Oregon Health Plan

Section 1115 Annual Report

Demonstration Year (DY): 21
Report Timeframe: 10/1/2022 – 9/30/2023
Federal Fiscal Year: 2023

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I. Introduction

A. Letter from the State Medicaid Director

During this reporting period, the Oregon Health Authority (OHA) continued to work with our partners in the health care and social services delivery system to significantly advance progress on the waiver. Highlights included:

- implementation of continuous eligibility policies
- defining HRSN service descriptions, clinical criteria and service provision flow
- designing the benefits expansion for youth with special health care needs (YSHCN) and bringing together key cross-agency partners to identify areas for development and collaboration
- convening regular meetings of internal systems teams including with the Oregon Eligibility (ONE) Information Exchange, Medicaid Management Information System (MMIS), and Mainframe groups to map out technological pathways to coverage and care, and
- Furthering efforts to define CMS-approved eligibility pathways

OHA looks forward to a continued partnership with CMS.

- Vivian Levy, Interim Medicaid Director

B. Demonstration description

On September 28, 2022, the Centers for Medicare & Medicaid Services (CMS) approved Oregon's renewed 1115 Demonstration waiver, effective October 1, 2022 to September 30, 2027. The renewal includes significant eligibility expansion authority, as well as new health-related social needs services for people experiencing life transitions. These reforms are expected to further OHA's goal of eliminating health inequities by 2030 and connecting underserved populations with effective health care and supports.

The eligibility authorities included in the waiver will help preserve coverage for many populations and create new opportunities to address historical health inequities. Children who are enrolled in Medicaid at any time prior to their 6th birthday can remain enrolled until age 6. People over age 6 can automatically remain enrolled for two years, instead of one. These eligibility changes will help OHP members remain covered longer and make it less likely that they will lose coverage because of short-term changes in eligibility (e.g., temporary income fluctuations). Avoiding costly and disruptive changes in coverage will make it easier for people to plan health care in advance and improve health outcomes.

In addition to expanded coverage eligibility for children, the approved waiver includes some benefit changes for youth. All federally required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children and youth to age 21 are now available in Oregon. For youth with special health care needs, eligibility criteria will allow access to expanded benefits, including EPSDT, until age 26.

The waiver also includes nationally innovative service expansions. In 2024, Oregon will begin introducing health-related social needs (HRSN) benefits (housing, nutrition, and climate-related services) to OHP members who are experiencing specific transitions in their lives. Eligible populations include:

- Individuals at risk of becoming houseless
- Adults and youth discharged from an Institution for Mental Disease (IMD)
- Adults and youth released from incarceration
- Individuals involved in the child welfare system
- Individuals transitioning from Medicaid-only to dual Medicaid and Medicare coverage
- Young adults, ages 19-26, with Special Healthcare Needs (YSHCN)

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

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

C. State contacts

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

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

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

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

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

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

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: 10/1/2022 – 9/30/2023
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III. Overview of the current annual reporting period

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

- Implementation of continuous eligibility policies
- Development and design of HRSN services delivery and critical partner mapping
- Implementation planning for youth with special health care needs eligibility expansion
- Submission of key deliverables including Designated State Health Programs (DSHP) claiming protocol and template, health-related social needs (HRSN) Infrastructure and Services protocols and the New Initiatives Implementation Plan

Oregon is poised and ready to engage with CMS and partners to further waiver implementation activities, but will need critical approval from CMS to move forward successfully and to meet proposed implementation timelines.

A. Enrollment progress

1. Oregon Health Plan eligibility

Title XIX and XXI enrollment rose incrementally throughout the COVID-19 Public Health Emergency (PHE) period. Oregon officially began unwinding from the PHE on April 1, 2023, which included eliminating some of the simplified eligibility and continuous coverage protections afforded under the Families First Coronavirus Response Act.

Oregon introduced many efforts to keep people covered during this time. The state launched an unwinding renewal cycle that added back processes to pend individuals for verification of certain eligibility factors when they couldn't otherwise be electronically verified. At the same time, Oregon also implemented a new transitional Medicaid program for renewing adults whose income put them between 138% - 200% of the Federal Poverty Level. This transitional "bridge" program is intended to maintain individuals on Medicaid instead of referring them to the federal marketplace until Oregon implements a Basic Health Plan in July 2024.

Additionally, new continuous eligibility policies were implemented in July 2023 and were retroactively applied to anyone who had been approved at post-PHE renewal. Continuous eligibility can be assigned at the time of initial application or at renewal for those who are determined to qualify. The new policies ensure coverage for eligible children from birth to age 6 and for two years for those age 6 and older, even if an increase in income would make them

otherwise ineligible. Once renewed and approved by new continuous eligibility rules, children may move to CHIP (Title XXI) for the remainder of their continuous eligibility period, if an increase in income makes them otherwise ineligible for Title XIX programs. This partially explains why Title XXI enrollment levels appear to be somewhat stable, even though some CHIP members are still losing coverage at their post-PHE renewals.

While expected renewal attrition has occurred, Oregon has implemented robust outreach and reminder strategies as part of the post-PHE renewal processes to minimize procedural terminations as much as possible. In 2023, Oregon has consistently been one of the top five states with the highest Medicaid renewal rates in the nation.

2. Coordinated Care Organization enrollment

Total Coordinated Care Organization (CCO) enrollment for October 2022 – September 2023 grew by 14.8%, across all plan levels (CCOA, CCOB, CCOE and CCOG). From January to September of 2023, total enrollment across all plans grew by 6.7%. Specific CCO membership growth ranged between 2.3% – 8.6%, except for Trillium Community Health Plan in the Portland metro area, which continued to experience greater enrollment growth at 20.9%.

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

DY20 Q1 (Oct-Dec 2022) Member Growth Zone	**CCO Service Areas**
Greater than 5.001%	10
3.00 - 4.99%	3
2.00 – 2.99%	1
0.00 – 1.99%	1
Reduction in enrollment	0

Overall enrollment growth was higher than last year for several reasons, including: the continuation of the Public Health Emergency into 2023, implementing a new transitional Medicaid program for renewing adults whose income put them between 138% - 200% of the

Federal Poverty Level, and expanding Medicaid through Healthier Oregon. The following table highlights overall OHP enrollment growth across all CCOs.

DY20Q1 7/21-9/21	DY20Q2 10/21-12/21	DY20Q3 1/22-3/22	DY20Q4 4/22-6/22	DY20EP 7/22-9/22	DY21Q1 10/22-12/22	DY21Q2 1/23-3/23	DY21Q3 4/23-6/23	DY21Q4 7/23-9/23
2.2%	2.4%	2.6%	1.4%	2.9%	2.5%	2.4%	1.8%	3.8%

As noted in previous reports, OHA waived the requirement in May of 2020 to limit each CCO enrollment to county limit(s) and grand total limit to mitigate enrollment challenges during the pandemic. This modification was initially established for CCO contract year 2020 and has been extended since then through contract year 2023 (December 31, 2023).

Between October 2022 and December 2022, six CCOs required adjustment above their 2022 contract limit in 27 county service areas, in order to sustain auto-enrollment algorithms. This was mostly due to adding a significant number of members to the CCOs as these members transitioned from Fee for Service to CCOF (dental services).

During 2023, 24 CCO county service areas – representing eight distinct CCOs – required adjustments above their 2022 contract limits, in order to sustain auto-enrollment algorithms. New enrollment limits have been established for 2024.

B. Benefits

Pharmacy and Therapeutics (P&T) Committee

From July 1, 2023 – September 30, 2023, the P&T Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: Oncology Agents, Sublingual Buprenorphine, Daybue™ (trofinetide), Benign Prostatic Hyperplasia (BPH) Class, Clostridioides difficile-Associated Infection, Sublingual Immunotherapy Tablets, Gonadotropin-Releasing Hormone (GnRH) Agonists, Estrogen Derivatives and Testosterone.

The committee also recommended the following changes to the preferred drug list (PDL): make Ubrelvy™ (ubrogepant) preferred, maintain Daybue™ (trofinetide) as non-preferred, maintain oral fecal microbiota capsules as non-preferred; make Lupron Depot-PED® kit formulations (1-

month, 3-month, and 6-month) preferred, and add Grastek®, Oralair ®, Ragwitek®, and Odactra® sublingual tablets as non-preferred.

The Health Evidence Review Commission

The October 1, 2022 prioritized list went into effect the same day and was reported in a Notification of Interim Changes. Errata to the October 1, 2022 prioritized list were published on October 20, 2022. The January 1, 2023 list went into effect the same day and was reported in a Notification of Interim Changes. Errata to the January 1, 2023 prioritized list were published on December 19, 2022. The February 1, 2023 prioritized list went into effect on the same day and was reported in a Notification of Interim Changes.

C. Access to care (ANNUAL)

Federal and State regulations require each Managed Care Entity (MCE) to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. OHA contracts with 16 CCOs to deliver managed care services for OHP members. Each contractor must demonstrate the capacity to serve its current and expected membership within its service area and submit documentation to the state Medicaid authority. To support federal and state network adequacy requirements, the MCEs are contractually required to develop and submit Delivery System Network (DSN) reports that consist of two components: an annual DSN Provider Narrative Report and quarterly DSN Provider Capacity Reports. All reports must 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.

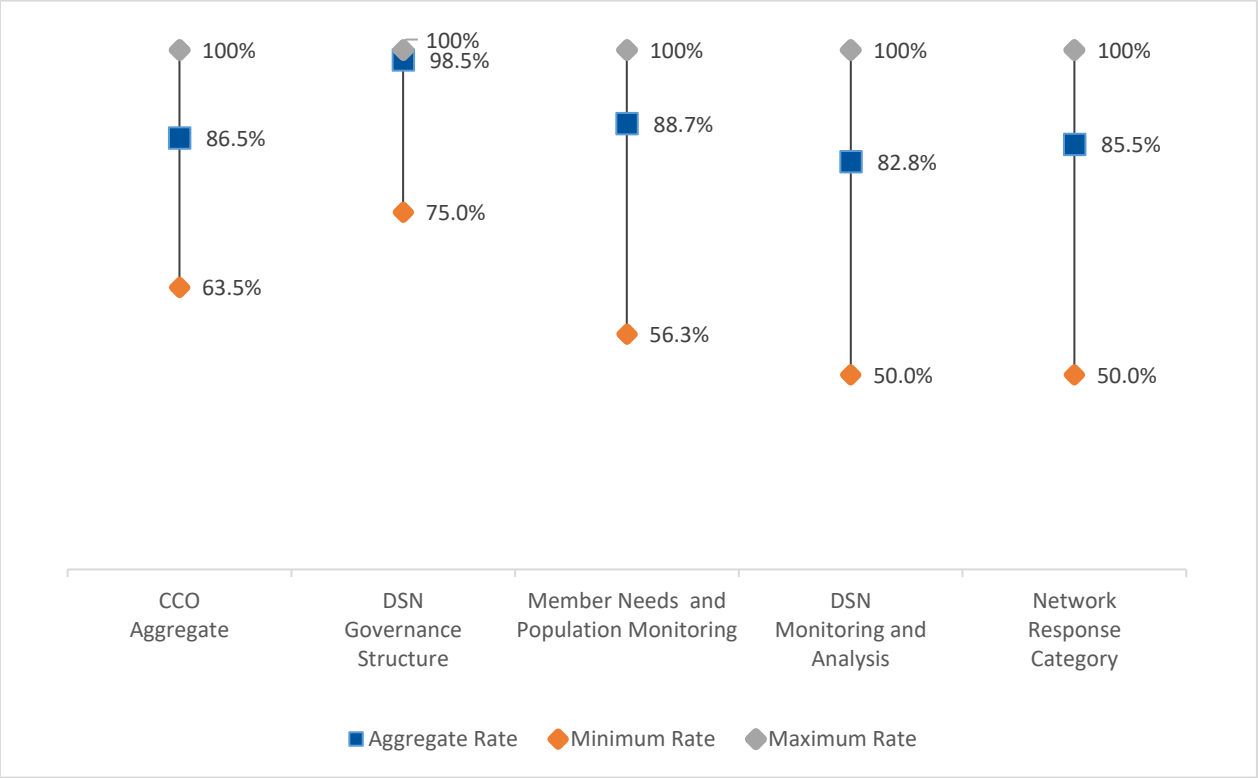
To meet oversight requirements, OHA contracted with Health Services Advisory Group, Inc. (HSAG) to conduct an evaluation of CCO delivery system networks (DSNs) to assess network adequacy and compliance with Oregon's standards for access to care. To assess CCO compliance with State network adequacy and availability of services requirements, HSAG:

- Conducted a review of all CCO network monitoring processes and procedures for ensuring the adequacy of its provider network, including member access to care and the availability of services
- Assessed the CCOs' network capacity and geographic distribution of providers relative to member populations
- Evaluated, summarized, and presented aggregate findings from OHA's quarterly *DSN Provider Capacity Reports*

Based on the review of the *DSN Provider Narrative Template* submissions, compliance with the state and federal requirements for maintaining and monitoring the adequacy and assurance of the provider network demonstrated opportunities for improvement across all CCOs. HSAG reviewed CCO submissions across 28 total elements representing four domains—i.e., DSN Governance Structure, Member Needs and Population Management, DSN Monitoring and Analysis, and Network Response Strategy.

