscal year.

Trends, Successes, or Issues:

While all 4 SRCH teams made progress over the year, SRCH teams were challenged by COVID-19 pandemic impacts on program delivery (in-person and virtual), health care and social service workforce fatigue, staffing challenges and staff turnover. These challenges necessitated flexible program plans to adapt to changing staff capacity and COVID-19 pandemic response needs. The SRCH teams applied for additional funding and technical assistance for FY23 to advance their work and plan for sustainability when funding ends.

Public Health Modernization

OHA's Public Health Division supported the goals of health care transformation through two strategic initiatives, Public Health Modernization, and the State Health Improvement Plan

With the Oregon Legislature's additional investment of $45 million in public health modernization for the 2021-23 biennium, Oregon expanded its work to ensure a nimble, community-based, and equity-centered public health system. This investment leverages changes to the public health workforce and system that have occurred throughout the COVID-19 pandemic, including new investments into communities experiencing the greatest harm from COVID-19. The majority of public health modernization funding is allocated to local public health authorities, federally recognized tribes, and community-based organizations. Funding supports public health interventions that are equitable, community-driven and address historical and contemporary injustices. Priorities in the past year included communicable disease and environmental health threats planning and response; communicable disease prevention; and strategies to address impacts of climate change on health.

The second strategic priority of OHA's Public Health Division was implementation of Healthier Together Oregon (HTO), the State Health Improvement Plan. HTO is intended to be an organizational alignment tool for collective impact towards OHA's 2030 goals of eliminating health inequities. Here are significant achievements of the past year.

- OHA convened the PartnerSHIP, the community-based steering committee charged with directing and decision making about implementation of this plan. The PartnerSHIP prioritized 7 strategies within the plan that focus on housing and transportation, food security, behavioral health, and broadband access. OHA supported implementation of these strategies through a number of different efforts. For example, with new SPINE funding from the National Association of Chronic Disease Directors, OHA has strengthened relationships with food systems partners who come together through the Oregon Community Food Systems Network. OHA is also convening other state agencies who have shared work in the space of affordable housing, active transportation, and health equity. Partners from Oregon Department of Transportation, Oregon Housing and Community Services, Department of Land Conservation and Development, Oregon Department of Human Services and Department of Environmental Quality have been participating.

- OHA provided communication about HTO through a variety of mechanisms, including but not limited to written communications via a monthly listserve with a reach of 8,000 subscribers, hosting of community events to learn about the strategies and activities of the plan, and development and promotion of alignment resources for Community Health Assessment and Improvement Plans.

- With members of the PartnerSHIP, OHA co-developed a Policy Option Package for the 2023 legislative session. This proposal requests $15 million in state general fund to support implementation through investment in state SDOH infrastructure, community grants, and communications.

- The HTO Core Group was reformed. As the backbone agency for HTO, this OHA work group serves as the hub of coordination, staff support and information sharing across six major functions: guided vision and strategy, support for aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing funding.

Innovator Agents

- **Community Advisory Council (CAC) involvement and participation in work related to Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and Transformation Plan:**
    - IAs engage actively with members on Oregon Health Plan via monthly Community Advisory Council meetings, Community Health Assessment and Community Health Improvement Plan meetings which support the inclusion of member voice at multiple impactful areas of CCO work.
    - IAs share resources and best practices related to community engagement, specifically in the dissemination of surveys and strategies that meaningfully engage unrepresented OHP and community members in the assessment process.
    - IAs regularly present information to CACs on a variety of info, including but not limited to: COVID updates for their county/region, Waiver and legislative updates and developments within OHA or other state departments, resources, opportunities to engage in legislative review, surveys, and committees, as well as consumer focused learning opportunities.

- **Spread of best practices around health system transformation and innovation:**
    - IAs understand the health needs of the regions, strengths, and gaps of the health resources in the CCO and articulate these needs and gaps to ensure statewide and local coordination. IAs help connect the dots between state legislative policy, OHA rule and contract authority and local systems that affect consumers.
    - Legislative examples:

- 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.
- ***Healthier Oregon Program:*** this new program in Oregon is a legislative mandate to expand services to a broader population of undocumented populations in Oregon. IAs have been active members of the planning team, and Healthier Oregon Member Escalation Workgroup.
- ***SB762 and SB1536****:* SB762 is an omnibus wildfire bill passed by the Oregon legislature in 2021, and SB1536 is a cooling systems support and renters right bill passed in 2022. While these bills are significantly different in nature, they each carry funds to support the distribution of air-filtration devices for protection against wildfire smoke (SB762) and air conditioners (SB1536) to vulnerable residents throughout Oregon. All IAs have taken an active role in coordination of this work between OHA, ODHS and CCOs to assure communication and engagement on the work is moving smoothly and quickly.

- **Tracking of CCO questions, issues, and resolutions in order to identify systemic issues;**
  - Baby Formula supply issues
  - How to use and access COVID-19 home tests, including finding of a video using American Sign Language and captioning
  - IAs have helped provide more information related to Measure 110 and the building and funding of new Behavioral Health Resource Networks.
  - IAs have provided continuous updates to leaders on the 1115 Waiver process and ongoing work within OHA. This has led to a continuous communication loop between OHA and CCOs, allowing for continuous feedback to be given to internal OHA processes that have impacts on OHP members.
  - IA worked with Ombuds and CCO related to member who moved out of state for inpatient TBI services due to the lack of these specific services being available in Oregon. This case was unique in that it involved significant care coordination outside of the state with partners and providers that had not worked together before and therefore required significant and ongoing communication.
  - 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
  - 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.

- **Assistance to CCOs implementing innovative projects and pilots (e.g., stakeholder feedback, adapting innovation to improve adoption rate);**
  - IAs acted as quasi local experts in the communities where the CCO they work with are located. They use relationships to connect OHA, local community organizations, and the CCO's they work with and ensure coordination across these groups. They play 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.
  - IA participated on 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.

- 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.
- IA coordinated a joint meeting between OHA staff leading work related to Traditional Health Workers within the agency and a CCO, to brainstorm ways for the Community Partners (who are OHP Assisters) in the CCO region to gain the ability to identify OHP members and their assigned CCO, for increased support via health systems navigation.
- 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).

- **Community partnerships supporting effective innovation.**
  - IA has worked with the Regional Outreach Coordinators (ROCs) from the Community Partner and Outreach Team within OHA, to create strategies for providing OHP members and Certified OHP Assisters Community Partners updates related to the Public Health Emergency Unwinding and Redeterminations.
  - IA received a concern from a CCO regarding the availability of Naloxone resources in Oregon and was able to meet with SMEs within OHA and relay the information back to the CCO and further assisted at the community level by passing this information along to the specific clinics in the CCO service region.
  - IA supported community partnerships through involvement with a local Farmworker Resource Group
  - 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.
  - 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.
  - 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.
  - 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.
  - Innovator Agents provided information to Community Based Organizations to apply for funding to support testing, contact tracing, and social supports for quarantine and isolation.
  - OHA updates are continually shared which has increased efficiency among the CCOs and partners. In addition, IAs have supported community organizations, public health, and OHP members with resources developed by OHA.
  - IA worked with the local Early Learning Hub and 4 local nursing students to develop a survey for families to best identify what type of early learning supports they currently need or would access, particularly in a post COVID-19 world.

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

Health-Related Services

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

Staff completed a final assessment of the 2020 CCO-reported HRS spending to determine if spending met HRS criteria. In 2019 OHA accepted $16,163,747 of CCO HRS spending as meeting HRS criteria, which more than doubled to $34,153,552 in 2020. This represents an improved acceptance rate of 87% of all reported CCO HRS spending in 2020 compared to 62% for 2019 spending. The spending also represents increases in per member per (PMPM) month HRS spending ($1.51 PMPM in 2019 and $2.93 PMPM in 2020) and percent of total CCO spending (0.36% in 2019 and 0.70% in 2020). The final analysis and summary of 2020 HRS spending will be released in November 2021.

Staff reviewed 2021 CCO HRS spending reports and gave CCOs the opportunity to submit additional spending details in response to initial OHA feedback. Staff will make final determinations of CCO HRS spending in July. Final determinations will be shared with CCOs and the OHA Office of Actuarial and Financial Analytics for use in the CCO Performance Based Reward calculations.

To improve future use of and support potential increases to HRS spending, staff held quarterly office hours for CCOs and continued to work with the Oregon Rural Practice-based Research Network on direct CCO TA, including the following:

- Held HRS webinars: HRS policies and procedures; HRS and HIT; and equity in CCO HRS programs; and
- Finalized the agenda for a fall virtual convening with alignment across HRS, SHARE (Supporting Health for All through REinvestment) and in lieu of services.

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.

The Transformation Center is supporting CCO ILOS guidance and technical assistance through a contract with ORPRN to provide webinars, guidance documents and direct CCO TA. Staff finalized the agenda for a fall virtual convening with alignment across HRS, SHARE (Supporting Health for All through REinvestment) and ILOS.

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.

Community advisory council activities

The center continued to host peer-to-peer meetings with community advisory council (CAC) coordinators. Topics included:

- Hybrid CAC meetings
- Oregon Health Plan member materials review process
- CAC Demographic Report submissions
- OHA Medicaid Advisory Committee consumer subcommittee recommendations
- How CCOs are structuring CAC meetings to meet CCO 2.0 requirements
- How CCOs are involving their CACs in the community health assessment process
- Consumer CAC member compensation
- CAC review of community health assessments

The center completed review of the first annual CAC Demographic Report submissions and provided feedback to CCOs.

The center held a four-session CAC member learning series focused on the social determinants of health and equity. The center also hosted a CAC best practices workshop for the four PacificSource Health Councils and other PacificSource staff who support CACs.

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 began a new six-session operations-focused CHA/CHP learning collaborative for CCOs and their collaborative CHA/CHP partners. The first session focused on resourcing CHA and CHP work, and the second session focused on governance.

The center updated and shared guidance with CCOs on completing a shared CHA and CHP and CHA/CHP evaluation criteria; shared the 2022 CHP progress report template; and hosted an office hours session on the new guidance.

Social Determinants of Health Measurement Workgroup

The SDOH Measurement Workgroup pilot tested the proposed SDOH measure concept ("Rate of social needs screening in the total member population using any qualifying data source") and received CCO feedback. On the whole, CCOs are supportive about the overall vision for this measure, and the potential for it to transform the system and address members' social needs. CCOs shared that implementing the measure with the current

technical specifications is possible, but that it would take time to implement the systems needed and that implementing the structural measure would take significant effort. CCOs differ significantly on how much screening is currently being conducted, who conducts the screening, which tools are being used, and their plans for implementing this measure. CCOs expressed appreciation for the approved list of screening tools. The requirements to document screener roles, track screening, and develop screening policies to avoid re-screening garnered both support and concerns from CCOs. Input from the pilot testing was incorporated by OHA into draft measure specifications.