Figure 0-1 displays the CCO aggregate compliance rates by *DSN Provider Narrative Template* domain as well as an aggregate compliance rate across domains. Results are given as a range of compliance rates including minimum (i.e., lowest CCO rate), maximum (i.e., highest CCO rate), and aggregate (i.e., CCO average) rates. The CCO aggregate category is a measure of the overall compliance rate across all domains.

Figure 0-1—Statewide *DSN Provider Narrative Template* Results

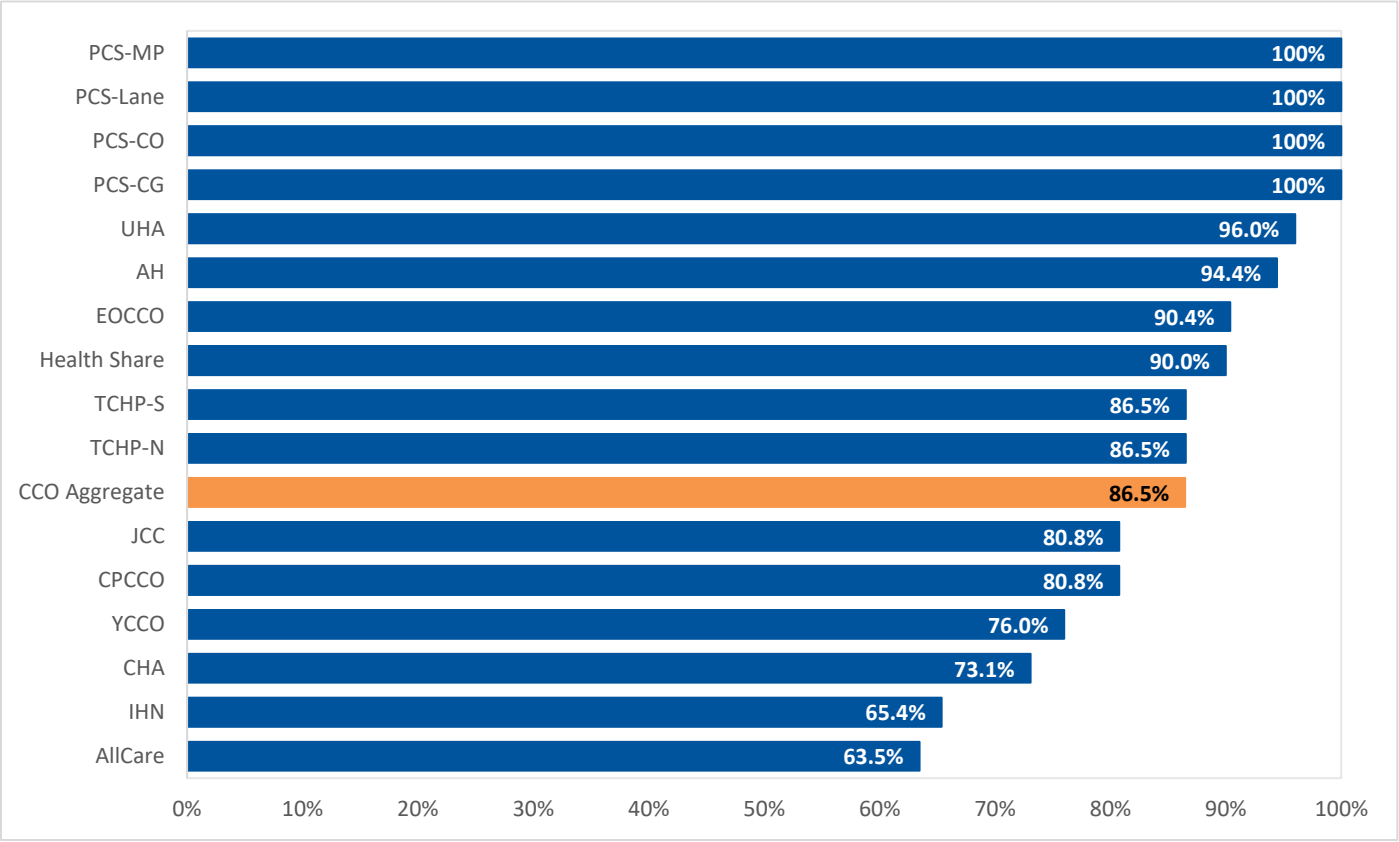


Statewide, the CCOs exhibited compliance with 86.5 percent of the elements across all *DSN Provider Narrative Template* domains, with individual domain CCO aggregate compliance ranging from 82.8 percent (i.e., *DSN Monitoring and Analysis*) to 98.5 percent (i.e., *DSN Governance Structure*). Overall, these results suggest a high level of compliance with state reporting

requirements but with room for improvement for the CCOs at the lower end of compliance rates.

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

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

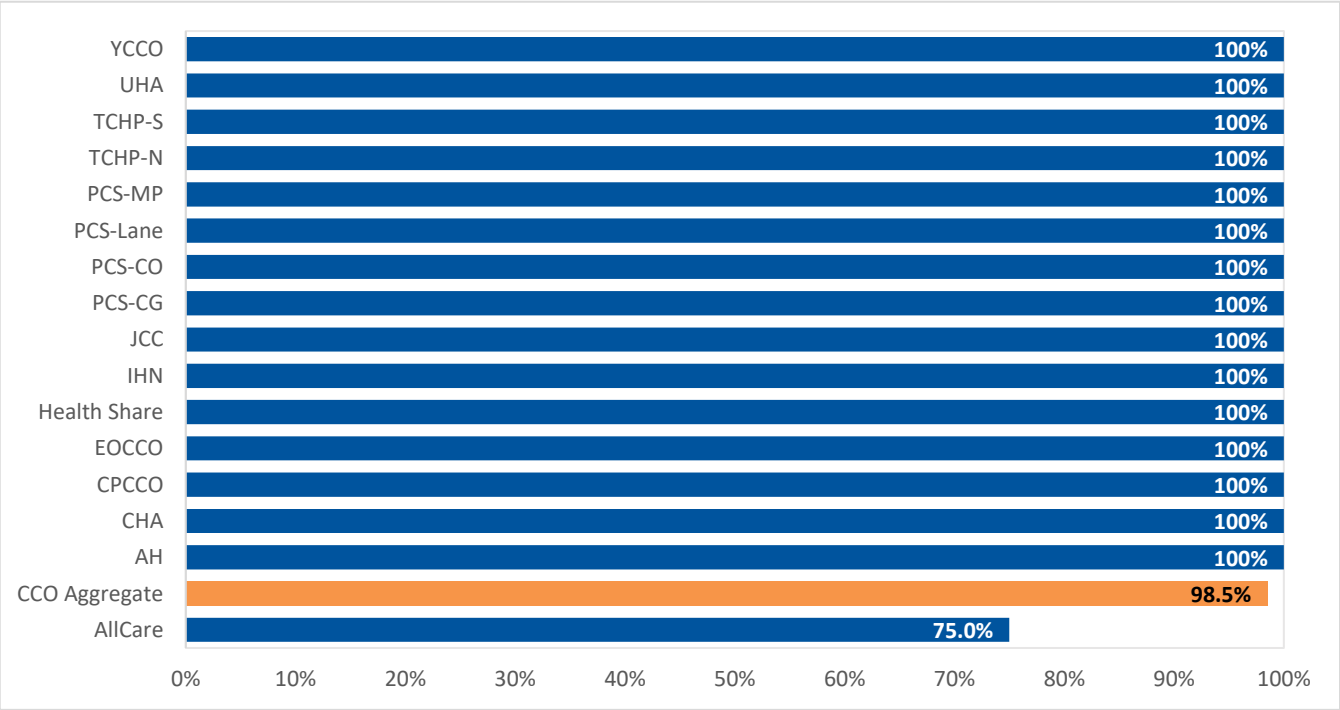


CCOs showed a greater range of overall compliance scores than in previous DSN Evaluations, with CCO-specific compliance scores ranging from 63.5 percent (AllCare) to 100 percent (PCS-CG, PCS-CO, PCS-Lane, and PCS-MP). Of the ten CCOs with compliance scores equal to or above the CCO aggregate, eight CCOs exhibited an overall high level of compliance (i.e., 90 percent or greater). Of the six CCOs performing below the CCO aggregate score, four (YCCO, CHA, IHN, and AllCare) had substantially lower overall scores (i.e., greater than 10 percent difference).

DSN Governance Structure

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

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



All but one CCO (AllCare) achieved 100 percent compliance with *DSN Governance Structure* domain elements. AllCare was not able to fully describe critical aspects of its operations due to a key staff departure, which impacted overall performance. These results suggest that the CCOs with well-documented policies and procedures tend to have more resilient operations in cases of staff turnover. Additional observations included the following:

- Most CCOs rely on multiple committees to conduct different aspects of network adequacy monitoring (e.g., provider contracting and management, population monitoring, cultural and linguistic needs). Committees tend to meet at least monthly and review network adequacy