The Metric and Scoring Committee adopted the work group's SDOH measure concept as part of the CCO incentive measure set. Measure implementation will begin January 1, 2023, and final measure specifications will be posted by the end of 2022. Staff began planning measure implementation and support to CCOs including: 1) developing a RACI matrix to coordinate across divisions and with external contractors and partners; 2) beginning contracting process with ORPRN (Oregon Rural Practice-based Research Network) to provide technical assistance to CCOs and health/social care system partners involved in metric implementation.

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. All CCOs must invest a portion of their SHARE dollars on housing-related supports and services.

CCOs submitted their first SHARE spending plans (based on their 2020 financials) in September and their first spending reports in June. After the rules process and public comment, staff finalized Oregon Administrative Rule updates, which sets the formula for SHARE spending starting in 2023 (based on 2022 financials).

The Transformation Center finalized and posted 2022 SHARE reporting templates and guidance: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx. Technical assistance for CCOs included monthly learning collaborative sessions and two webinars facilitated by ORPRN. The center hosted three office hours sessions to support SHARE planning and reporting, but no CCO staff attended. Registration opened for a fall virtual convening for CCOs with alignment across HRS, SHARE and ILOS.

CCO incentive metrics technical assistance

Diabetes (HbA1c control)

The Transformation Center launched a training series for Oregon Medicaid providers on using motivational interviewing for diabetes management. These no-cost virtual trainings (with continuing medical education credits) focus on improving providers' confidence and skills in conversations about sensitive behavior change topics required for diabetes management. Three types of trainings are available: level 1, level 2 and using motivational interviewing in diabetes management groups. Providers have multiple opportunities to attend through February 2023. Thirty-two people attended the first level 1 training.

Kindergarten readiness

- **Preventive dental** – The Transformation Center is leading a two-year learning collaborative in the state to increase rates of topical fluoride varnish applied in primary care and improve overall performance on the preventive dental care metric. The group held its kick-off meeting in July. Eleven CCOs, three

DCOs, five county health departments, one tribal entity, the school of dentistry, a fee-for-service care coordination contractor, and the chief professional organization for primary care clinics in the state have joined the effort to date. In September, OHA decided to put the effort on hold until 2022 in response to stakeholder concerns about their capacity to engage in quality improvement during Oregon's greatest surge of COVID-19 infections. Upon restarting, four CCOs and the care coordination contractor for the fee-for-service program are engaged in the work. In addition to the learning collaborative, the center is holding office hours between sessions to help the entities develop their quality improvement efforts.

- **System-level social emotional health** – Implementation of this new CCO incentive metric began in January 2022 and is focused on improving the system of care and services for young children birth to five years old. 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 held needs assessment calls and based on CCO request, launched a 12-month learning collaborative for CCOs in May. The first two sessions focused on introducing the measure and using, interpreting, and sharing reach report data with community and clinical partners involved in care and services for young children. The monthly learning collaborative sessions will focus on supporting CCOs to implement the four measure components. The center also held two webinars focused on asset mapping and behavioral health services for children (infant to five years).

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. Sixty-two clinics were 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. Learning collaborative content is based on information collected from participants in late 2021; the highest priority for participants is clarification of Oregon administrative rules and CCO contract requirements related to care coordination.

Sessions so far have also focused opportunities for improving care coordination programs with traditional health workers, a Family Preservation Demonstration Project, and transitions from pediatric to adult health care for young adults with medical complexity. The first three sessions 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.

COVID-19 vaccines: virtual learning series for providers

Oregon Health Authority

The Transformation Center partnered with the OHA Vaccine Planning Unit & COVID-19 Response & Recovery Unit to host six learning sessions for providers in support of COVID-19 vaccine rollout for the 6-month to four-year-old populations. An average of 150 people attended each session.

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 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.

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.

The consultants have trained 15 providers and are actively recruiting additional providers. Community presentations are being scheduled, with six locations identified across three regions in the state. Materials for community presentations have been developed and are being translated into the most common languages.

Health information exchange

The Transformation Center, in partnership with the Office of Health Information Technology provided technical assistance to primary care clinics serving Oregon Medicaid members to produce reliable, accurate eCQM reports using the QRDA III standard (aggregated data), and to improve these metric performance rates. This work facilitated clinics' meeting current eCQM reporting needs for programs such as the Medicaid Electronic Health Record (EHR) Incentive Program, CPC+ and MIPS. Additionally, the technical assistance supported the implementation of workflows and the integration of health information exchange with EHRs to identify and target complex patients with recent transitions of care and reduce hospital readmissions.

Statewide CCO learning collaborative for the Quality and Health Outcomes Committee

The Transformation Center coordinated three statewide CCO learning collaborative sessions to support improved quality and health outcomes.

- How CCOs are integrating and paying for traditional health workers (THWs), and THW programs and services, to support improved quality and health outcomes. All evaluation respondents (six) rated the session as valuable for supporting their work.
- CCO and clinic strategies to increase initiation and engagement to treatment for substance use disorders
- CCO and clinic strategies for increasing routine childhood immunizations. All evaluation respondents (five) rated the immunization session as very valuable for supporting their work.

Transformation and quality strategy (TQS) technical assistance

OHA held individual calls with seven CCOs to discuss their 2021 TQS assessments. These calls were optional and by CCO request.

OHA finalized TQS guidance for 2022 submissions, which were due March 15. All guidance documents and details about the fall technical assistance series are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx.

OHA held five TA webinars for CCOs focused on 2022 TQS guidance updates and components with the greatest opportunities for improvement. Staff also held monthly TQS office hours November–March.

OHA subject matter experts reviewed and provided feedback on CCOs' 2022 TQS submissions. The average score across CCOs increased 5.9 percentage points over the previous year. On average, CCOs earned 83.5% of points possible (range = 51–91.7%). Outcomes reported from fully matured projects include the following:

- Established social determinants of health screening during intake for intensive care coordination. CCO uses results for crafting member-centered care plans and, in aggregate, to set health-related services spending priorities.
- Expanded a primary care behavioral health model of care to 10 PCPCH-integrated practices.
- Incorporated depression screening into three dental practices, with plans to scale the project across CCO's entire service area. 66% of patients who screened positive received a referral to behavioral health.
- Expanded Project Nurture, which integrates substance use treatment and maternity care for pregnant people with SUD. An initial evaluation showed that participants had lower rates of C-sections than non-participants.
- Brought cross-sector provider communities together to develop a shared understanding and tools for creating a trauma-informed culture and system of care grounded in equity and connection.
- Reached a saturation point with available PCPCHs by achieving its goal of priority assignment to PCPCHs. 94% of members are currently assigned to a PCPCH.

TQS leads held optional feedback calls with two CCOs, with five more scheduled through the summer.

In an evaluation survey about the TQS TA provided for the 2022 submissions, CCOs reported the most valuable supports were the guidance document, individual written assessments, and FAQ. The top two TQS components that respondents prioritized for future TA were special health care needs and utilization review. Additional comments from respondents are below:

- "The scoring and feedback you provide is invaluable; thank you for taking the time to review our work."
- "I have found that the one-on-one sessions with TQS and OHA representatives have been the most helpful as they allow a more informal mix of discussion elements without the risk of competitive scrutiny. Nobody wants to ask a dumb question in front of their CCO peers."

B. Lower cost

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

Reported separately as an Appendix.

C. Better care and Better health (ANNUAL)

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

Quality Pool – Coordinated Care Organization Incentives

Throughout the demonstration year, the Oregon Health Authority (OHA) produced regular reports as well as final calendar year 2020 data at the state and coordinated care organization (CCO) level.
The CCO quality incentive program contributes to the OHA's strategic goal of eliminating health inequities by 2030. 2021 was the first year that the measure Health equity measure – Meaningful access to health care services for persons with limited English proficiency was incentivized. This is part of Oregon's plan for upstream measures addressing health inequities. The measure was incentivized in 2021 following multi-year development work by a public workgroup and other partners.

Progress Reporting
The OHA continued to provide CCOs with monthly metrics dashboards, an interactive tool to analyze performance on CCO incentive and quality and access test measures. Measure results are reflected for a rolling 12-month period and member-level detail is included for claims-based measures to facilitate measure validation and quality improvement activities.

2021 Calendar Year Report and Performance
The OHA published a report on the CCOs incentive, state performance and core performance measures for the 2021 calendar year. All CCOs had performance data successfully reported for the year. This report is available online here:
https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2021_CCO_metrics_report.pdf?utm_medium=email&utm_source=govdelivery

While this report only shows statewide averages for CCO members as a whole, upcoming data briefs and dashboards will other stratifications of many metrics by key performance factors including race, ethnicity, language, and disability.

The report indicates that the CCO model continues to demonstrate improvement in several areas. Although the COVID-19 public health emergency continued and various variants drove a surge in hospitalizations and deaths, performance on CCO incentive metrics began to rebound in 2021 after sharp declines in 2020. For example, oral health measures regained substantial growth in 2021 after falling sharply in 2020 as clinics suspended in-person services. For calendar year 2020, OHA suspended incentive measure benchmarks and required CCOs to only report measures. For calendar year 2021, benchmarks were set again though at significantly reduced levels. Restoring aspirational benchmarks is anticipated to be a multi-year process.

Specific successes include:

- Preventive dental/oral services (ages 1-5)
  Performance on this measure improved by 25.9% from 2020 to 2021
- Preventive dental/oral services (ages 6-9)
  Performance on this measure improved by 17.1% from 2020 to 2021
- Oral evaluation for adults with diabetes
  Performance on this measure improved by 21.7% from 2020 to 2021.

- Health equity measure: Meaning access to health care services for persons with limited English proficiency
  For the first year of this measure, CCOs were required to conduct a self-assessment of language access and attest to work to identity and assess communication needs, provide language assistance services, train staff, and provide notice of language assistance services to members. All but one CCO met this measure in 2021. In 2022, CCOs will also be required to report on how often interpreter services were provided when CCO members with identified interpreter needs had physical, behavioral, or dental health visits.