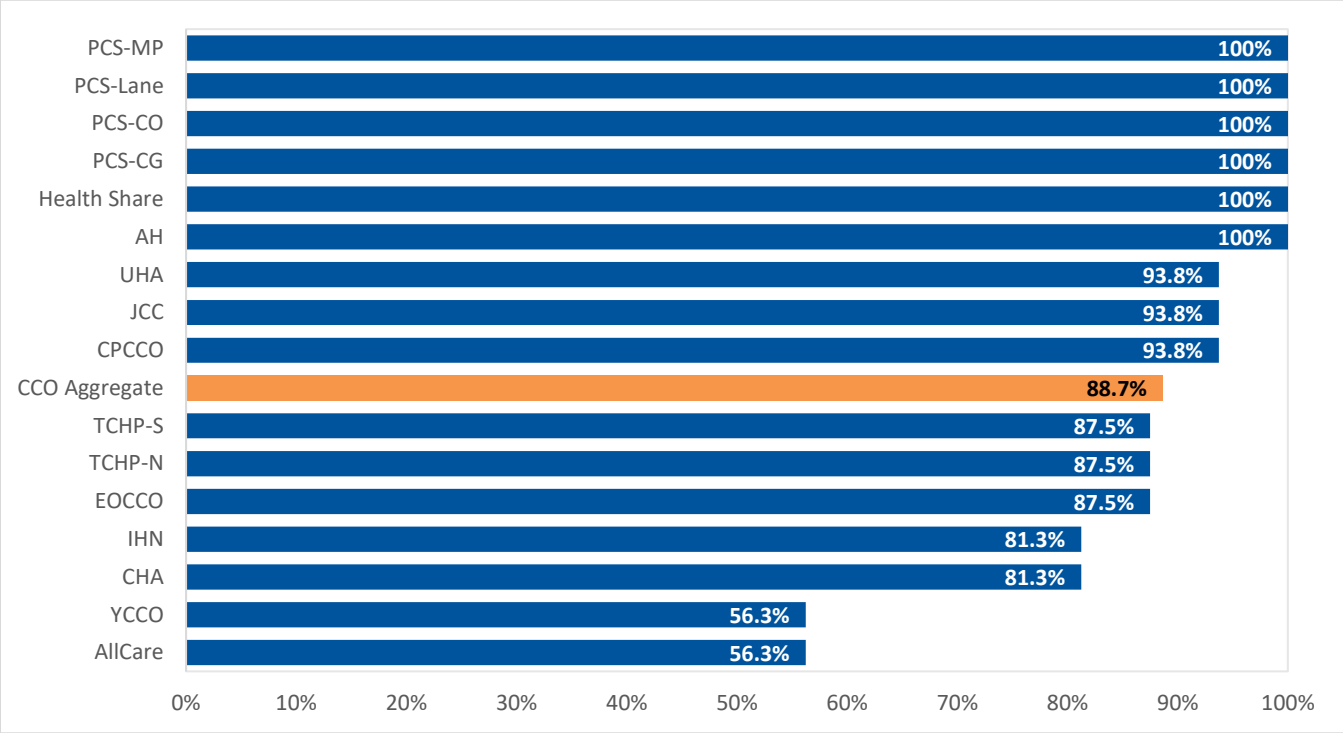
reports at frequencies varying from monthly to annually, with most reporting conducted quarterly.

- Most CCOs with direct service subcontractors (e.g., dental plans) delegate provider-related network adequacy functions to them (i.e., provider credentialing and contracting), with some CCOs also delegating member-related functions (e.g., monitoring member access to care).
- All but one CCO (AH) attested to having made no changes to the information systems used to support the management of DSNs and monitoring of network adequacy since the 2022 completion of the ISCAT and compliance monitoring review of health information systems. AH described the nature of changes made since completion of the 2022 ISCAT, namely implementation of a contract with QuestAnalytics to perform ongoing network adequacy analysis beginning late 2023.

Member Needs and Population Management

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

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



Six CCOs achieved 100 percent compliance with *Member Needs and Population Management* domain elements, yet the CCO aggregate compliance score was less than 90 percent (i.e., 88.7 percent). Two CCOs (AllCare and YCCO) were outliers, each scoring only 56.3 percent compliance. In both cases, the CCOs struggled to provide adequate answers and/or documentation for most elements. Additionally, the two CCOs generally could not describe or demonstrate both the collection and use of member data to support network adequacy monitoring requirements, particularly in regard to disease prevalence and population health. These results suggest that TA and guidance from OHA is necessary. Additional observations included the following:

- Most CCOs have implemented data dashboards to assist in visualization and reporting of member data, and in some cases have shared access to these dashboards with subcontractors to assist in their operational decision-making.
- All CCOs relied heavily on the OHA-produced member enrollment file (i.e., 834 file) to support member needs trending and population management efforts.
- Most CCOs described using race, ethnicity, language, and disability (REALD) data available from the 834 file, encounter data, and electronic health records to support network adequacy monitoring. This information was often supplemented with social determinants of health (SDOH) data to support various initiatives both related and unrelated to network adequacy.
- Some CCOs struggled to demonstrate how member data (e.g., demographics, diagnoses, service utilization) were used to support network adequacy monitoring rather than individual care coordination efforts. This was especially the case for member populations with SHCN and those with physical, intellectual, and developmental disabilities. This suggested an over-

reliance on care coordination to meet member needs, rather than monitoring of network adequacy and subsequent adjustment to fill any gaps.

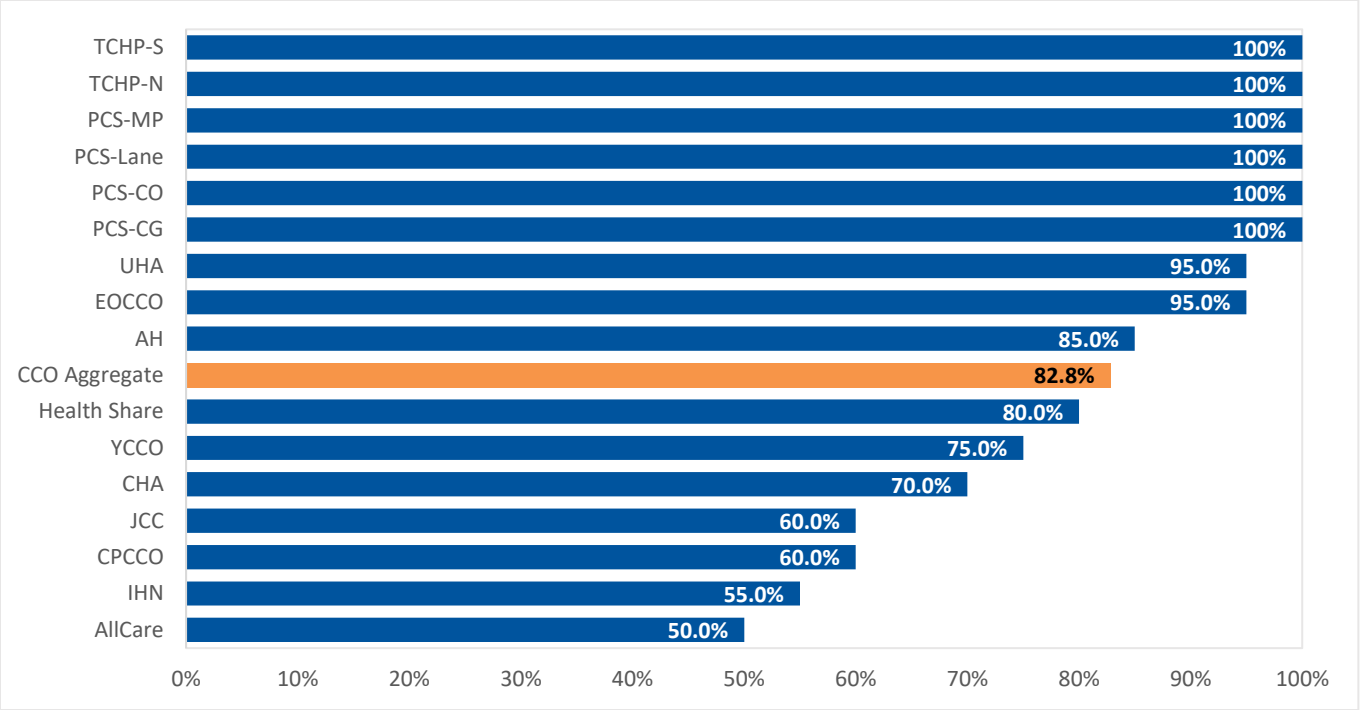
- Most CCOs relied on language preference data, typically taken from the 834 file and combined with interpreter service utilization data, as a proxy assessment for cultural needs monitoring.
- Several CCOs described preparing to incorporate additional sexual orientation and gender identity (SOGI) data associated with the 834 file, pending forthcoming requirements, guidance, and availability from OHA.
- Several CCOs struggled to describe how member information was used to support disease prevalence monitoring and population health efforts, instead focusing on monitoring narrow measures for diseases selected by State performance improvement projects (PIPs). In one case, a CCO only monitored for the top 100 members by service utilization cost, though this may have been due to the CCO misunderstanding the element and providing unrelated information.

DSN Monitoring and Analysis

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

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

Six



CCOs achieved 100 percent compliance with *DSN Monitoring and Analysis* domain elements, and two CCOs achieved 95 percent compliance; however, the CCO aggregate compliance score was less than 90 percent (i.e., 82.8 percent) and represented the lowest CCO aggregate compliance score across the domains. Of the seven CCOs with compliance scores lower than the CCO aggregate, six were 75 percent compliant or less. Most deficiencies in this domain were related to collecting required data in ways that were not methodologically robust, and/or being unable to demonstrate consideration of the data to support network adequacy monitoring and decision-making. This was especially true for elements related to provider-to-member ratios, use of telehealth modalities, and the availability of physical accessibility accommodations, with CCO aggregate compliance scores of 78 percent, 59 percent, and 69 percent, respectively. While OHA has not yet established contractual standards for some elements related to DSN monitoring and analysis, it has consistently conveyed the expectation that the CCOs should at least collect, analyze, and consider data associated with the elements in this domain. These results suggest that additional and targeted guidance, TA, or standards from OHA are necessary. Additional observations included the following:

- Most CCOs have implemented data dashboards to assist in visualization and reporting of provider network data, and in some cases have shared access to these dashboards with subcontractors to assist in their operational decision-making.
- Some CCOs were not compliant with OHA provider monitoring standards, particularly related to specialty provider taxonomy updates that were effective as of January 1, 2023.

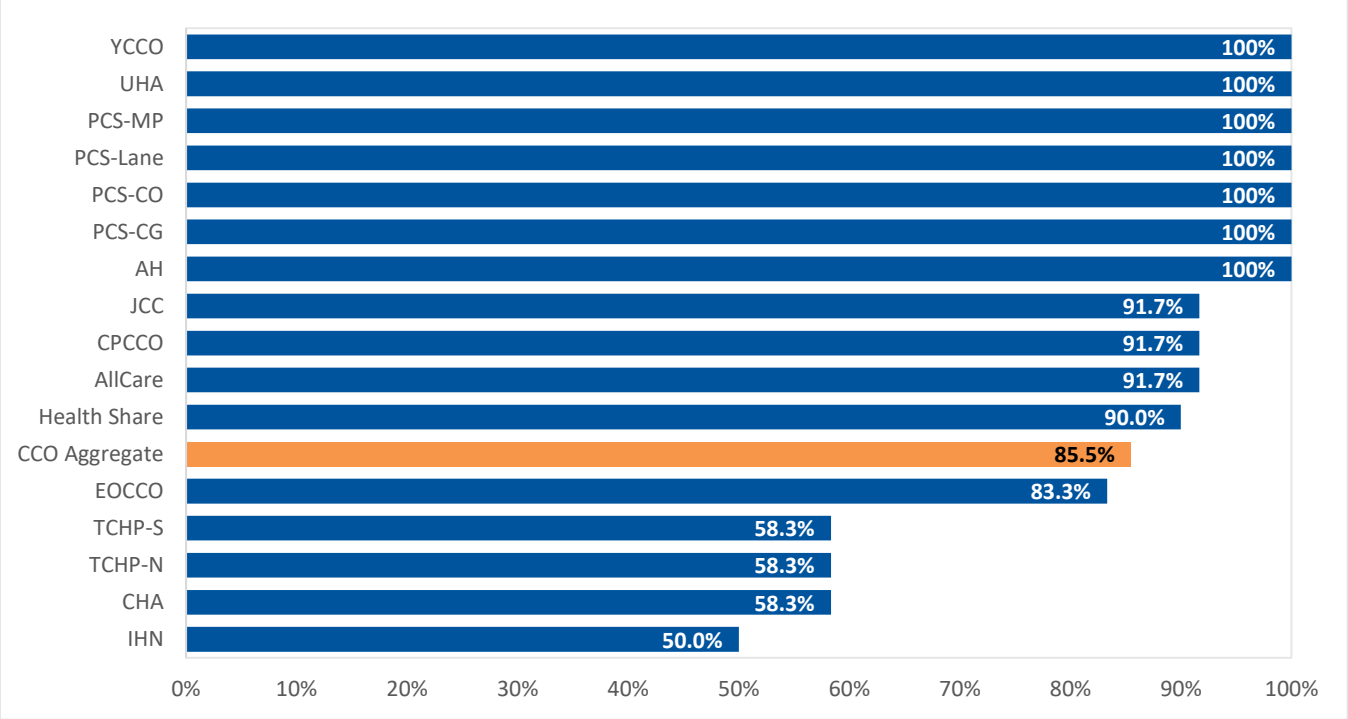
- While some CCOs reported challenges in meeting Oregon's time and distance standards for some provider types or facilities, most reported being able to meet the revised standards (i.e., 95 percent of members within time and distance access standards rather than the previous 100 percent standard).
- The CCOs showed a variety of approaches to using provider-to-member ratios as a component of network adequacy monitoring. Of the CCOs using provider-to-member ratios, none identified network gaps or needed follow-up investigation based on ratio analysis. Most CCOs described using Medicare provider-to-member standards as a baseline, particularly those CCOs with Medicare lines of business. While this approach may be efficient for the CCOs, both OHA and HSAG have provided feedback that this approach does not necessarily align with OHP member needs, as the populations served through Medicare and Medicaid are fundamentally different.
- Most CCOs improved their monitoring efforts related to wait time to appointment availability. In addition to grievance monitoring, most CCOs described the use of quarterly to annual provider attestation surveys to inform network adequacy monitoring and decision-making; however, most CCOs did not describe or provide sufficient evidence for monitoring beyond provider attestation surveys. Only two CCOs conducted secret shopper surveys of provider offices, while five CCOs proactively surveyed members regarding their experiences with appointment availability.
- All CCOs were compliant with the call center performance element for both in-house and subcontractor call centers. In some cases, monitoring extended to weekly or daily reports of call center and individual employee performance and may have represented excessive oversight effort.
- Some CCOs made sophisticated use of telehealth utilization data, combining claims data with member and provider demographic and geographic information to assess their network for provider gaps or service modality trends; however, most CCOs do not yet have a process for collecting and using telehealth utilization data regularly to inform network adequacy decision-making.
- Most CCOs have not yet incorporated the availability of physical accessibility accommodations into network adequacy monitoring efforts. Where such information has been incorporated, data collection is often limited, assessing relatively few individual practitioners annually or only determining whether a facility is "ADA compliant" rather than the specific accommodations available.

Network Response Strategy

The *Network Response Strategy* domain provides insight into the methodologies used by the CCO to identify barriers affecting network adequacy, implement interventions to resolve barriers, evaluate the efficacy of any interventions, and the actions taken to address any previously identified areas for improvement.

Figure 0-6 shows the individual CCO compliance scores for elements in the *Network Response Strategy* domain. All CCO compliance scores are ranked from highest to lowest, including the overall CCO aggregate score, within the domain.

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



Seven CCOs achieved 100 percent compliance with *Network Response Strategy* domain elements; however, the CCO aggregate compliance score was less than 90 percent (i.e., 85.5 percent). Of the five CCOs with compliance scores lower than the CCO aggregate, four (TCHP-N, TCHP-S, CHA, and IHN) were less than 60 percent compliant. Most deficiencies in this domain were related to providing irrelevant or incomplete answers to elements, lack of plans (i.e., methods, metrics, and timelines) for how to monitor the efficacy of planned network interventions, and failing to resolve all findings from the 2022 DSN Evaluation. These results suggest that the CCOs would benefit from additional guidance and TA. Additional observations included the following:

- Many CCOs demonstrated consideration of both their global provider network and region-specific provider networks (both at the county and city level) when assessing network adequacy gaps and planning interventions. These gap assessments were often driven by time and distance assessment and community and provider feedback.
- Most CCOs identified a network adequacy gap around certified and qualified health care interpreters. Some CCOs described intervention plans that included funding scholarship programs for qualified and certified health care interpreters.

- Most CCOs described plans to address anticipated decreases in OHP membership resulting from the resumption of OHP redetermination schedules, including provider capacity projections, staffing adjustments, panel reassignments, and other efforts.

Network Capacity and Adequacy Assessment

Network Capacity

To address provider network capacity, HSAG conducted a review of CCO provider network data files and synthesized the results to understand the provider network infrastructure in place to provide health care services to members. Using CCO data captured in OHA's quarterly *DSN Provider Capacity Reports,* HSAG aggregated the data and reported two core metrics for PCPs, PCDs, MHPs, and SUD providers[3-1]—i.e., provider counts and network stability and provider-to-member ratios. These provider types were selected as key measures of network capacity due to their role in providing front-line medical services, which serve the widest array of needs and act as intake points. The results are unweighted, and percentages were calculated based on the number of unique, individual practitioners within each category. For comprehensive individual- and facility-based network capacity results, see the CCO-specific results contained in the appendices.

Provider Counts

Table 0-1 shows the total number of PCPs contracted with each CCO and the percentage of PCPs providing care to adults and children. The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., á, or 10 percent) or decrease (i.e., â, or 10 percent) in the total number of PCPs. Due to how providers were grouped depending on population served, percentages may not total 100 percent.

Table 0-1—Number and Percentage of PCPs by Quarter

CCO	Q2 2022			Q1 2023			Difference PCP-All	
	PCP-All (N)	PCP-Adult (%)	PCP-Child (%)	PCP-All (N)	PCP-Adult (%)	PCP-Child (%)	#	% Change
AH	91	91.2%	67.0%	83	90.4%	74.7%	-8	-8.8%

[3-1] This used data from Q2 2022 and Q1 2023, representing a calendar difference of approximately nine months to one year. Provider data used to generate Q2 2022 network capacity counts and provider-to-member ratios used different data elements to classify PCPs, PCDs, MHPs, and SUD providers. Although a comparative review of the distribution of providers showed significant differences in some cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

CCO	Q2 2022			Q1 2023			Difference PCP-All	
	PCP-All (N)	PCP-Adult (%)	PCP-Child (%)	PCP-All (N)	PCP-Adult (%)	PCP-Child (%)	#	% Change
AllCare	253	87.4%	100%	344	95.6%	61.3%	91	36.0% á
CHA	92	88.0%	21.7%	83	86.7%	24.1%	-9	-9.8%
CPCCO	3,614	89.2%	95.3%	1,527	84.2%	98.2%	-2,087	-57.7% â
EOCCO	3,525	72.2%	28.5%	1,718	54.3%	46.3%	-1,807	-51.3% â
Health Share	3,751	88.1%	86.3%	1,915	83.7%	81.3%	-1,836	-48.9% â
IHN	265	86.4%	83.4%	273	86.8%	14.3%	88	3.0%
JCC	3,625	89.1%	95.3%	1,556	84.2%	98.3%	-2,069	-57.1% â
PCS-CG	62	95.2%	79.0%	76	89.5%	80.3%	14	22.6% á
PCS-CO	241	82.2%	85.9%	232	81.9%	86.2%	-9	-3.7%
PCS-Lane	389	86.6%	86.1%	383	87.2%	86.9%	-6	-1.5%
PCS-MP	359	87.2%	79.9%	326	86.2%	85.0%	-33	-9.2%
TCHP-N	1,311	91.9%	99.6%	574	99.0%	100%	-737	-56.2% â
TCHP-S	775	93.7%	99.7%	477	99.8%	100%	-298	-38.5% â
UHA	114	93.0%	89.5%	147	92.5%	97.3%	33	28.9% á
YCCO	937	78.3%	22.6%	782	76.7%	72.8%	-155	-16.5% â

Between 2022 and 2023, OHA updated PCP reporting instructions such that counts of PCPs substantially decreased for some CCOs, likely without substantial decreases in actual PCP counts. Three CCOs showed substantial increases in counts of PCPs serving both adult and pediatric members (i.e., AllCare, PCS-CG, and UHA). In the case of AllCare, the increase was likely due to improved DSN Provider Capacity Reporting. In the case of PCS-CG and UHA, the increase was substantial due to the relatively small number of PCPs in the network, amplifying the impact of a modest increase in PCP counts (i.e., 14 and 33 PCPs, respectively). Overall, the change in PCP counts between 2022 and 2023 for most CCOs likely represented the PCP reporting instruction changes and general improvements in CCO DSN Provider Capacity Reporting rather than substantial changes in actual PCP counts. EOCCO reported that many of its providers restricted their practices to adult or pediatric populations only, with few providers documented as serving both adults and children. It was unclear from the analysis whether these practice characteristics were accurately reported in EOCCO's quarterly provider capacity data files. As such, caution should be used when interpreting adult and pediatric results. However, the CCO's results for the combined "all" category are likely more accurate.

Table 0-2 shows the total number of PCDs contracted with each CCO and the percentage of PCDs providing care to adults and children. The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., á, or 10 percent) or decrease (i.e., â, or 10 percent) in the total number of PCDs. Due to how providers were grouped depending on population served, percentages may not total 100 percent.

Table 0-2—Number and Percentage of PCDs by Quarter

CCO	Q2 2022			Q1 2023			Difference	
	PCD-All (N)	PCD-Adult (%)	PCD-Child (%)	PCD-All (N)	PCD-Adult (%)	PCD-Child (%)	#	% Change
AH	26	96.2%	100%	26	84.6%	100%	0	0.0%
AllCare	1	100%	100%	45	86.7%	62.2%	44	4400.0% á
CHA	26	76.9%	100%	30	66.7%	100%	4	15.4% á
CPCCO	270	85.9%	100%	200	79.5%	100%	-70	-25.9% â
EOCCO	174	87.9%	96.0%	164	85.4%	97.6%	-10	-5.7%
Health Share	598	89.8%	87.3%	551	88.9%	86.0%	-47	-7.9%
IHN	147	91.8%	100%	163	89.6%	100%	16	10.9% á
JCC	93	91.4%	100%	87	86.2%	100%	-6	-6.5%
PCS-CG	344	84.6%	99.7%	356	84.0%	99.2%	12	3.5%
PCS-CO	344	84.6%	99.7%	356	84.0%	99.2%	12	3.5%
PCS-Lane	344	84.6%	99.7%	356	84.0%	99.2%	12	3.5%
PCS-MP	344	84.6%	99.7%	356	84.0%	99.2%	12	3.5%
TCHP-N	426	87.6%	100%	399	87.0%	99.2%	-27	-6.3%
TCHP-S	147	84.4%	100%	137	85.4%	100%	-10	-6.8%
UHA	43	95.3%	97.7%	36	91.7%	100%	-7	-16.3% â
YCCO	57	84.2%	98.2%	60	80.0%	98.3%	3	5.3%

At the end of 2022, OHA ended its dental prepaid ambulatory health plan (PAHP) program for Oregonians not enrolled with OHP FFS or a CCO. These members, who historically received limited oral health care benefits via dental care organizations (DCOs), were transitioned into existing CCOs. Already subcontracted to provide dental services to CCO members, many DCOs expanded current delegation agreements with the CCOs to continue to provide dental services to the newly transitioned population. As a result, the dental provider network reported by the CCOs in 2023 remained stable with a few exceptions (i.e., AllCare, CHA, CPCCO, IHN, and UHA). AllCare showed a substantial increase in PCDs from one to 45 providers in 2023; however, this

change is likely due to improvement in the accuracy and completeness of provider data rather than an actual change in its network. AllCare did not provide sufficient PCD data for the 2022 DSN Evaluation. CHA and UHA also showed substantial changes, but these changes were due to relatively small provider pools (i.e., differences of four and seven PCDs, respectively). IHN showed a substantial increase in PCDs that was likely due to additional contracting. Conversely, CPCCO showed a substantial decrease in PCDs (i.e., 70 PCDs, or a quarter of its 2022 network). Within its *DSN Provider Narrative Template*, CPCCO noted a workforce shortage for PCDs within its service areas and stated it was offering incentive programs and working with national recruiters to improve access to oral health care services; however, dental workforce shortages have been observed statewide, and it was unclear from the results why CPCCO demonstrated a larger decrease compared to other CCOs with greater membership (e.g., Health Share) and/or equally rural service areas (e.g., PCS).