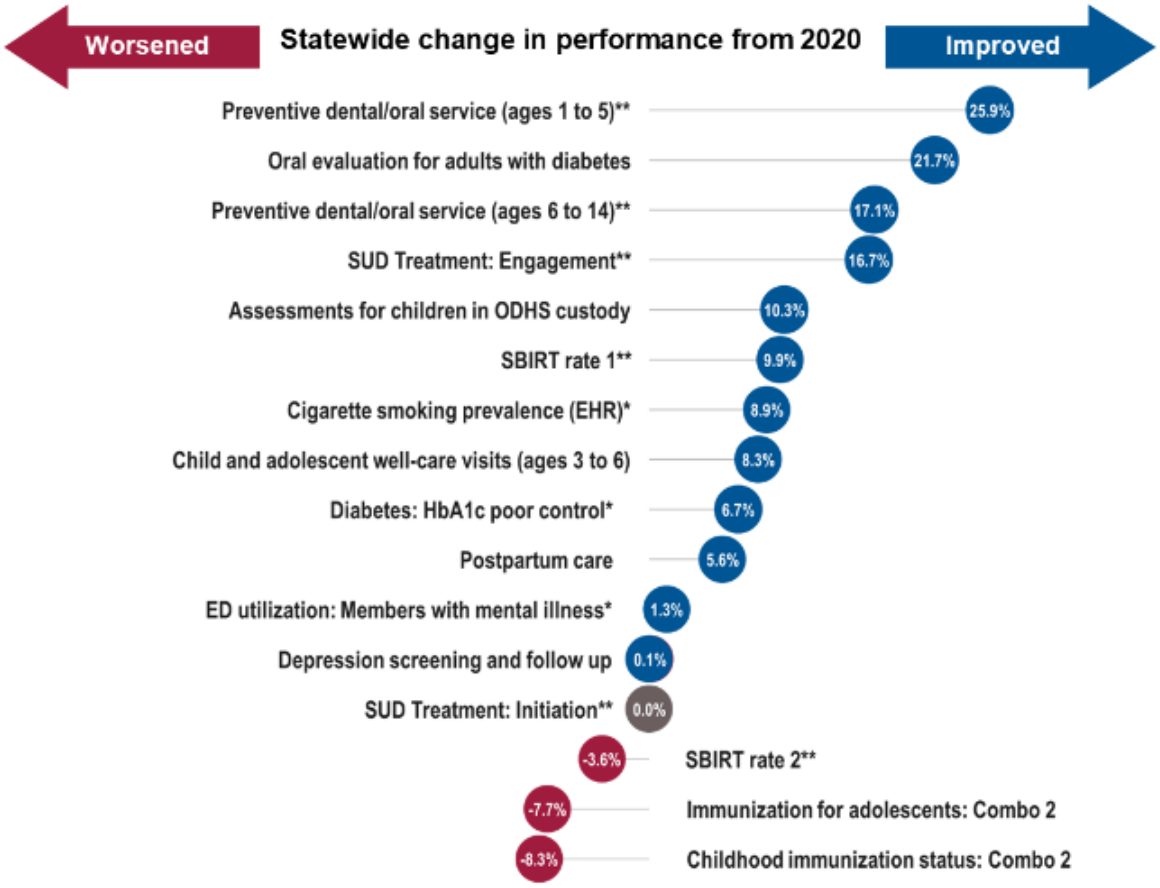
Areas of opportunities include:

- Childhood immunization status – Combo 2 and Immunization for adolescents – Combo 2
  Performance on these measures declined in 2021 likely as a lingering effect of pandemic-related disruptions during 2020.

The table on the next two pages are included in the 2021 report. The first shows performance on each incentive measure by CCO for 2021. The second one displays performance results for each CCO in achieving benchmarks or improvement targets for each 2021 incentive metric.

Key findings

Performance on most CCO incentive metrics improved in 2021 compared with 2020



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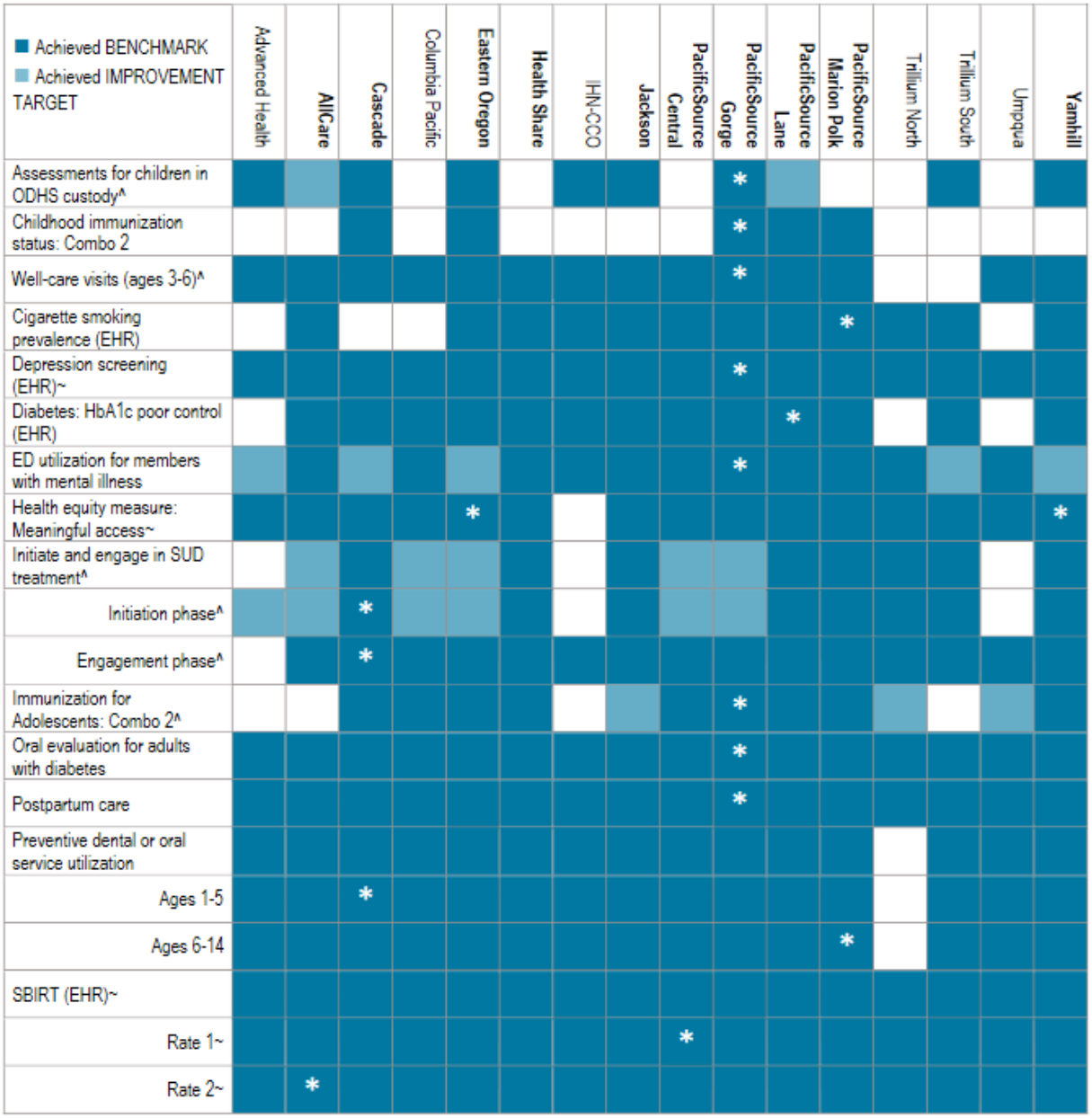
* For these measures a lower rate indicates better performance. To enable easy comparison across the measure set, measures are listed in the chart based on whether performance moved in the desired direction. For example, performance on the cigarette smoking prevalence measure improved by 8.9%, meaning a 8.9% *decrease* in the rate of smoking.

** Each of these three measures (SUD treatment, Preventive dental/oral health, and SBIRT) has two separately reported rates.

2021 incentive measure performance overview



✱ Top performing CCO in each measure
Bold indicates CCOs earned 100% Quality Pool
~ indicates must pass measure
^ indicates Challenge Pool measure
To meet a measure with two rates, CCOs may be required to achieve the benchmark or target for one or both rates.

CCO Incentives

Disbursement of the CCO quality pool funds continues to be contingent on CCO performance relative to benchmark and improvement targets for measures. The 2021 Quality Pool for CCO incentive metrics was almost $235million, representing 3.75% of the total amount all CCOs were paid in 2021. The share of these funds that a CCO can earn depends on the number of members it serves and its performance on the 14 incentive metrics. Money left over from the quality pool formed the challenge pool, which was distributed to CCOs the met benchmarks or improvement targets on a subset of measures. Challenge pool measures for 2021 were:

1. Immunizations for adolescents: Combo 2
2. Child and adolescent well-care visits (incentivized for ages 3-6)
3. Assessments for children in ODHS custody
4. Initiation and Engagement of SUD Treatment

CCO	Stage 1 Distribution			Challenge Pool		Total	
	# Measures met (11 possible)	Total payment earned in Stage 1*	% Quality Pool funds earned	# Challenge Pool measures met (4 possible)	$ Challenge Pool earned	Total payment (Stage 1 + Challenge Pool + MCO tax + EOT**)	Total % Quality Pool earned
Advanced Health	6	$3,406,464	60%	2	$414,233	$3,898,670	67.3%
AllCare Health Plan	9	$10,835,854	100%	3	$1,260,532	$12,343,251	111.6%
Cascade Health Alliance	10	$4,498,997	100%	4	$661,281	$5,265,590	114.7%
Columbia Pacific	8	$6,072,302	80%	3	$586,241	$7,723,865	87.7%
Eastern Oregon	11	$14,580,982	100%	4	$1,805,361	$16,720,758	112.4%
Health Share of Oregon	9	$77,043,647	100%	3	$7,165,986	$96,410,326	109.3%
Intercommunity Health Network	8	$11,182,526	70%	2	$1,168,167	$14,776,222	77.3%
Jackson Care Connect	10	$11,415,297	100%	4	$1,643,652	$14,124,196	114.4%
PacificSource – Central	9	$14,775,731	100%	3	$1,189,011	$16,290,553	108.0%
PacificSource – Gorge	11	$3,228,265	100%	4	$429,577	$4,171,711	113.3%
PacificSource – Lane	11	$16,401,287	100%	4	$2,189,796	$21,201,961	113.4%
PacificSource – Marion Polk	10	$23,663,809	100%	3	$2,263,678	$29,676,186	109.6%
Trillium North	8	$5,954,558	80%	2	$590,238	$7,560,841	87.9%
Trillium South	6	$2,021,978	60%	2	$203,987	$2,670,942	66.1%
Umpqua Health Alliance	6	$4,194,862	60%	2	$405,393	$4,694,138	65.8%
Yamhill Community Care	10	$6,736,585	100%	4	$911,538	$8,720,750	113.5%
Total		$216,013,143			$22,888,671	$266,249,959	

Disbursement of the CCO quality pool funds continues to be contingent on CCO performance relative to both the absolute benchmark and improvement targets for the selected measures. Funds from the quality pool will be distributed on an annual basis, with the calendar year payment made by June 30 of the following year.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately

2. State reported enrollment table

Enrollment	April/2022	May/2022	June/2022
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,231,279	1,236,532	1,242,201
Title XXI funded State Plan	127,545	128,287	129,485
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%	3	36	0.00%	0.00%
		Pregnant women FPL > 170%	N/A	N/A	N/A	N/A
	Title XXI	SCHIP FPL > 170%	72,564	705,587	0.40%	23.51%
Optional	**Title XIX**	PLM women FPL 133-170%	2	24	0.00%	0.00%
	Title XXI	SCHIP FPL < 170%	180,095	1,776,096	-0.35%	23.15%
Mandatory	**Title XIX**	Other OHP Plus	210,626	2,310,197	2.76%	16.82%
		MAGI adults/children	1,066,394	11,719,552	1.41%	21.65%
		MAGI pregnant women	221,868	221,868	16.49%	41.08%
		QUARTER TOTALS	1,751,552			

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

OHP eligible and managed care enrollment

OHP eligible*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
July	1,194,287	1,116,697	1,950	189	14,255	1,950	N/A
August	1,206,333	1,128,702	2,491	177	14,576	2,491	N/A
September	1,213,147	1,134,768	1,986	156	14,349	1,986	N/A
October	1,220,016	1,141,231	1,992	170	14,414	1,992	N/A
November	1,231,578	1,152,750	2,527	182	14,616	2,527	N/A

December	1,240,824	1,162,185	2,453	184	14,434	2,453	N/A
January	1,252,003	1,172,545	2,378	190	14,305	2,378	N/A
February	1,259,814	1,180,380	2,690	184	13,964	2,690	N/A
March	1,266,956	1,187,176	2,398	187	13,904	2,398	N/A
April	1,273,208	1,192,310	2,179	192	13,788	2,179	N/A
May	1,281,162	1,199,651	2,199	155	13,816	2,199	N/A
June	1,286,704	1,204,447	2,024	165	13,783	2,024	N/A
Annual average	1,243,836	1,164,404	2,272	178	14,184	2,272	N/A
	Average percentage	93.61%	0.18%	0.01%	1.14%	0.18%	

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

B. Complaints and grievances

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

C. CCO appeals and hearings

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

D. Neutrality reports

Budget monitoring spreadsheets

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

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

CHIP Statistical Enrollment Data Reports

Form 21E | OR | 2022 | Quarter 3

Conception to birth:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	1,599	262	10	3	0	**1,874**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**1,599**	**262**	**10**	**3**	**0**	**1,874**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	469	66	3	2	0	**540**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**469**	**66**	**3**	**2**	**0**	**540**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	757	113	4	1	0	**875**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**757**	**113**	**4**	**1**	**0**	**875**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	3,820	646	22	7	0	**4,495**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**3,820**	**646**	**22**	**7**	**0**	**4,495**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.4	2.5	2.2	2.3	0	**2.4**
B. Managed Care Arrangements	0	0	0	0	0	**0.0**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**2.4**	**2.5**	**2.2**	**2.3**	**0.0**	**2.4**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	1,143	192	7	3	0	**1,345**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**1,143**	**192**	**7**	**3**	**0**	**1,345**

Birth through age 12 months:

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

	% of FPL 0-133	**% of FPL 134-200**	**% of FPL 201-250**	**% of FPL 251-300**	**% of FPL 301-300**	**Totals**
A. Fee-for-Service	0	13	19	18	0	**50**
B. Managed Care Arrangements	0	154	383	279	0	**816**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**167**	**402**	**297**	**0**	**866**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	11	13	14	0	**38**
B. Managed Care Arrangements	0	60	140	88	0	**288**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**71**	**153**	**102**	**0**	**326**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	5	4	5	0	**14**
B. Managed Care Arrangements	0	22	25	20	0	**67**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**27**	**29**	**25**	**0**	**81**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	19	32	29	0	**80**
B. Managed Care Arrangements	0	402	1,048	751	0	**2,201**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**421**	**1,080**	**780**	**0**	**2,281**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	1.5	1.7	1.6	0	**1.6**
B. Managed Care Arrangements	0	2.6	2.7	2.7	0	**2.7**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**0.0**	**2.5**	**2.7**	**2.6**	**0.0**	**2.6**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	9	16	14	0	**39**
B. Managed Care Arrangements	0	138	363	254	0	**755**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**147**	**379**	**268**	**0**	**794**

Age 1 year through age 5 years:

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

	% of FPL 0-133	**% of FPL 134-200**	**% of FPL 201-250**	**% of FPL 251-300**	**% of FPL 301-300**	**Totals**
A. Fee-for-Service	0	1,509	529	647	0	**2,685**
B. Managed Care Arrangements	0	21,063	6,933	5,531	0	**33,527**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**22,572**	**7,462**	**6,178**	**0**	**36,212**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	251	72	71	0	**394**
B. Managed Care Arrangements	0	5,998	1,667	1,306	0	**8,971**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**6,249**	**1,739**	**1,377**	**0**	**9,365**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	142	35	35	0	**212**
B. Managed Care Arrangements	0	2,576	415	260	0	**3,251**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**2,718**	**450**	**295**	**0**	**3,463**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	4,107	1,459	1,834	0	**7,400**
B. Managed Care Arrangements	0	56,730	19,544	15,671	0	**91,945**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**60,837**	**21,003**	**17,505**	**0**	**99,345**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	2.7	2.8	2.8	0	**2.8**
B. Managed Care Arrangements	0	2.7	2.8	2.8	0	**2.7**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**0.0**	**2.7**	**2.8**	**2.8**	**0.0**	**2.7**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	1,415	503	623	0	**2,541**
B. Managed Care Arrangements	0	19,305	6,662	5,349	0	**31,316**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**20,720**	**7,165**	**5,972**	**0**	**33,857**

Age 6 years through age 12 years:

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

	% of FPL 0-133	**% of FPL 134-200**	**% of FPL 201-250**	**% of FPL 251-300**	**% of FPL 301-300**	**Totals**
A. Fee-for-Service	0	2,278	860	850	0	**3,988**
B. Managed Care Arrangements	0	31,034	10,989	8,608	0	**50,631**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**33,312**	**11,849**	**9,458**	**0**	**54,619**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	317	100	92	0	**509**
B. Managed Care Arrangements	0	7,291	2,047	1,607	0	**10,945**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**7,608**	**2,147**	**1,699**	**0**	**11,454**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	207	41	37	0	**285**
B. Managed Care Arrangements	0	3,190	477	356	0	**4,023**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**3,397**	**518**	**393**	**0**	**4,308**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	6,294	2,424	2,449	0	**11,167**
B. Managed Care Arrangements	0	86,229	31,637	24,830	0	**142,696**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**92,523**	**34,061**	**27,279**	**0**	**153,863**

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

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

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	2,135	833	827	0	**3,795**
B. Managed Care Arrangements	0	28,808	10,671	8,364	0	**47,843**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**30,943**	**11,504**	**9,191**	**0**	**51,638**

Age 13 years through age 18 years:

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

	% of FPL 0-133	**% of FPL 134-200**	**% of FPL 201-250**	**% of FPL 251-300**	**% of FPL 301-300**	**Totals**
A. Fee-for-Service	0	1,914	698	688	0	**3,300**
B. Managed Care Arrangements	0	24,630	9,438	7,416	0	**41,484**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**26,544**	**10,136**	**8,104**	**0**	**44,784**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	270	83	90	0	**443**
B. Managed Care Arrangements	0	5,292	1,578	1,360	0	**8,230**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**5,562**	**1,661**	**1,450**	**0**	**8,673**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	196	28	42	0	**266**
B. Managed Care Arrangements	0	2,351	390	263	0	**3,004**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**2,547**	**418**	**305**	**0**	**3,270**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	5,227	1,958	1,921	0	**9,106**
B. Managed Care Arrangements	0	68,887	27,334	21,464	0	**117,685**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**74,114**	**29,292**	**23,385**	**0**	**126,791**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	0	2.7	2.8	2.8	0	**2.8**
B. Managed Care Arrangements	0	2.8	2.9	2.9	0	**2.8**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**0.0**	**2.8**	**2.9**	**2.9**	**0.0**	**2.8**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	0	1,772	677	657	0	**3,106**
B. Managed Care Arrangements	0	23,034	9,193	7,224	0	**39,451**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**0**	**24,806**	**9,870**	**7,881**	**0**	**42,557**

Add any notes here to accompany the form submission:

CHIP Statistical Enrollment Data Reports

Form 64.EC | OR | 2022 | Quarter 3

Birth through age 12 months:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	967	0	0	0	0	**967**
B. Managed Care Arrangements	20,320	0	0	0	0	**20,320**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**21,287**	**0**	**0**	**0**	**0**	**21,287**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	587	0	0	0	0	**587**
B. Managed Care Arrangements	8,299	0	0	0	0	**8,299**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**8,886**	**0**	**0**	**0**	**0**	**8,886**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	41	0	0	0	0	**41**
B. Managed Care Arrangements	362	0	0	0	0	**362**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**403**	**0**	**0**	**0**	**0**	**403**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	1,839	0	0	0	0	**1,839**
B. Managed Care Arrangements	56,930	0	0	0	0	**56,930**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**58,769**	**0**	**0**	**0**	**0**	**58,769**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	1.9	0	0	0	0	**1.9**
B. Managed Care Arrangements	2.8	0	0	0	0	**2.8**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**2.8**	**0.0**	**0.0**	**0.0**	**0.0**	**2.8**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	931	0	0	0	0	**931**
B. Managed Care Arrangements	20,116	0	0	0	0	**20,116**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**21,047**	**0**	**0**	**0**	**0**	**21,047**

Age 1 year through age 5 years:

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

	% of FPL 0-133	**% of FPL 134-200**	**% of FPL 201-250**	**% of FPL 251-300**	**% of FPL 301-300**	**Totals**
A. Fee-for-Service	4,704	0	0	0	0	**4,704**
B. Managed Care Arrangements	87,689	0	0	0	0	**87,689**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**92,393**	**0**	**0**	**0**	**0**	**92,393**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	512	0	0	0	0	**512**
B. Managed Care Arrangements	20,242	0	0	0	0	**20,242**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**20,754**	**0**	**0**	**0**	**0**	**20,754**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	419	0	0	0	0	**419**
B. Managed Care Arrangements	6,335	0	0	0	0	**6,335**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**6,754**	**0**	**0**	**0**	**0**	**6,754**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	13,041	0	0	0	0	**13,041**
B. Managed Care Arrangements	253,120	0	0	0	0	**253,120**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**266,161**	**0**	**0**	**0**	**0**	**266,161**

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

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

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	4,419	0	0	0	0	**4,419**
B. Managed Care Arrangements	83,585	0	0	0	0	**83,585**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**88,004**	**0**	**0**	**0**	**0**	**88,004**