Table 0-3 shows the total number of MHPs contracted with each CCO and the percentage of MHPs providing care to adults and children. The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., á, or 10 percent) or decrease (i.e., â, or 10 percent) in the total number of MHPs.

Table 0-3—Number and Percentage of MHPs by Quarter

CCO	Q2 2022			Q1 2023			Difference	
	MHP-All (N)	MHP-Adult (%)	MHP-Child (%)	MHP-All (N)	MHP-Adult (%)	MHP-Child (%)	#	% Change
AH	159	93.7%	81.8%	202	97.5%	99.0%	43	27.0% á
AllCare	118	98.3%	99.2%	526	99.6%	48.9%	408	345.8% á
CHA	148	88.5%	40.5%	141	90.1%	56.0%	-7	-4.7%
CPCCO	2,255	97.1%	100%	2,409	97.3%	100%	154	6.8%
EOCCO	1,373	98.5%	3.8%	1,358	98.6%	2.1%	-15	-1.1%
Health Share	1,902	94.1%	99.3%	2,503	95.9%	99.8%	601	31.6% á
IHN	1,271	99.9%	99.9%	1,608	99.9%	99.8%	337	26.5% á
JCC	2,258	97.9%	100%	2,528	97.5%	100%	270	12.0% á
PCS-CG	3,607	100%	99.9%	4,250	100%	100%	643	17.8% á
PCS-CO	3,608	100%	99.9%	4,251	100%	100%	643	17.8% á
PCS-Lane	3,610	100%	99.9%	4,250	100%	100%	640	17.7% á
PCS-MP	3,612	100%	99.9%	4,253	100%	100%	641	17.7% á
TCHP-N	1,971	98.0%	99.7%	1,993	100%	100%	22	1.1%

CCO	Q2 2022			Q1 2023			Difference	
	MHP-All (N)	MHP-Adult (%)	MHP-Child (%)	MHP-All (N)	MHP-Adult (%)	MHP-Child (%)	#	% Change
TCHP-S	1,598	99.1%	100%	1,814	100%	100%	216	13.5% á
UHA	147	89.1%	69.4%	177	88.7%	93.2%	30	20.4% á
YCCO	1,868	99.5%	42.6%	2,382	98.7%	97.9%	514	27.5% á

Between 2022 and 2023, CCOs showed substantial increases in MH provider counts across the board with few decreases. Several factors likely contributed to these increases, including efforts by the CCOs to increase enrollment and contracting with MH providers in response to members' needs as well as improvements to the quality of provider data and changes in study protocols (e.g., provider categorization). However, caution should be used when interpreting the results, as some CCOs report provider network capacity data at an enterprise level, which may increase the overall number of providers regardless of location and/or availability to Medicaid members. This situation is often identified with CCOs managing multiple service areas or with extensive delegated services (e.g., PCS, TCHP, and Health Share). Additionally, PCS reported a somewhat higher percentage of its provider workforce as MH providers in comparison to other CCOs (i.e., approximately 30 percent for PCS compared to approximately 20 percent to 25 percent overall), which may also indicate a data issue.

Table 0-4 shows the total number of SUD providers contracted with each CCO and the percentage of SUD providers providing care to adults and children. The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., á, or 10 percent) or decrease (i.e., â, or 10 percent) in the total number of SUD providers. Due to how providers were grouped depending on population served, percentages may not total 100 percent.

Table 0-4—Number and Percentage of SUD Providers by Quarter

CCO	Q2 2022			Q1 2023			Difference	
	SUD-All (N)	SUD-Adult (%)	SUD-Child (%)	SUD-All (N)	SUD-Adult (%)	SUD-Child (%)	#	% Change
AH	33	87.9%	24.2%	56	100%	92.9%	23	69.7% á
AllCare	38	94.7%	100%	144	98.6%	18.1%	106	278.9 % á
CHA	66	97.0%	13.6%	69	95.7%	14.5%	3	4.5%
CPCCO	486	100%	100%	528	99.8%	100%	42	8.6%
EOCCO	337	100%	29.7%	292	100%	2.1%	-45	-13.4% â

CCO	Q2 2022 SUD-All (N)	Q2 2022 SUD-Adult (%)	Q2 2022 SUD-Child (%)	Q1 2023 SUD-All (N)	Q1 2023 SUD-Adult (%)	Q1 2023 SUD-Child (%)	Difference #	Difference % Change
Health Share	522	100%	100%	582	99.8%	100%	60	11.5% á
IHN	334	100%	99.7%	412	100%	99.3%	78	23.4% á
JCC	486	100%	100%	534	99.8%	100%	48	9.9%
PCS-CG	505	100%	100%	551	100%	100%	46	9.1%
PCS-CO	505	100%	100%	551	100%	100%	46	9.1%
PCS-Lane	505	100%	100%	551	100%	100%	46	9.1%
PCS-MP	505	100%	100%	551	100%	100%	46	9.1%
TCHP-N	293	100%	100%	293	100%	100%	0	0.0%
TCHP-S	357	100%	100%	415	100%	100%	58	16.2% á
UHA	82	96.3%	7.3%	100	96.0%	99.0%	18	22.0% á
YCCO	304	100%	97.7%	417	100%	98.3%	113	37.2% á

Between 2022 and 2023, demand for SUD services greatly increased in Oregon. Most CCOs responded with some level of increase in SUD provider networks, with seven CCOs (i.e., AH, AllCare, Health Share, IHN, TCHP-S, UHA, and YCCO) showing substantial increases in the number of contracted SUD providers. The reported increase in providers was likely due to efforts by the CCOs to increase enrollment of SUD providers, as well as general improvement in the completeness and quality of the CCOs' provider data. One CCO, EOCCO, exhibited a substantial decrease (13.4 percent, or 45 providers). Further analysis of the CCO's data showed that the decrease was driven by losses in SUD providers serving pediatric members; however, this finding likely reflects a data quality issue as EOCCO reported nearly all its providers as exclusively serving either adult or pediatric populations, with few providers documented as serving both adults and children. Additionally, several CCOs reported comparatively small numbers of providers (i.e., AH and CHA), which may also impact reported changes in rates. As such, caution should be used when interpreting these results.

Provider-to-Member Ratios

HSAG calculated CCO-specific provider-to-member ratios for all provider types in order to standardize the reporting of provider capacity. The provider-to-member ratio was calculated by dividing the total number of members enrolled in each CCO by the total number of providers within the CCO's network. The number of members enrolled in each CCO was determined by extracting members from the OHA enrollment and eligibility files who were active with the CCO as of March 31, 2023. HSAG applied member restrictions when calculating the provider-to-

member ratios for MHPs and SUD providers based on the number of members with at least one inpatient or outpatient claim with an MH or SUD diagnosis during calendar year 2022. This metric serves as a way to standardize estimations of a CCO's provider network as it accounts for service area and membership size. Because OHA does not currently have specific provider-to-member ratio standards for any provider type, the results below are presented for informational purposes.

Table 0-5 shows the provider-to-member ratios for PCPs stratified by the adult, pediatric, and total member populations.

Table 0-5—Provider-to-Member Ratios for PCPs by Member Population

CCO	PCP-All			PCP-Adult			PCP-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
AH	28,967	83	1:349	20,196	75	1:270	8,771	62	1:142
AllCare	65,667	344	1:191	46,488	329	1:142	19,179	211	1:91
CHA	27,299	83	1:329	17,403	72	1:242	9,896	20	1:495
CPCCO	37,501	1,527	1:25	24,637	1,286	1:20	12,864	1,500	1:9
EOCCO	76,146	1,718	1:45	44,542	933	1:48	31,604	795	1:40
Health Share	439,034	1,915	1:230	290,023	1,603	1:181	149,011	1,556	1:96
IHN	84,219	273	1:309	55,375	237	1:234	28,844	39	1:740
JCC	66,084	1,556	1:43	40,438	1,310	1:31	25,646	1,529	1:17
PCS-CG	17,247	76	1:227	10,398	68	1:153	6,849	61	1:113
PCS-CO	77,028	232	1:333	49,553	190	1:261	27,475	200	1:138
PCS-Lane	91,951	383	1:241	60,330	334	1:181	31,621	333	1:95
PCS-MP	148,087	326	1:455	85,242	281	1:304	62,845	277	1:227
TCHP-N	55,283	574	1:97	41,457	568	1:73	13,826	574	1:25
TCHP-S	38,090	477	1:80	29,415	476	1:62	8,675	477	1:19
UHA	40,040	147	1:273	26,601	136	1:196	13,439	143	1:94

CCO	PCP-All			PCP-Adult			PCP-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
YCCO	37,208	782	1:48	22,751	600	1:38	14,457	569	1:26

Overall, most CCOs showed approximately equivalent ratios with the exceptions of CPCCO (i.e., 1:25), EOCCO (i.e., 1:45), JCC (i.e., 1:43), and YCCO (i.e., 1:48). Differences between CCOs were more pronounced in terms of PCPs serving pediatric members, with ratios ranging from 1:9 (i.e., CPCCO) to 1:740 (i.e., IHN). These results highlight the need for the CCOs and OHA to continue to monitor trends, follow up on outliers, and assess the appropriateness of any potential provider-to-member ratio standards.

Table 0-6 shows an example of the provider-to-member ratios for PCDs stratified by the adult, pediatric, and total member populations.

Table 0-6—Provider-to-Member Ratios for PCDs by Member Population

CCO	PCD-All			PCD-Adult			PCD-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
AH	28,967	26	1:1,115	20,196	22	1:918	8,771	26	1:338
AllCare	65,667	45	1:1,460	46,488	39	1:1,192	19,179	28	1:685
CHA	27,299	30	1:910	17,403	20	1:871	9,896	30	1:330
CPCCO	37,501	200	1:188	24,637	159	1:155	12,864	200	1:65
EOCCO	76,146	164	1:465	44,542	140	1:319	31,604	160	1:198
Health Share	439,034	551	1:797	290,023	490	1:592	149,011	474	1:315
IHN	84,219	163	1:517	55,375	146	1:380	28,844	163	1:177
JCC	66,084	87	1:760	40,438	75	1:540	25,646	87	1:295
PCS-CG	17,247	356	1:49	10,398	299	1:35	6,849	353	1:20
PCS-CO	77,028	356	1:217	49,553	299	1:166	27,475	353	1:78
PCS-Lane	91,951	356	1:259	60,330	299	1:202	31,621	353	1:90
PCS-MP	148,087	356	1:416	85,242	299	1:286	62,845	353	1:179

CCO	PCD-All			PCD-Adult			PCD-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
TCHP-N	55,283	399	1:139	41,457	347	1:120	13,826	396	1:35
TCHP-S	38,090	137	1:279	29,415	117	1:252	8,675	137	1:64
UHA	40,040	36	1:1,113	26,601	33	1:807	13,439	36	1:374
YCCO	37,208	60	1:621	22,751	48	1:474	14,457	59	1:246

Overall, the CCOs showed a broad range of ratios for PCDs. PCS-CG was a notable outlier for overall PCDs (i.e., 1:49 ratio) due to its relatively low member population and PCS reporting all PCDs globally. Because of the geographically disparate nature of the four PCS CCOs, ratios for each likely do not show a complete picture of the true pool of PCDs available to PCS members within their respective CCO service areas. These results highlight the need for the CCOs and OHA to continue to monitor trends, follow up on outliers, and assess the appropriateness of any potential provider-to-member ratio standards.

Table 0-7 shows an example of the provider-to-member ratios for MHPs stratified by the adult, pediatric, and total member populations.