Age 6 years through age 12 years:

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

	% of FPL 0-133	**% of FPL 134-200**	**% of FPL 201-250**	**% of FPL 251-300**	**% of FPL 301-300**	**Totals**
A. Fee-for-Service	8,391	0	0	0	0	**8,391**
B. Managed Care Arrangements	101,030	0	0	0	0	**101,030**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**109,421**	**0**	**0**	**0**	**0**	**109,421**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	679	0	0	0	0	**679**
B. Managed Care Arrangements	23,259	0	0	0	0	**23,259**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**23,938**	**0**	**0**	**0**	**0**	**23,938**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	526	0	0	0	0	**526**
B. Managed Care Arrangements	6,682	0	0	0	0	**6,682**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**7,208**	**0**	**0**	**0**	**0**	**7,208**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	23,692	0	0	0	0	**23,692**
B. Managed Care Arrangements	290,591	0	0	0	0	**290,591**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**314,283**	**0**	**0**	**0**	**0**	**314,283**

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

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

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	7,994	0	0	0	0	**7,994**
B. Managed Care Arrangements	96,085	0	0	0	0	**96,085**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**104,079**	**0**	**0**	**0**	**0**	**104,079**

Age 13 years through age 18 years:

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

	% of FPL 0-133	**% of FPL 134-200**	**% of FPL 201-250**	**% of FPL 251-300**	**% of FPL 301-300**	**Totals**
A. Fee-for-Service	8,730	0	0	0	0	**8,730**
B. Managed Care Arrangements	83,424	0	0	0	0	**83,424**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**92,154**	**0**	**0**	**0**	**0**	**92,154**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	614	0	0	0	0	**614**
B. Managed Care Arrangements	17,558	0	0	0	0	**17,558**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**18,172**	**0**	**0**	**0**	**0**	**18,172**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	494	0	0	0	0	**494**
B. Managed Care Arrangements	4,507	0	0	0	0	**4,507**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**5,001**	**0**	**0**	**0**	**0**	**5,001**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	24,864	0	0	0	0	**24,864**
B. Managed Care Arrangements	241,163	0	0	0	0	**241,163**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**266,027**	**0**	**0**	**0**	**0**	**266,027**

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

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

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	8,320	0	0	0	0	**8,320**
B. Managed Care Arrangements	80,011	0	0	0	0	**80,011**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**88,331**	**0**	**0**	**0**	**0**	**88,331**

Age 19 years through age 20 years:

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	5,648	0	0	0	0	**5,648**
B. Managed Care Arrangements	3,855	0	0	0	0	**3,855**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**9,503**	**0**	**0**	**0**	**0**	**9,503**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	549	0	0	0	0	**549**
B. Managed Care Arrangements	7,389	0	0	0	0	**7,389**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**7,938**	**0**	**0**	**0**	**0**	**7,938**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	153	0	0	0	0	**153**
B. Managed Care Arrangements	890	0	0	0	0	**890**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**1,043**	**0**	**0**	**0**	**0**	**1,043**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	16,261	0	0	0	0	**16,261**
B. Managed Care Arrangements	111,404	0	0	0	0	**111,404**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**127,665**	**0**	**0**	**0**	**0**	**127,665**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-317	Totals
A. Fee-for-Service	2.9	0	0	0	0	**2.9**
B. Managed Care Arrangements	28.9	0	0	0	0	**28.9**
C. Primary Care Case Management	0	0	0	0	0	**0.0**
Totals:	**13.4**	**0.0**	**0.0**	**0.0**	**0.0**	**13.4**

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	5,556	0	0	0	0	**5,556**
B. Managed Care Arrangements	37,832	0	0	0	0	**37,832**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**43,388**	**0**	**0**	**0**	**0**	**43,388**

Add any notes here to accompany the form submission:

CHIP Statistical Enrollment Data Reports

Form 64.21E | OR | 2022 | Quarter 3

Birth through age 12 months:

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

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

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

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

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

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

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

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

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

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

Values will not appear until source data is provided

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

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

Age 1 year through age 5 years:

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

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

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

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

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

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

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

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

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

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

Values will not appear until source data is provided

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

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

Age 6 years through age 12 years:

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

	% of FPL 0-133	**% of FPL 134-200**	**% of FPL 201-250**	**% of FPL 251-300**	**% of FPL 301-300**	**Totals**
A. Fee-for-Service	28,354	0	0	0	0	**28,354**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**28,354**	**0**	**0**	**0**	**0**	**28,354**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	6,236	0	0	0	0	**6,236**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**6,236**	**0**	**0**	**0**	**0**	**6,236**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	3,984	0	0	0	0	**3,984**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**3,984**	**0**	**0**	**0**	**0**	**3,984**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	74,130	0	0	0	0	**74,130**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**74,130**	**0**	**0**	**0**	**0**	**74,130**

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

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

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	25,163	0	0	0	0	**25,163**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**25,163**	**0**	**0**	**0**	**0**	**25,163**

Age 13 years through age 18 years:

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

	% of FPL 0-133	**% of FPL 134-200**	**% of FPL 201-250**	**% of FPL 251-300**	**% of FPL 301-300**	**Totals**
A. Fee-for-Service	22,965	0	0	0	0	**22,965**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**22,965**	**0**	**0**	**0**	**0**	**22,965**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	3,988	0	0	0	0	**3,988**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**3,988**	**0**	**0**	**0**	**0**	**3,988**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	3,158	0	0	0	0	**3,158**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**3,158**	**0**	**0**	**0**	**0**	**3,158**

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	61,060	0	0	0	0	**61,060**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**61,060**	**0**	**0**	**0**	**0**	**61,060**

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

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

Values will not appear until source data is provided

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

	% of FPL 0-133	% of FPL 134-200	% of FPL 201-250	% of FPL 251-300	% of FPL 301-300	Totals
A. Fee-for-Service	20,449	0	0	0	0	**20,449**
B. Managed Care Arrangements	0	0	0	0	0	**0**
C. Primary Care Case Management	0	0	0	0	0	**0**
Totals:	**20,449**	**0**	**0**	**0**	**0**	**20,449**

Add any notes here to accompany the form submission:

CHIP Statistical Enrollment Data Reports

Form GRE | OR | 2022 | Quarter 3

Conception through age 18 years:

1. What is the number of enrollees by gender?

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
1. Female	67,686	25,698	**93,384**	175,147	0	**268,531**
2. Male	70,482	26,796	**97,278**	184,111	0	**281,389**
3. Unspecified Gender	0	0	**0**	0	0	**0**
Totals:	**138,168**	**52,494**	**190,662**	**359,258**	**0**	**549,920**

2. What is the number of enrollees by race?

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
1. White	17,640	7,695	**25,335**	65,447	0	**90,782**
2. Black or African American	1,028	507	**1,535**	5,819	0	**7,354**
3. American Indian or Alaska Native	564	254	**818**	3,498	0	**4,316**
4. Asian Indian	68	23	**91**	91	0	**182**
5. Chinese	228	97	**325**	461	0	**786**
6. Filipino	130	41	**171**	201	0	**372**
7. Japanese	10	4	**14**	41	0	**55**
8. Korean	68	17	**85**	124	0	**209**
9. Vietnamese	302	125	**427**	599	0	**1,026**
10. Other Asian	280	183	**463**	932	0	**1,395**
11. Asian Unknown	1	3	**4**	167	0	**171**
12. Native Hawaiian	66	20	**86**	144	0	**230**

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
13. Guamanian or Chamorro	19	7	**26**	61	0	**87**
14. Samoan	29	12	**41**	138	0	**179**
15. Other Pacific Islander	118	59	**177**	446	0	**623**
16. Native Hawaiian or Other Pacific Islander Unknown	150	88	**238**	764	0	**1,002**
17. Some other race	12,903	6,171	**19,074**	30,598	0	**49,672**
18. Two or more races (regardless of ethnicity)	64,079	22,570	**86,649**	155,067	0	**241,716**
19. Unspecified Race	40,485	14,618	**55,103**	94,660	0	**149,763**
Totals:	**138,168**	**52,494**	**190,662**	**359,258**	**0**	**549,920**

3. What is the number of enrollees by ethnicity?

	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled	Totals
1. Not of Hispanic, Latino/a, or Spanish origin	63,042	22,508	**85,550**	171,558	0	**257,108**
2. Mexican, Mexican American, Chicano/a	0	0	**0**	0	0	**0**
3. Puerto Rican	0	0	**0**	0	0	**0**
4. Cuban	4	0	**4**	1,451	0	**1,455**
5. Another Hispanic, Latino, or Spanish Origin	0	0	**0**	0	0	**0**
6. Hispanic or Latino Unknown	18,562	8,857	**27,419**	47,896	0	**75,315**
7. Unspecified Ethnicity	56,560	21,129	**77,689**	138,353	0	**216,042**
Totals:	**138,168**	**52,494**	**190,662**	**359,258**	**0**	**549,920**

Add any notes here to accompany the form submission:

Form GRE | OR | 2022 | Quarter 3

CY 2022 Q2	Advanced Health	AllCare	Cascade Health	Columbia Pacific	Eastern Oregon
ACCESS - "A"					
TOTAL:	34	9	7	34	78
PENDING:	0	0	0	0	0
RESOLVED:	34	9	7	34	78
INTERACTION WITH PROVIDER OR PLAN - "IP"					
TOTAL:	27	26	12	39	91
PENDING:	0	0	0	0	0
RESOLVED:	27	26	12	39	91
CONSUMER RIGHTS - "CR"					
TOTAL:	5	8	2	5	7
PENDING:	0	0	0	0	0
RESOLVED:	5	8	2	5	7
Quality-of-Care - "QC"					
TOTAL:	19	3	1	2	14
PENDING:	0	0	0	0	0
RESOLVED:	19	3	1	2	14
QUALITY OF SERVICE - "QS"					
TOTAL:	1	1	0	1	11
PENDING:	0	0	0	0	0
RESOLVED:	1	1	0	1	11
CLIENT BILLING ISSUES - "CB"					
TOTAL:	0	1	0	6	11
PENDING:	0	0	0	0	0
RESOLVED:	0	1	0	6	11
OTHER	0	0	0	0	0
PENDING:	0	0	0	0	0
GRAND TOTAL	86	48	22	87	212
Enrollment Numbers: as of 6/30/2022	26,631	59,711	24,702	29,712	69,572
Per 1000 members:	3.23	0.80	0.89	2.93	3.05

Health Share	IHN	Jackson Care	PCSC CG	PCSC CO	PCSC Lane	PCSC MP	Trillium Lane	Trillium TriCo
751	47	32	12	72	181	110	57	40
46	0	0	0	0	8	2	6	0
705	47	32	12	72	173	108	51	40
565	99	35	6	41	141	92	43	9
39	0	0	0	1	4	1	7	0
526	99	35	6	40	137	91	36	9
115	30	6	12	49	105	68	7	1
5	0	0	2	0	0	2	1	0
110	30	6	10	49	105	66	6	1
270	19	7	1	16	46	44	5	1
16	0	0	0	0	2	2	0	0
254	19	7	1	16	44	42	5	1
44	27	1	1	8	7	16	3	2
1	0	0	0	0	0	0	1	0
43	27	1	1	8	7	16	2	2
69	13	6	2	11	12	12	59	23
2	0	0	0	0	0	1	10	0
67	13	6	2	11	12	11	49	23
0	0	0	0	0	0	0	0	0
109	0	0	2	1	14	8	25	0
1814	235	87	34	197	492	342	174	76
420,578	78,202	54,678	16,079	70,722	85,151	134,479	36,011	27,358
4.31	3.01	1.59	2.11	2.79	5.78	2.54	4.83	2.78

Umpqua	Yamhill County	FFS	Totals
110	36	8	1618
4	0	0	66
106	36	8	1552
19	30	2	1277
0	0	0	52
19	30	2	1225
11	4	1	436
0	0	0	10
11	4	1	426
21	14	27	510
0	0	0	20
21	14	27	490
2	3	13	141
0	0	0	2
2	3	13	139
2	7	182	416
0	0	0	13
2	7	182	370
0	0	0	0
4	0	0	163
165	94	233	4398
35,957	34,015	271,606	1,475,164
4.59	2.76	0.86	2.98

Average Plan Enrollment by Quarter

Plane Name	Jul - Sep 2021	Oct - Dec 2021
ADVANCED HEALTH	26196	26818
ALLCARE HEALTH PLAN, INC.	58669	59680
CASCADE HEALTH ALLIANCE	24,025	24,480
COLLUMBIA PACIFIC CCO, LLC	33,259	34,011
EASTERN OREGON CCO, LLC	66,386	67,707
HEALTH SHARE OF OREGON	402,609	413,125
INTERCOMMUNITY HEALTH NETWORK	74,389	76,414
JACKSON CARE CONNECT	59,831	60,589
PACIFICSOURCE COMM. SOLUTIONS- Central	67,186	68,814
PACIFICSOURCE COMM. SOLUTIONS- Gorge	15,644	15,948
PACIFICSOURCE COMM. SOLUTIONS - Lane	80,218	82,488
PACIFICSOURCE COMM. SOLUTIONS - Marion Polk	128,562	131,349
TRILLIUM COMM. HEALTH PLAN TRI COUNTY	22,667	24,389
TRILLIUM COMM. HEALTH PLAN	37,162	37,374
UMPQUA HEALTH ALLIANCE, DCIPA	34,519	35,221
YAMHILL CO CARE ORGANIZATION	33,159	33,631
ADVANTAGE DENTAL	25020	25268
CAPITOL DENTAL CARE INC.	18310	18377
FAMILY DENTAL CARE	4191	4184
MANAGED DENTAL CARE OF OREGON	4104	4135
ODS COMMUNITY HEALTH INC.	16539	16694
FFS	267796	274049
TOTALS	1,500,441	1,534,745

Jan - Mar 2022	Apr - Jun 2022	Average
27,270	27,498	26945.5
60,922	62,028	60324.75
25,087	25,631	24805.75
34,818	35,432	34380
69,209	71,151	68613.25
418,437	425,636	414951.75
78,092	80,231	77281.5
61,680	62,800	61225
70,599	72,070	69667.25
16,296	16,804	16173
84,976	87,362	83761
134,538	139,024	133368.25
28,217	34,933	27551.5
37,544	37,522	37400.5
36,017	36,716	35618.25
34,239	35,177	34051.5
25,867	27,156	25827.75
18,884	19,240	18702.75
4,312	4,491	4294.5
4,272	4,457	4242
17,192	17,644	17017.25
274814	271606	272066.25
1,563,282	1,594,609	1548269.25

Hearings Processed 2021-2022

Issues	Jul - Sept 2021	Oct - Dec 2021	Jan - Mar 2022
Ambulance Denial	0	0	0
Billing Issue	40	51	24
Dental Denial	15	23	22
Disenrollment	1	3	3
DME Denial	12	19	19
ER Denial	0	0	0
FFS Denial	1	0	0
Hearing Denial	0	0	0
Mental Health	6	2	3
Misc.	1	0	0
Non-Medical Hearing	2	7	7
Provider	0	2	0
Referral Denial	44	31	44
Rx Denial	38	21	28
Surgery Denial	95	59	45
Therapy Denial	11	12	3
Transplant Denial	0	0	0
Transportation	8	1	2
Vision Denial	1	1	1
Totals	**275**	**232**	**201**

Outcome - Resolution	July - Sep, 2021	Oct - Dec, 2021	Jan - Mar, 2022
Decision overturned after second review	26	27	14
Client withdrew request after pre-hearing conference	66	45	40
Dismissed by OHA as not hearable	128	111	105
Decision affirmed*	37	31	28
Client failed to appear*	17	16	12
Dismissed as non-timely	0	0	0
Dismissed because of non-jurisdiction	0	0	0
Decision reversed*	1	2	2
Set Aside	1	0	0
Totals	**276**	**232**	**201**

Apr - Jul 2022	**Year End Totals**
0	**0**
31	**146**
30	**90**
2	**9**
16	**66**
0	**0**
2	**3**
0	**0**
2	**13**
1	**2**
15	**31**
0	**2**
25	**144**
24	**111**
58	**257**
7	**33**
0	**0**
3	**14**
4	**7**
220	**928**

Apr - Jun, 2022	**Year End Totals**
22	**89**
42	**193**
102	**446**
25	**121**
16	**61**
0	**0**
0	**0**
3	**8**
1	**2**
211	**920**

Hearing Requests Received Fiscal Year

Total Hearing Requests Received by Quarter

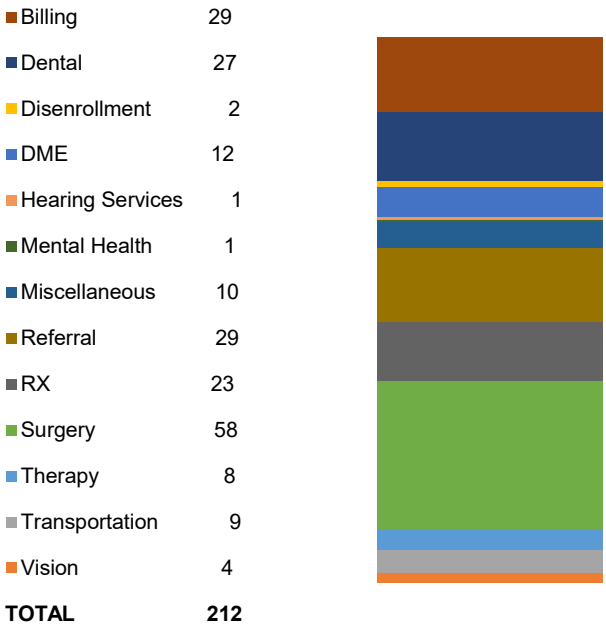
PlanName	Jul - Sep 2021	Oct - Dec 2021	Jan - Mar 2022	Apr - Jun 2022	Year End Total
ADVANCED HEALTH	4	3	2	4	**13**
ALLCARE HEALTH PLAN, INC.	7	4	2	3	**16**
CASCADE HEALTH ALLIANCE	5	3	3	4	**15**
COLUMBIA PACIFIC CCO, LLC	3	2	1	1	**7**
EASTERN OREGON CCO, LLC	3	2	9	11	**25**
HEALTH SHARE of Oregon	89	64	42	73	**268**
INTERCOMMUNITY HEALTH NETWORK	4	2	19	4	**18**
JACKSON CARE CONNECT	10	10	4	5	**52**
PACIFICSOURCE COMM. SOLUTIONS - Central	22	14	9	15	**60**
PACIFICSOURCE COMM. SOLUTIONS -Gorge	2	3	1	3	**9**
PACIFICSOURCE COMM. SOULUTIONS-Lane	22	28	22	29	**75**
PACIFICSOURCE COMM. SOLUTIONS - Marion Polk	31	43	38	24	**66**
TRILLIUM COMM. HEALTH PLAN - Tri County	2	1	2	0	**5**
TRILLIUM COMM. HEALTH PLAN	5	2	5	4	**16**
UMPQUA HEALTH ALLIANCE, DCIPA	12	3	12	2	**29**
YAMHILL CO CARE ORGANIZATION	4	6	7	5	**22**
ADVANTAGE DENTAL					**0**
CAPITOL DENTAL CARE INC					**0**
FAMILY DENTAL CARE					**0**
MANAGED DENTAL CARE OF OR					**0**
ODS COMMUNITY HEALTH INC					**0**
FFS	22	32	27	24	**105**
				1	**1**
Total	**247**	**222**	**205**	**212**	**886**

Avg. Plan Enrollment	Per 1000 Members
26,946	0.48
60,325	0.27
24,806	0.60
34,380	0.20
68,613	0.36
414,952	0.65
77,282	0.23
61,225	0.85
69,667	0.86
16,173	0.56
83,761	0.90
133,368	0.49
27,552	0.18
37,401	0.43
35,618	0.81
34,052	0.65
25,828	0.00
18,703	0.00
4,295	0.00
4,242	0.00
17,017	0.00
272,066	0.39
1	
1,548,273	0.57

Hearing Requests Received
04/01/2022-06/30/2022
by CCO, DCO and FFS

Plan Name	Total Hearing Requests Received	Avg. Plan Enrollment *	Per 1000 Members
ADVANCED HEALTH	4	27,498	0.15
ALLCARE HEALTH PLAN, INC.	3	62,028	0.05
CASCADE HEALTH ALLIANCE	4	25,631	0.16
COLUMBIA PACIFIC CCO, LLC	1	35,432	0.03
EASTERN OREGON CCO, LLC	11	71,151	0.15
HEALTH SHARE of OREGON	73	425,636	0.17
INTERCOMMUNITY HEALTH NETWORK	4	80,231	0.05
JACKSON CARE CONNECT	5	62,800	0.08
PACIFICSOURCE COMM. SOLUTIONS - Central	15	72,070	0.21
PACIFICSOURCE COMM. SOLUTIONS - Gorge	3	16,804	0.18
PACIFICSOURCE COMM. SOLUTIONS - Lane	29	87,362	0.33
PACIFICSOURCE COMM. SOLUTIONS – Mar/Polk	24	139,024	0.17
TRILLIUM COMM. HEALTH PLAN	4	37,522	0.11
TRILLIUM COMM. HEALTH PLAN – Tri-County	0	34,933	0.00
UMPQUA HEALTH ALLIANCE, DCIPA	2	36,716	0.56
YAMHILL CO CARE ORGANIZATION	5	35,177	0.14
ADVANTAGE DENTAL		27,156	0.00
CAPITOL DENTAL CARE INC		19,240	0.00
FAMILY DENTAL CARE		4,491	0.00
MANAGED DENTAL CARE OF OR		4,457	0.00
ODS COMMUNITY HEALTH INC		17,644	0.00
FFS	24	271,606	0.09
Total	**212**	**1,594, 609**	**0.13**