Table 0-7—Provider-to-Member Ratios for MHPs by Member Population

CCO	MHP-All			MHP-Adult			MHP-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
AH	28,967	202	1:144	20,196	197	1:103	8,771	200	1:44
AllCare	65,667	526	1:125	46,488	524	1:89	19,179	257	1:75
CHA	27,299	141	1:194	17,403	127	1:138	9,896	79	1:126
CPCCO	37,501	2,409	1:16	24,637	2,343	1:11	12,864	2,409	1:6
EOCCO	76,146	1,358	1:57	44,542	1,339	1:34	31,604	28	1:1,129
Health Share	439,034	2,503	1:176	290,023	2,400	1:121	149,011	2,498	1:60
IHN	84,219	1,608	1:53	55,375	1,606	1:35	28,844	1,605	1:18
JCC	66,084	2,528	1:27	40,438	2,465	1:17	25,646	2,528	1:11
PCS-CG	17,247	4,250	1:5	10,398	4,250	1:3	6,849	4,248	1:2

CCO	MHP-All			MHP-Adult			MHP-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
PCS-CO	77,028	4,251	1:19	49,553	4,251	1:12	27,475	4,249	1:7
PCS-Lane	91,951	4,250	1:22	60,330	4,250	1:15	31,621	4,248	1:8
PCS-MP	148,087	4,253	1:35	85,242	4,253	1:21	62,845	4,251	1:15
TCHP-N	55,283	1,993	1:28	41,457	1,993	1:21	13,826	1,993	1:7
TCHP-S	38,090	1,814	1:21	29,415	1,814	1:17	8,675	1,814	1:5
UHA	40,040	177	1:227	26,601	157	1:170	13,439	165	1:82
YCCO	37,208	2,382	1:16	22,751	2,350	1:10	14,457	2,333	1:7

Overall, CPCCO, JCC, and YCCO were outliers with low ratios (i.e., 1:16, 1:27, and 1:16 respectively) and listed relatively large networks of MHPs (i.e., 2,409, 2,528, and 2,382 respectively). EOCCO's MHP-to-pediatric member ratio was much higher than other CCOs, which may have been due to its previously identified data issue of reporting providers as serving either adult or pediatric members exclusively. These results highlight the need for the CCOs and OHA to continue to monitor trends, follow up on outliers, and assess the appropriateness of any potential provider-to-member ratio standards.

Table 0-8 shows an example of the provider-to-member ratios for SUD providers stratified by the adult, pediatric, and total member populations.

Table 0-8—Provider-to-Member Ratios for SUD Providers by Member Population

CCO	SUD Provider-All			SUD Provider-Adult			SUD Provider-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
AH	28,967	56	1:518	20,196	56	1:361	8,771	52	1:169
AllCare	65,667	144	1:457	46,488	142	1:328	19,179	26	1:738
CHA	27,299	69	1:396	17,403	66	1:264	9,896	10	1:990
CPCCO	37,501	528	1:72	24,637	527	1:47	12,864	528	1:25
EOCCO	76,146	292	1:261	44,542	292	1:153	31,604	6	1:5,268
Health Share	439,034	582	1:755	290,023	581	1:500	149,011	582	1:257

CCO	SUD Provider-All			SUD Provider-Adult			SUD Provider-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
IHN	84,219	412	1:205	55,375	412	1:135	28,844	409	1:71
JCC	66,084	534	1:124	40,438	533	1:76	25,646	534	1:49
PCS-CG	17,247	551	1:32	10,398	551	1:19	6,849	551	1:13
PCS-CO	77,028	551	1:140	49,553	551	1:90	27,475	551	1:50
PCS-Lane	91,951	551	1:167	60,330	551	1:110	31,621	551	1:58
PCS-MP	148,087	551	1:269	85,242	551	1:155	62,845	551	1:115
TCHP-N	55,283	293	1:189	41,457	293	1:142	13,826	293	1:48
TCHP-S	38,090	415	1:92	29,415	415	1:71	8,675	415	1:21
UHA	40,040	100	1:401	26,601	96	1:278	13,439	99	1:136
YCCO	37,208	417	1:90	22,751	417	1:55	14,457	410	1:36

Ratios for SUD providers-to-members showed a broad range across all categories, with several outliers that for reasons previously cited in this section were likely due to either global reporting of providers (e.g., PCS) or potential issues in reporting providers serving adults or children (i.e., EOCCO). These results highlight the need for the CCOs and OHA to continue to monitor trends, follow up on outliers, and assess the appropriateness of any potential provider-to-member ratio standards.

Overall, provider-to-member ratios for both MH and SUD providers were low, indicating the CCOs had a large number of providers contracted to perform MH and SUD services relative to members with an MH or SUD diagnosis. However, this does not mean that members had greater access to MH and SUD providers compared to other provider types (e.g., PCPs, specialty providers). While provider-to-member ratios are not indicative of network adequacy in and of themselves, they serve as useful general trend indicators that often help to identify potential network outliers and data issues.

Time and Distance Analysis

This section highlights the CCOs' compliance with OHA time and distance standards (i.e., 95 percent of members within 30 miles or 30 minutes of a provider in urban settings, and 95 percent of members within 60 miles or 60 minutes of a provider in rural settings). The findings in

this section are limited to a subset of core providers[3-2] that represent and perform fundamental health services covered by the CCOs. These provider types were selected due to their role in providing front-line medical services, which serve the widest array of needs and act as critical intake points. Table 0-9 and Table 0-10 show the percentages of CCO members with access to core service categories by urban and rural geographic classifications, respectively. Results showing less than 95 percent of members meeting the state-defined time and distance access standards are shaded red.

Table 0-9—Time and Distance Results by Provider Type—Urban

CCO	PCP	PCD	MHP	SUD Provider	OB/ GYN	OPT	DME	HOSP	Rx	SNF
AllCare	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CPCCO	100%	100%	100%	**92.3%**	**92.5 %**	**92.3 %**	100%	100%	100%	**92.7 %**
EOCCO	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Health Share	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
IHN	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
JCC	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-CO	100%	100%	100%	100%	100%	100%	100%	95.4%	100%	98.8%
PCS-Lane	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-MP	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-N	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-S	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
YCCO	100%	100%	100%	100%	100%	100%	99.6%	100%	100%	100%

Note: Results shown in red font indicate that less than 95 percent of members had access to the provider type within the time and distance standard.

Not all CCOs have urban settings within their service areas (i.e., AH, CHA, PCS-CG, and UHA). All CCOs with urban settings met the urban time and distance access standards for the listed provider types, with the exception of CPCCO, which did not meet the access standard for SUD providers, and OB/GYN, OPT, and SNF specialty providers; however, these provider types were

[3-2] For detailed time and distance CCO findings for all provider specialties and oral health service providers, see the CCO-specific appendices.

very nearly compliant with the access standard, ranging from 92.3 percent compliant to 92.7 percent compliant and impacting between 147 members (i.e., OB/GYN) and approximately 370 members. Additionally, the CCO's urban setting within its otherwise rural service area is a small, remote community that had been classified under OHA's methodology as urban due to the community's proximity to a sufficiently populous town located just across the Washington border. CPCCO's results for rural time and distance access indicate 100 percent access for members to all but SNF facilities for the listed aggregate provider types. As such, these results should not necessarily be interpreted to mean that CPCCO members were without access to key services.

Table 0-10—Time and Distance Results by Provider Type—Rural

CCO	PCP	PCD	MHP	SUD Provider	OB/ GYN	OPT	DME	HOSP	Rx	SNF
AH	100%	100%	100%	100%	100%	100%	**90.8 %**	100%	**94.3 %**	**94.5 %**
AllCare	100%	98.5%	100%	100%	100%	100%	**92.9 %**	100%	100%	**81.3 %**
CHA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CPCCO	100%	100%	100%	100%	100%	100%	100%	100%	100%	**93.9 %**
EOCCO	99.8%	99.6%	99.5%	98.5%	96.5%	98.6%	**89.5 %**	98.5%	99.5%	**75.0 %**
Health Share	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
IHN	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
JCC	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-CG	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-CO	99.9%	99.9%	100%	>99.9 %	>99.9 %	100%	99.9%	98.7%	100%	99.2%
PCS-Lane	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-MP	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-N	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-S	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
UHA	100%	100%	100%	>99.9 %	>99.9 %	>99.9 %	>99.9 %	>99.9 %	99.8%	>99.9 %

CCO	PCP	PCD	MHP	SUD Provider	OB/ GYN	OPT	DME	HOSP	Rx	SNF
YCCO	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Note: Results shown in red font indicate that less than 95 percent of members had access to the provider type within the time and distance standard.

All CCO service areas include at least some rural settings. The CCOs met the rural time and distance access standards for the listed provider types with the exceptions of AH (i.e., DME, Rx, and SNF), AllCare (i.e., DME and SNF), CPCCO (i.e., SNF), and EOCCO (i.e., DME and SNF). These results are representative of the often constrained pool of facilities available for contracting in rural areas; however, each CCO with noncompliant access rates had one or more facilities that were far enough below standards to merit further review or follow-up from OHA.

DSN Provider Capacity Report Findings

DSN Provider Capacity Reporting results are based on the Q1 2023 Quarterly DSN Provider Capacity Analysis conducted and reported by OHA. This section highlights key findings from OHA's analyses; a summary of CCO-specific results is available in the appendices.

Quality of Provider Network Data

The ability of the CCOs to collect, integrate, and report high quality provider data is critical to the ongoing monitoring and assessment of network adequacy. The completeness, accuracy, and timeliness of CCO provider data is also important in determining the utility of the CCOs' provider directories. Drawing upon the quarterly *DSN Provider Capacity Reports* submitted by the CCOs, OHA evaluated incoming provider data files based on the percentage of data entry fields that demonstrated whether:

1. A data value was present.
2. If present, the data were populated according to the requirements of that field.
3. If complete, the data were submitted in the required format.

Table 0-11 displays the percentage of provider directory-focused data elements present in provider capacity data files by CCO. Results showing less than 95 percent of data values present are shaded red, and results showing less than 99 percent but more than 95 percent are shaded yellow.

Table 0-11—Percentage of Key Provider Directory Data Elements Present in CCO Individual Practitioner Data

CCO	Practitioner Name	Business Name	Address	Phone Number	Taxonomy	New Patient Indicator	PCP Indicator
AH	100%	100%	NA	100%	100%	100%	100%
AllCare	100%	100%	NA	100%	100%	100%	100%
CHA	100%	100%	NA	100%	100%	100%	100%
CPCCO	100%	100%	NA	100%	100%	98.2%	100%
EOCCO	100%	100%	NA	100%	100%	100%	100%
Health Share	100%	99.9%	NA	100%	100%	100%	100%
IHN	100%	98.7%	NA	100%	100%	99.8%	100%

CCO	Practitioner Name	Business Name	Address	Phone Number	Taxonomy	New Patient Indicator	PCP Indicator
JCC	100%	100%	NA	100%	100%	99.0%	100%
PCS-CO	100%	98.7%	NA	100%	100%	100%	100%
PCS-CG	100%	98.7%	NA	100%	100%	100%	100%
PCS-Lane	100%	98.7%	NA	100%	100%	100%	100%
PCS-MP	100%	98.8%	NA	100%	100%	100%	100%
TCHP-N	100%	100%	NA	100%	100%	100%	100%
TCHP-S	100%	100%	NA	100%	100%	100%	100%
UHA	100%	100%	NA	100%	100%	100%	100%
YCCO	100%	100%	NA	99.4%	100%	100%	100%

Table 0-12 displays the percentage of network adequacy-focused data elements present in provider capacity data files by CCO, not reported in Table 0-11, per CCO. Results showing less than 95 percent of data values present are shaded red, while results showing less than 99 percent but more than 95 percent are shaded yellow.