Hearing Requests Received
04/01/2022-06/30/2022
by Issue



Data Source: DSS
Data Extraction Date: 08/15/2022
Data Analyst: Rosey Ball
*** Avg. Plan Enrollment based on average of Preliminary Member Months for April, May, and June 2022**

	PMPM WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGET	TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
	Without HST Baseline Growth (Per ST&Cs)	**5.40%**	**5.40%**	**5.40%**	**5.40%**	**5.40%**
	Without HST Baseline Growth PMPM	**$ 591**	**$ 623**	**$ 656**	**$ 692**	**$ 729**
	With HST Spending Reduction Growth Target	**3.40%**	**3.40%**	**3.40%**	**3.40%**	**3.40%**
Level 1: Global Budget	**Capitation**					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)[3]					
	Incentive Payment Pool					
	Total Capitation PMPM					
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
	Targeted Case Management					
	Federally Qualified Health Center and Rural Health Center Wrap					
	Hospital Transformation Performance Program					
	Global Budget PMPM	**$ 580**	**$ 611**	**$ 644**	**$ 679**	**$ 715**
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative[2]					
	Hospital Presumptive Eligibilty					
	Health Insurer Fee (HIF)					
	Services Outside of Capitation + NOT Subject to Evaluation PMPM					

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

	TOTAL EXPENDITURES WITHOUT HEALTH SYSTEM TRANSFORMATION AND ANNUAL HST TARGETS	TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
Level 1: Global Budget	**Capitation**					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)[3]					
	Incentive Payment Pool					
	Total Capitation					
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
	Targeted Case Management					
	Federally Qualified Health Center and Rural Health Center Wrap					
	Hospital Transformation Performance Program					
	Global Budget	**$ 6,575,707,618**	**$ 6,969,750,610**	**$ 7,689,815,878**	**$ 9,270,858,919**	**$ 10,802,775,002**
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative[2]					
	Hospital Presumptive Eligibilty					
	Health Insurer Fee (HIF)					
	Services Outside of Capitation + NOT Subject to Evaluation					

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

	PMPM ACTUALS UNDER HEALTH SYSTEM TRANSFORMATION	TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
Level 1: Global Budget	**Capitation**					
	Total Managed Care					
	Total Fee For Service (for equivalent CCO services)[3]					
	Incentive Payment Pool					
	Total Capitation PMPM	**503**	**547**	**571**	**541**	**581**
	Services Outside of Capitation + Subject to Evaluation					
	Babies First					
	Adult Residential Mental Health Services					
	Cost-sharing for Medicare skilled nursing facility care					
	Young Adults in Transition Mental Health Residential					
	Targeted Case Management					
	Federally Qualified Health Center and Rural Health Center Wrap					
	Hospital Transformation Performance Program					
	Global Budget PMPM	**533**	**572**	**591**	**565**	**608**
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**					
	Mental health remaining in fee-for-service					
	Long Term Care					
	School Based Health Services					
	Behavioral Rehabilitative Services (BRS)					
	Personal Care 20 Client Employed Provider					
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011					
	Mental Health Habilitative[2]					
	Hospital Presumptive Eligibilty					
	Health Insurer Fee (HIF)					
	Services Outside of Capitation + NOT Subject to Evaluation PMPM	**135**	**144**	**147**	**144**	**143**
	Total Expenditures PMPM	**668**	**715**	**738**	**709**	**750**

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

	TOTAL ACTUAL EXPENDITURES UNDER HEALTH SYSTEM TRANSFORMATION	TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
Level 1: Global Budget	**Capitation**					
	Total Managed Care	**5,026,520,737**	**5,646,477,092**	**6,168,142,765**	**6,992,812,144**	**8,092,843,776**
	Total Fee For Service (for equivalent CCO services)[3]	**494,993,215**	**408,965,547**	**425,520,358**	**397,157,220**	**407,500,877**
	Incentive Payment Pool	**178,435,533**	**188,264,693**	**166,713,799**	**-**	**266,215,650**
	Total Capitation	**5,699,949,485**	**6,243,707,331**	**6,814,281,985**	**7,389,969,365**	**8,766,560,303**
	Services Outside of Capitation + Subject to Evaluation					
	Babies First	**132,622**	**75,179**	**39,665**	**152,370**	**98,146**
	Adult Residential Mental Health Services	**44,856,082**	**42,321,672**	**41,152,746**	**36,142,533**	**74,152,542**
	Cost-sharing for Medicare skilled nursing facility care	**2,351,715**	**2,291,814**	**1,684,555**	**1,301,411**	**839,865**
	Young Adults in Transition Mental Health Residential	**4,022,544**	**3,814,005**	**4,567,809**	**5,420,759**	**7,356,762**
	Targeted Case Management	**10,102,379**	**6,108,889**	**7,136,874**	**11,221,128**	**11,106,084**
	Federally Qualified Health Center and Rural Health Center Wrap	**189,491,587**	**221,089,823**	**184,967,724**	**272,655,703**	**316,162,567**
	Hospital Transformation Performance Program	**89,758,991**	**-**	**-**	**-**	**-**
	Global Budget	**6,040,665,405**	**6,519,408,713**	**7,053,831,358**	**7,716,863,269**	**9,176,276,269**
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**					
	Mental health remaining in fee-for-service	**89,952,295**	**91,257,803**	**102,398,052**	**119,895,931**	**132,563,673**
	Long Term Care	**1,345,159,895**	**1,426,539,285**	**1,509,190,786**	**1,691,877,557**	**1,879,269,324**
	School Based Health Services	**20,545,464**	**27,083,146**	**17,833,858**	**20,484,213**	**16,253,914**
	Behavioral Rehabilitative Services (BRS)	**2,626,899**	**3,133,369**	**3,074,951**	**2,156,294**	**1,873,810**
	Personal Care 20 Client Employed Provider	**1,922,387**	**1,955,989**	**1,736,893**	**1,792,577**	**1,923,349**
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011	**20,658,591**	**25,165,781**	**32,579,798**	**33,083,664**	**38,720,923**
	Mental Health Habilitative[2]	**54,968,175**	**56,317,041**	**85,661,472**	**90,919,831**	**80,825,228**
	Hospital Presumptive Eligibilty	**80,251**	**9,647,008**	**5,022,676**	**3,082,194**	**2,453,104**
	Health Insurer Fee (HIF)	**-**	**-**	**-**	**-**	**-**
	Services Outside of Capitation + NOT Subject to Evaluation	**1,535,913,956**	**1,641,099,421**	**1,757,498,487**	**1,963,292,261**	**2,153,883,325**

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

Caseload		TOTAL SFY 2018	TOTAL SFY 2019	TOTAL SFY 2020	TOTAL SFY 2021	TOTAL SFY 2022
HSD Category	Eligibility Group					
Non-disabled adult	PCR	870,550	941,899	1,020,799	1,111,015	1,130,290
Non-disabled adult	PWO	130,733	115,525	105,479	103,288	143,895
Children	CMO 0-1	299,132	268,402	262,593	249,849	251,103
Children	CMO 1-5	1,066,586	1,021,673	1,003,396	1,065,126	1,022,229
Children	CMO 6-18	1,841,500	1,829,187	1,843,203	2,023,946	2,038,677
Children	CMO 6-18 (100-133% FPL)	515,691	502,479	468,321	524,790	546,097
Disabled/elderly[1]	AB/AD w/o Medicare	625,551	618,548	623,928	665,819	681,558
Dual eligible[1]	AB/AD w/Medicare	387,438	387,431	387,569	403,393	445,328
Disabled/elderly[1]	OAA w/o Medicare	27,970	21,457	20,234	28,394	48,038
Dual eligible[1]	OAA w/Medicare	506,040	533,333	552,685	607,006	704,886
Children	FC/SAC	246,601	242,049	238,633	228,629	215,619
Non-disabled adult	BCCP	2,256	2,210	2,354	2,354	2,119
ACA	Families ACA 19-44/ ACA 19-44 [2]	772,129	2,769,421	2,898,078	3,736,646	4,449,476
ACA	Families ACA 45-54/ ACA 45-54	153,692	774,470	780,432	923,589	1,051,194
ACA	Families ACA 55-65 / ACA 55-65	83,339	764,650	773,007	914,102	1,023,086
ACA	Adults/Couples ACA 19-44	1,951,942	-	-	-	-
ACA	Adults/Couples ACA 45-54	646,107	-	-	-	-
ACA	Adults/Couples ACA 55-65	675,766	-	-	-	-
Children	CHIP 0-1	12,037	8,683	10,140	9,333	10,153
Children	CHIP 1-5	281,151	293,104	298,819	309,291	388,569
Children	CHIP 6-18	687,658	751,195	779,924	857,496	1,076,163
Children	Cover All Kids 0-1	76	156	142	113	157
Children	Cover All Kids 1-5	3,249	8,406	11,225	9,917	9,811
Children	Cover All Kids 6-18	23,656	54,587	64,104	67,018	72,157
Children	Cover All Kids Prenatal	219	373	369	339	430
Caseload Subtotal:		11,811,067	11,909,239	12,145,434	13,841,453	15,311,035
TPL Kids		18,834	18,549	17,136	18,678	18,542
TPL Non-Disabled		4,276	4,392	3,977	4,561	3,645
TPL Disabled		4,435	4,513	4,356	4,484	4,177
TPL Duals		48,651	51,089	41,580	38,157	34,786
TPL ACA		20,870	22,641	19,738	23,965	26,124
Less Total TPL Caseload:		97,066	101,184	86,787	89,845	87,274
Less Duals Non-Enrollees:		343,946	337,925	42,524	16,507	42,046
Less Cover All Kids:		27,200	63,522	75,840	77,387	82,555
Total Caseload (Less TPL & Dual Non-Enro		**11,342,855**	**11,406,608**	**11,940,283**	**13,657,714**	**15,099,160**

Footnote:

[1] AB/AD w/o Medicare and AB/AD w/Medicare populations include disabled children.

[2] Starting in SFY 2019, ACA age bands no longer shown by families and adults/couples

#

	State Fiscal Year 2018 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care	1,140,167,898	613,659,712	936,404,143	213,062,755	2,123,226,228		5,026,520,737
	Total Fee For Service (for equivalent CCO services)	138,623,842	51,747,087	57,726,767		246,895,519		494,993,215
	Incentive Payment Pool						178,435,533	178,435,533
	Total Capitation	1,278,791,740	665,406,799	994,130,911	213,062,755	2,370,121,747	178,435,533	5,699,949,485
	Services Outside of Capitation + Subject to Evaluation							
	Babies First						132,622	132,622
	Adult Residential Mental Health Services						44,856,082	44,856,082
	Cost-sharing for Medicare skilled nursing facility care						2,351,715	2,351,715
	Young Adults in Transition Mental Health Residential						4,022,544	4,022,544
	Targeted Case Management						10,102,379	10,102,379
	Federally Qualified Health Center and Rural Health Center Wrap						189,491,587	189,491,587
	Hospital Transformation Performance Program						89,758,991	89,758,991
	Total Global Expenditures							**6,040,665,405**
	Total Caseload							**11,342,855**
	Global Budget PMPM							**533**
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service	6,350,058	7,595,403	34,601,598	49,687	41,355,550		89,952,295
	Long Term Care						1,345,159,895	1,345,159,895
	School Based Health Services						20,545,464	20,545,464
	Behavioral Rehabilitative Services (BRS)						2,626,899	2,626,899
	Personal Care 20 Client Employed Provider	89,281	-	694,319	1,040,738	98,048		1,922,387
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011						20,658,591	20,658,591
	Mental Health Habilitative[2]						54,968,175	54,968,175
	Hospital Presumptive Eligibilty						80,251	80,251
	Health Insurer Fee (HIF)	-	-	-	-	-		-
	Services Outside of Capitation + NOT Subject to Evaluation							**1,535,913,956**

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, Cover All Kids, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

	State Fiscal Year 2019 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care	1,276,738,334	707,980,854	936,726,916	242,884,191	2,482,146,796		5,646,477,092
	Total Fee For Service (for equivalent CCO services)[3]	120,899,244	40,997,009	40,672,804		206,396,489		408,965,547
	Incentive Payment Pool						188,264,693	188,264,693
	Total Capitation	1,397,637,579	748,977,863	977,399,720	242,884,191	2,688,543,286	188,264,693	6,243,707,331
	Services Outside of Capitation + Subject to Evaluation							
	Babies First						75,179	75,179
	Adult Residential Mental Health Services						42,321,672	42,321,672
	Cost-sharing for Medicare skilled nursing facility care						2,291,814	2,291,814
	Young Adults in Transition Mental Health Residential						3,814,005	3,814,005
	Targeted Case Management						6,108,889	6,108,889
	Federally Qualified Health Center and Rural Health Center Wrap						221,089,823	221,089,823
	Hospital Transformation Performance Program						-	-
	Total Global Expenditures						**463,966,075**	**6,519,408,713**
	Total Caseload							**11,406,608**
	Global Budget PMPM							**572**
							Without QDP and Ins Tax:	521
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service	6,153,310	7,758,392	34,669,626	49,732	42,626,743		91,257,803
	Long Term Care						1,426,539,285	1,426,539,285
	School Based Health Services						27,083,146	27,083,146
	Behavioral Rehabilitative Services (BRS)						3,133,369	3,133,369
	Personal Care 20 Client Employed Provider	90,842	-	706,455	1,058,929	99,762		1,955,989
	FQHC/RHC Wrap for new centers and change of scope after						25,165,781	25,165,781
	Mental Health Habilitative[2]						56,317,041	56,317,041
	Hospital Presumptive Eligibilty						9,647,008	9,647,008
	Health Insurer Fee (HIF)						-	-
	Services Outside of Capitation + NOT Subject to Evaluation	**6,244,152**	**7,758,392**	**35,376,082**	**1,108,661**	**42,726,505**	**1,547,885,630**	**1,641,099,421**

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

	State Fiscal Year 2020 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care	1,340,288,043	776,024,250	941,261,118	399,653,346	2,710,916,008		6,168,142,765
	Total Fee For Service (for equivalent CCO services)[3]	127,668,165	44,085,399	46,981,287		206,785,508		425,520,358
	Incentive Payment Pool						166,713,799	166,713,799
	Future Incentive Pool Withheld						53,905,062	53,905,062
	Total Capitation	1,467,956,208	820,109,649	988,242,405	399,653,346	2,917,701,516	220,618,861	6,814,281,985
	Services Outside of Capitation + Subject to Evaluation							
	Babies First						39,665	39,665
	Adult Residential Mental Health Services						41,152,746	41,152,746
	Cost-sharing for Medicare skilled nursing facility care						1,684,555	1,684,555
	Young Adults in Transition Mental Health Residential						4,567,809	4,567,809
	Targeted Case Management						7,136,874	7,136,874
	Federally Qualified Health Center and Rural Health Center Wrap						184,967,724	184,967,724
	Hospital Transformation Performance Program						-	-
	Total Global Expenditures						**460,168,234**	**7,053,831,358**
	Total Caseload							**11,940,283**
	Global Budget PMPM							**591**
							Without QDP and Ins Tax:	512
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service	5,940,943	8,879,438	37,392,962	50,825	50,133,885	-	102,398,052
	Long Term Care						1,509,190,786	1,509,190,786
	School Based Health Services						17,833,858	17,833,858
	Behavioral Rehabilitative Services (BRS)						3,074,951	3,074,951
	Personal Care 20 Client Employed Provider	-	555	723,340	980,797	32,201	-	1,736,893
	FQHC/RHC Wrap for new centers and change of scope after						32,579,798	32,579,798
	Mental Health Habilitative[2]						85,661,472	85,661,472
	Hospital Presumptive Eligibility						5,022,676	5,022,676
	Health Insurer Fee (HIF)						-	-
	Services Outside of Capitation + NOT Subject to Evaluation	**5,940,943**	**8,879,993**	**38,116,302**	**1,031,622**	**50,166,086**	**1,653,363,541**	**1,757,498,487**

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

	State Fiscal Year 2021 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care	1,406,598,957	831,594,233	1,034,652,934	466,949,617	3,253,016,404		6,992,812,144
	Total Fee For Service (for equivalent CCO services)	104,993,719	41,164,046	47,184,346		203,815,109		397,157,220
	Incentive Payment Pool						-	-
								-
	Total Capitation	1,511,592,676	872,758,280	1,081,837,280	466,949,617	3,456,831,513	-	7,389,969,365
	Services Outside of Capitation + Subject to Evaluation							
	Babies First						152,370	152,370
	Adult Residential Mental Health Services						36,142,533	36,142,533
	Cost-sharing for Medicare skilled nursing facility care						1,301,411	1,301,411
	Young Adults in Transition Mental Health Residential						5,420,759	5,420,759
	Targeted Case Management						11,221,128	11,221,128
	Federally Qualified Health Center and Rural Health Center Wrap						272,655,703	272,655,703
	Hospital Transformation Performance Program						-	-
	Total Global Expenditures						**326,893,904**	**7,716,863,269**
	Total Caseload							**13,657,714**
	Global Budget PMPM							**565**
							Without QDP and Ins Tax:	478
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service	6,945,415	10,130,266	44,250,143	46,459	58,523,649	-	119,895,931
	Long Term Care						1,691,877,557	1,691,877,557
	School Based Health Services						20,484,213	20,484,213
	Behavioral Rehabilitative Services (BRS)						2,156,294	2,156,294
	Personal Care 20 Client Employed Provider	-	6,037	727,148	1,018,064	41,328	-	1,792,577
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011						33,083,664	33,083,664
	Mental Health Habilitative[2]						90,919,831	90,919,831
	Hospital Presumptive Eligibility						3,082,194	3,082,194
	Health Insurer Fee (HIF)							-
	Services Outside of Capitation + NOT Subject to Evaluation	**6,945,415**	**10,136,303**	**44,977,291**	**1,064,522**	**58,564,977**	**1,841,603,753**	**1,963,292,261**

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.

	State Fiscal Year 2022 Detail	Children	Non-Disabled Adults	Disabled/Elderly	Dual Eligible	ACA	Services Not Identified by Population	Total
Level 1: Global Budget	**Capitation**							
	Total Managed Care	1,569,906,720	946,437,296	1,133,690,491	531,014,614	3,911,794,655		8,092,843,776
	Total Fee For Service (for equivalent CCO services [3]	112,222,949	44,955,095	49,176,602		201,146,232		407,500,877
	Incentive Payment Pool						266,215,650	266,215,650
	Total Capitation	1,682,129,669	991,392,390	1,182,867,093	531,014,614	4,112,940,887	266,215,650	8,766,560,303
	Services Outside of Capitation + Subject to Evaluation							
	Babies First						98,146	98,146
	Adult Residential Mental Health Services [4]						74,152,542	74,152,542
	Cost-sharing for Medicare skilled nursing facility care						839,865	839,865
	Young Adults in Transition Mental Health Residential						7,356,762	7,356,762
	Targeted Case Management						11,106,084	11,106,084
	Federally Qualified Health Center and Rural Health Center Wrap						316,162,567	316,162,567
	Total Global Expenditures						**675,931,615**	**9,176,276,269**
	Total Caseload							**15,099,160**
	Global Budget PMPM							**608**
							Without QDP and Ins Tax:	511
Level 2	**Services for CCO clients Outside of Capitation[1] + NOT Subject to Evaluation**							
	Mental health remaining in fee-for-service	9,226,376	10,620,311	46,572,768	(49,172)	66,193,390	-	132,563,673
	Long Term Care						1,879,269,324	1,879,269,324
	School Based Health Services						16,253,914	16,253,914
	Behavioral Rehabilitative Services (BRS)						1,873,810	1,873,810
	Personal Care 20 Client Employed Provider	-	12,433	1,006,115	834,055	70,745	-	1,923,349
	FQHC/RHC Wrap for new centers and change of scope after 7/01/2011						38,720,923	38,720,923
	Mental Health Habilitative[2]						80,825,228	80,825,228
	Hospital Presumptive Eligibility						2,453,104	2,453,104
	Health Insurer Fee (HIF)							-
	Services Outside of Capitation + NOT Subject to Evaluation	**9,226,376**	**10,632,745**	**47,578,883**	**784,883**	**66,264,135**	**2,019,396,303**	**2,153,883,325**

Footnote:

[1] QMB, CAWEM, Cawem Prenatal, TPL, Duals & Tribal members not enrolled in CCOs are excluded.

[2] Mental health habilitative expenditures are the cost for providing services under Oregon's approved 1915(i) state plan amendment. While these services replace some adult residential mental health services, they also promote increased opportunities for individuals to transition from restrictive levels of care to independent community-based settings. Mental health habilitative services include recreation, socialization, and community survival skills. Expenditures for these services are excluded from the expenditure trend test because federal approval and state implementation of the 1915(i) state plan amendment came after the test base period of calendar year 2011.