Table 0-12—Percentage of Key Network Adequacy Data Elements Present in CCO Individual Practitioner Data

CCO	NPI	DMAP ID	Service Area	Participation Status	PCP Capacity	PCP Assignment
AH	100%	100%	100%	100%	100%	100%
AllCare	100%	100%	100%	100%	100%	100%
CHA	100%	100%	100%	100%	100%	100%
CPCCO	100%	100%	100%	100%	100%	100%
EOCCO	100%	100%	100%	100%	100%	100%
Health Share	100%	99.8%	100%	100%	100%	100%
IHN	100%	96.4%	100%	100%	100%	100%
JCC	100%	100%	100%	100%	100%	100%
PCS-CO	100%	99.4%	100%	100%	100%	100%
PCS-CG	100%	99.4%	100%	100%	100%	100%
PCS-Lane	100%	99.4%	100%	100%	100%	100%
PCS-MP	100%	99.4%	100%	100%	100%	100%

CCO	NPI	DMAP ID	Service Area	Participation Status	PCP Capacity	PCP Assignment
TCHP-N	100%	98.4%	100%	100%	100%	100%
TCHP-S	100%	99.2%	100%	100%	100%	100%
UHA	100%	100%	100%	100%	100%	100%
YCCO	99.1%	95.6%	100%	100%	100%	100%

As shown in Table 0-11 and Table 0-12, the percentage of key data fields present across all CCOs was high, with only a few CCOs reporting percent present results between 95 percent and 99 percent. Overall, the percentage of key data fields that were present, complete, and reported in valid formats was greater than 99 percent, indicating substantial improvement in the completeness of quarterly provider data submitted to OHA. Aggregate CCO performance showed 99.7 percent of data elements were present, 99.8 percent were populated in alignment with requirements, and 99.9 percent were in the expected format. HSAG aggregated and summarized individual CCO performance findings on the quality of CCO data based on a review of key data elements using the criteria above to assess whether data values were present, populated according to requirements, and in the required format for key provider directory data elements across all CCOs.

Table 0-13 displays the overall level of confidence in the quality of each CCO's provider network data by file and data element type. A *High* level of confidence reflects CCO performance where all data quality metric results (i.e., percent present, percent complete, and percent reported in valid formats) were 99 percent or higher. A *Moderate* level of confidence reflects CCO performance with at least one quality metric less than 99 percent, but all results greater than or equal to 95 percent, and are shaded yellow. A *Low* level of confidence was assigned if one or more data quality metric fell below 95 percent, and are shaded red.

Table 0-13—Overall Level of Confidence in Key Data Elements by File and Data Element Type by CCO

CCO	Data Quality Confidence Level			
	Individual		Facility	
	Directory	Network Adequacy	Directory	Network Adequacy
AH	High	High	High	High
AllCare	High	High	High	High
CHA	High	High	High	High
CPCCO	Moderate	Moderate	High	High

CCO	Data Quality Confidence Level			
	Individual		Facility	
	Directory	Network Adequacy	Directory	Network Adequacy
EOCCO	High	High	High	High
Health Share	High	Low	High	Low
IHN	Moderate	Moderate	High	Low
JCC	High	Low	High	High
PCS-CG	Moderate	Moderate	High	Moderate
PCS-CO	Moderate	Moderate	High	Moderate
PCS-Lane	Moderate	Moderate	High	Moderate
PCS-MP	Moderate	Moderate	High	Moderate
TCHP-N	High	Moderate	High	Moderate
TCHP-S	High	High	High	Moderate
UHA	High	High	Moderate	Low
YCCO	High	Moderate	High	Moderate

In general, data quality results for provider directory-related data elements were higher among the CCOs than the results for network adequacy-related data elements, with all but one CCO (i.e., UHA) exhibiting a *High* level of confidence (i.e., 99 percent or better) in their facility-based data elements. For individual files, the CCOs generally exhibited a *High* level of confidence in the quality of provider directory-related data elements with only six CCOs exhibiting a *Moderate* level of confidence. Data quality performance related to network adequacy-related variables was substantially lower, with only six CCOs exhibiting a *High* level of confidence in these data elements. Four CCOs exhibited a *Low* level of confidence (i.e., less than 95 percent) in one or more data elements across the individual practitioner and facility data files. Most often, lower levels of confidence were related to the following data elements (in descending order of frequency): DMAP ID, NPI, business name, new patient indicator, and taxonomy. This represented a substantial general improvement over prior reporting years and is due to the collaborative process of reporting and TA between OHA and the CCOs via quarterly DSN reporting and error log feedback. Provider address information compliance, while a key data element in CCO provider directory data sets, was not assessed by OHA in a data quality context in 2023. CCOs and OHA should continue to coordinate to improve and maintain data reporting compliance.

Provider Availability and Accessibility

OHA assessed the availability of CCOs network providers by assessing the percentage of PCPs, PCDs, MHPs, and SUD providers who were active, accepting new patients, and located within a CCO service area. These service categories were selected as key measures of the adequacy of accessibility to front-line medical services, which serve the widest array of needs and act as intake points and facilitators to more specialized care. Additionally, for PCPs, OHA also evaluated the percentage of a PCP's total capacity available for assignment as of Q1 2023. Table 0-14 through Table 0-17 display the overall percentage of providers who speak a prevalent non-English language in Oregon. While CCOs are required to provide qualified health care interpreter services (typically via subcontractor), assessing the number of providers within a network who speak a non-English language contributes to an understanding of how each CCO evaluates and adjusts its ability to provide services in a linguistically accessible and culturally responsive manner.

Table 0-14 shows the unweighted results for PCPs stratified by CCO.

Table 0-14—Availability and Accessibility of PCPs by CCO

CCO	Count	Availability				Accessibility
		Active (%)	Within Service Area (%)	Accepting New Patients (%)	PCP Capacity (%)	Prevalent Non-English Speaking (%)
AH	89	96.6%	100%	100%	53.9%	5.6%
AllCare	353	96.9%	98.9%	39.4%	90.9%	9.9%
CHA	92	98.9%	100%	75.0%	100%	21.7%
CPCCO	1,703	98.4%	7.6%	60.5%	98.0%	16.7%
EOCCO	1,475	95.7%	18.3%	80.6%	47.0%	1.2%
Health Share	2,096	97.9%	84.3%	71.0%	81.1%	11.8%
IHN	290	99.0%	78.6%	97.9%	0.0%	3.4%
JCC	1,733	98.4%	10.9%	63.8%	92.8%	17.0%
PCS-CO	248	100%	97.2%	75.8%	80.7%	12.9%
PCS-CG	90	98.9%	93.3%	90.0%	86.7%	26.7%
PCS-Lane	402	98.5%	98.5%	51.5%	77.4%	14.9%
PCS-MP	342	99.4%	98.5%	62.9%	76.3%	14.9%
TCHP-N	619	93.1%	91.9%	100%	98.1%	14.5%

CCO	Count	Availability				Accessibility
		Active (%)	Within Service Area (%)	Accepting New Patients (%)	PCP Capacity (%)	Prevalent Non-English Speaking (%)
TCHP-S	500	96.2%	55.2%	100%	99.0%	12.2%
UHA	150	96.7%	54.0%	35.3%	56.7%	12.0%
YCCO	785	98.9%	100%	63.7%	83.2%	8.7%

In general, OHA determined that a relatively high percentage of contracted PCPs were active during the review period for all CCOs, with TCHP-N having the lowest percentage of active PCPs (i.e., 93.1 percent). Most CCOs had a high percentage (i.e., 90 percent or more) of PCPs operating within their service area. Some CCOs had a low percentage (54.0 percent to 84.3 percent) of PCPs operating within their service area, which could be due to reporting errors or issues with global provider reporting (e.g., TCHP-S). Several CCOs reported exceptionally low percentages of PCPs operating within their service areas, including CPCCO (7.6 percent), EOCCO (18.3 percent), and JCC (10.9 percent), which are very likely due to reporting errors or global reporting of non-OHP networks.[3-3] CPCCO and JCC have historically reported low percentages of providers operating within their service areas and have not responded to or addressed continued deficiencies related to these potential issues within their network reporting.

In general, the percentage of PCPs accepting new patients continued to vary markedly between CCOs, with overall rates ranging from 35.3 percent (i.e., UHA) to 100 percent (i.e., AH, TCHP-N, and TCHP-S). Only five of the 16 CCOs reported rates greater than or equal to 90 percent (i.e., AH, IHN, PCS-CG TCHP-N, and TCHP-S), while seven of the CCOs' rates indicated that less than 66 percent (or two-thirds) of its PCPs were accepting new patients, suggesting potential access issues. Some CCOs reported unusually high percentages (i.e., 100 percent or almost 100 percent) of PCPs accepting new patients, unusually low percentages (i.e., 0.0 percent) of PCP capacity, or vice-versa, likely representing data errors. These results indicate room for improvement in reporting accuracy from the CCOs.

Most CCOs showed that 10 percent or more of PCPs spoke a prevalent non-English language, with five CCOs showing less than 10 percent of PCPs speaking a prevalent non-English language.

[3-3] During the 2023 compliance monitoring review activity, HSAG found that several CCOs' provider directories, particularly EOCCO, included large numbers of non-OHP providers in distant locations (i.e., Hawaii, Montana, Alaska, and other states).

AH, EOCCO, and IHN showed particularly low percentages (i.e., 5.6 percent, 1.2 percent, and 3.4 percent, respectively), suggesting either a reporting issue or a potential accessibility gap.

Table 0-15 shows the unweighted results for PCDs stratified by CCO.

Table 0-15—Availability and Acceptability of PCDs by CCO

CCO	Count	Availability			Accessibility
		Active (%)	Within Service Area (%)	Accepting New Patients (%)	Prevalent Non-English Speaking (%)
AH	23	95.7%	82.6%	100%	NA
AllCare	36	100%	100%	100%	30.6%
CHA	28	92.9%	64.3%	78.6%	10.7%
CPCCO	181	98.9%	13.3%	0.0%	19.3%
EOCCO	145	95.2%	78.6%	85.5%	13.1%
Health Share	504	95.0%	95.6%	73.2%	26.8%
IHN	139	81.3%	77.7%	90.6%	15.1%
JCC	76	98.7%	69.7%	0.0%	26.3%
PCS-CO	296	97.0%	23.6%	72.0%	19.9%
PCS-CG	296	97.0%	6.8%	72.0%	19.9%
PCS-Lane	296	97.0%	27.7%	72.0%	19.9%
PCS-MP	296	97.0%	36.5%	72.0%	19.9%
TCHP-N	365	92.9%	97.5%	62.7%	39.5%
TCHP-S	116	97.4%	67.2%	70.7%	26.7%
UHA	29	100%	96.6%	96.6%	NA
YCCO	54	100%	40.7%	94.4%	20.4%

Note: Results given as "NA" indicate that no contracted PCDs were reported by the CCO as speaking a prevalent non-English language.

Most CCOs contract with former DCOs to provide or supplement CCO-provided direct dental services and manage PCD networks. Additionally, most dental subcontractors operate practices or contract with individual PCDs statewide. These factors make it difficult to assess PCD availability and accessibility on a CCO-by-CCO basis. However, some trends and outliers are

apparent, including generally high percentages of active PCDs, PCDs accepting new patients, and PCDs speaking a prevalent non-English language where data were available. However, six CCOs reported less than 50 percent of PCDs operating within their service area, suggesting a potential access issue. CPCCO and JCC both indicated that no PCDs were accepting new patients, likely indicating a reporting or data issue.

Table 0-16 shows the unweighted results for MHPs stratified by CCO.

Table 0-16—Availability and Accessibility of MHPs by CCO

CCO	Count	Availability			Accessibility
		Active (%)	Within Service Area (%)	Accepting New Patients (%)	Prevalent Non-English Speaking (%)
AH	179	89.4%	73.7%	100%	2.2%
AllCare	458	91.3%	96.9%	96.9%	2.8%
CHA	122	93.4%	91.0%	100%	9.0%
CPCCO	1,760	87.1%	10.2%	0.1%	3.5%
EOCCO	1,025	77.8%	40.6%	0.0%	0.1%
Health Share	1,735	90.8%	77.9%	11.0%	4.2%
IHN	1,038	79.7%	39.5%	98.5%	0.2%
JCC	1,920	87.7%	18.5%	0.1%	2.8%
PCS-CO	3,374	92.3%	18.8%	89.4%	4.1%
PCS-CG	3,373	92.3%	32.7%	89.4%	4.1%
PCS-Lane	3,373	92.3%	34.2%	89.4%	4.1%
PCS-MP	3,376	92.3%	16.9%	89.4%	4.1%
TCHP-N	1,625	83.1%	94.3%	100%	2.7%
TCHP-S	1,583	80.3%	70.3%	100%	2.8%
UHA	128	90.6%	89.8%	93.0%	1.6%
YCCO	1,381	86.1%	100%	98.3%	1.7%

Overall, OHA found that relatively high percentages of MHPs were active within the network. Across all CCOs, very few MHPs spoke prevalent non-English languages, with CHA demonstrating the highest at 9.0 percent and no other CCO reporting higher than 4.2 percent. This consistently low percentage across the CCOs points to a likely statewide language accessibility barrier for MH services. CCOs generally showed either very high (i.e., 90 to 100 percent) or very low (i.e., 10 to 40 percent) percentages of MHPs operating within their service area, suggesting data quality issues for most CCOs or heavy reliance on out-of-network and telehealth MHPs. While most CCOs indicated that a high percentage (i.e., 89 percent or higher) of MHPs were accepting new patients, three CCOs (i.e., CPCCO, EOCCO, and JCC) reported that 0.0 to 0.1 percent of MHPs were accepting new patients, and one CCO (i.e., Health Share) reported that only 11 percent of

MHPs were accepting new patients. Although these results are likely due to data errors, they are part of a consistent pattern of potential data errors associated with MHP and SUD provider types.

Table 0-17 shows the unweighted results for SUD providers stratified by CCO.

Table 0-17—Availability and Accessibility of SUD Providers by CCO

CCO	Count	Availability			Accessibility
		Active (%)	Within Service Area (%)	Accepting New Patients (%)	Prevalent Non-English Speaking (%)
AH	56	91.1%	48.2%	100%	NA
AllCare	144	88.2%	86.8%	97.2%	1.4%
CHA	69	84.1%	52.2%	100%	2.9%
CPCCO	528	85.0%	9.3%	0.4%	3.4%
EOCCO	292	78.4%	43.2%	0.0%	NA
Health Share	583	87.8%	71.5%	3.4%	4.5%
IHN	411	78.3%	36.0%	99.3%	NA
JCC	536	88.4%	20.7%	0.4%	3.2%
PCS-CO	552	85.9%	14.9%	97.3%	3.4%
PCS-CG	552	85.9%	1.1%	97.3%	3.4%
PCS-Lane	552	85.9%	38.8%	97.3%	3.4%
PCS-MP	552	85.9%	25.9%	97.3%	3.4%
TCHP-N	293	74.1%	91.8%	100%	2.4%
TCHP-S	414	71.3%	52.4%	100%	0.2%
UHA	96	55.2%	42.7%	100%	NA
YCCO	336	89.0%	100%	100%	0.3%

Note: Results given as “NA” indicate that no contracted SUD providers were reported by the CCO as speaking a prevalent non-English language.

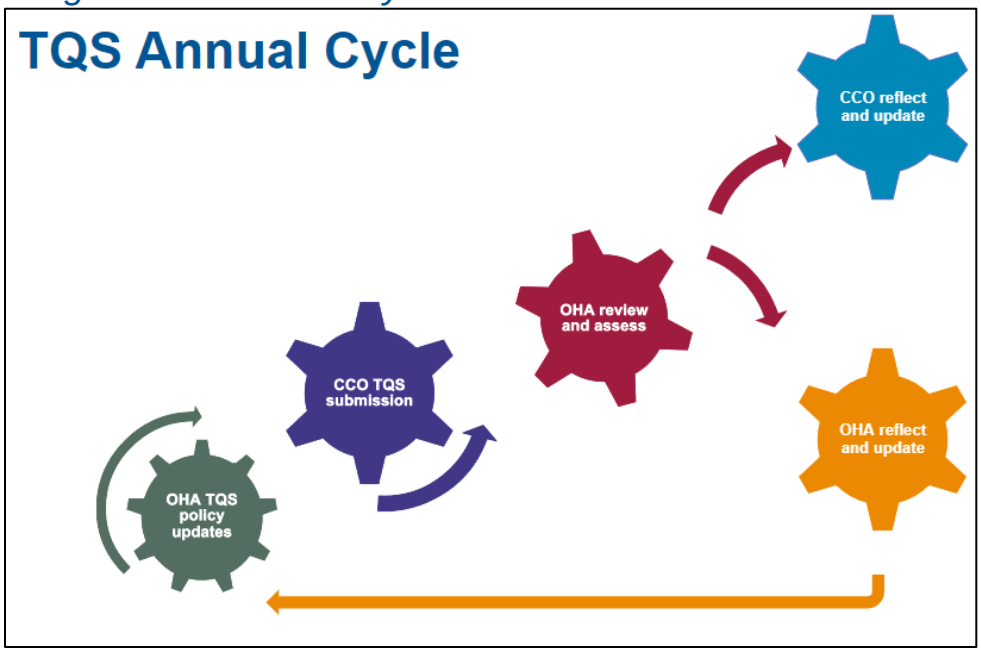
Overall, OHA determined that moderate percentages of SUD providers were active within the network, with no CCO having more than 91.1 percent of SUD providers active and most showing 84.1 percent to 89.0 percent active. This was the lowest percentage of active providers for any

reviewed provider type, and could indicate a potential availability barrier, high provider churn, or other challenges. Across all CCOs, very few SUDs spoke prevalent non-English languages (where reported), with Health Share demonstrating the highest at 4.5 percent and no other CCO reporting higher than 3.4 percent. This consistently low percentage across the CCOs points to a likely statewide language accessibility barrier for SUD services. CCOs generally showed a range of low percentages of SUD providers operating within their service area, suggesting either data quality issues or substantial network adequacy concerns. While most CCOs indicated that a high percentage (i.e., 97 percent or higher) of SUD providers were accepting new patients, three CCOs (i.e., CPCCO, EOCCO, and JCC) reported that 0.0 percent to 0.4 percent of SUD providers were accepting new patients, and one CCO (i.e., Health Share) reported that only 3.4 percent of SUD providers were accepting new patients. Although these results are likely due to data errors, they are part of a consistent pattern of potential data errors associated with MHP and SUD provider types.

D. Quality of care (ANNUAL)

Transformation Quality Strategy (TQS)

Annually, CCOs receive TQS guidance from OHA which includes: a 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, changes to move and incorporates edits as a result of the TQS assessment from the prior year. For example, in 2023, a policy change requiring CCOs to submit REAL-D was made. For the March 2023 submission, REAL-D was required for all components across TQS. The update was made to further align quality, health equity and move CCOs towards the OHA strategic goal of eliminating health inequities by 2030.



TQS 2023 Assessment Review Timeline

- October: Guidance documents posted, including scoring criteria
- October–March: Technical assistance webinars and office hours
- March: CCOs submitted TQS to OHA
- April-May: OHA SME review
- June: Individual CCO scores and written assessment shared with CCO
- June-July: Individual CCO assessment calls *required for all CCOs
- 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).

2023 TQS scoring results summary

- Range (out of 117 points possible) = 88–114 = 75.2–97.4%
  - Average = 105.5 points = 90.1%
- Prior year (2022) range = 51–91.7% (average 83.5%)
- Average CCO score increased 6.6 percentage points, even with added REALD requirement
  - 12 CCOs improved.

- In 2023, 84.5% of projects earned full points for relevance (compared to 64.8% in 2022, excluding access components which were dropped in 2023).

Projects statistics

# of projects

- Range = 8–15
- Average = 10.8

% projects continued

- Range = 42%–100% of projects continued from prior year
- Average = 84% of projects continued from prior year
    - Six CCOs continued 100% of projects

Figure 7: CCO score by TQS component

	Advanced Health	AllCare	CHA	CPCCO	EOCCO	Health Share	IHN	JCC	PS-Central	PS-Gorge	PS-Lane	PS-M/P	Trillium-North	Trillium-Southest	Umpqua	Yamhil	Avg CCO score
BHI	8	8	8	7	8	8	9	8	9	9	9	9	9	9	8.5	9	8.47
CLAS Standards	5	8	3	8	8.5	6	4	9	9	9	9	9	9	9	6	9	7.53
Grievances and Appeals	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9.00
Health Equity: Cultural Respons	6	9	6	8	9	9	6	9	9	9	9	9	8	8	5	9	8.00
Health Equity: Data	8	7.5	9	9	9	9	6	9	9	9	9	9	7.5	7.5	9	9	8.47
OHI	8	8	7	9	9	9	4	9	9	9	9	9	8	8	9	7	8.19
PCPCH Enrollment	9	9	8	9	9	9	9	9	9	9	9	9	9	9	9	9	8.94
PCPCH Tiers	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9.00
SPMI	9	9	8	9	9	7	8	7	9	9	9	9	9	9	9	9	8.63
SDOH-E	5	9	8	9	8	9	5	8	9	9	9	9	7	9	9	8	8.13
SHCN FBDE	7	6	8	9	8	8	6	5	8	8	8	7	6	6	8	0	6.75
SHCN Non-duals	6	7	7	8	8	5	5	7	7	7	7	7	6	6	7	6	6.63
Utilization Review	7	6.3	6.5	7	8.7	9	8	7.3	9	9	9	9	8	8	9	3.3	7.76
TOTAL SCORE	96	104.8	96.5	110	112.2	106	88	105.3	114	114	114	113	104.5	106.5	106.5	96.3	105.48
Percent of total possible	82.1%	89.6%	82.5%	94.0%	95.9%	90.6%	75.2%	90.0%	97.4%	97.4%	97.4%	96.6%	89.3%	91.0%	91.0%	82.3%	90.1%
Prior year %	72.9%	76.7%	89.2%	83.3%	70.9%	84.4%	81.9%	91.0%	91.7%	91.7%	91.7%	91.7%	88.2%	88.9%	51.0%	91.5%	83.5%

REALD and SOGI data deep dive

This was the first year CCOs were asked to use REALD data to identify and address disparities for any projects that use member-level data. CCOs were also asked to provide at least a plan for doing the same with SOGI data. The following data is for 239 project reviews (a project could include multiple reviews, depending on the number of components attached):

- 166 (69%) appeared to meet REALD and SOGI requirements
- Of the 73 (31%) that did not, reviewers noted the following:
    - 29 (12%) – CCO included analysis of REALD data, but did not use it to inform intervention or did not include tracking by REALD in monitoring activities
    - 22 (9%) – deeper dive or more detail needed; for example, project addressed language but not race, ethnicity or disability
    - 14 (6%) – missing plan for using SOGI data

  - 12 (5%) – no use of REALD or SOGI data
  - 4 (2%) – region-specific data or analysis needed
- Every CCO had some projects that fully met REALD and SOGI requirements, indicating CCOs have internal capacity for doing this work.
- Every CCO had some projects that needed REALD or SOGI improvements, indicating opportunities for technical assistance and opportunities within CCOs to share across their internal project teams.

Statewide Performance Improvement Project (PIP)

In the time period for this annual report, CCOs undertook two distinct areas for statewide PIPs: 1) integration statewide PIP and 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.

Mental Health Service Access Monitoring

In October 2022, CCOs submitted through external quality review (EQR) for the integration statewide PIP annual validation. 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.

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

Measurement:
Percentage of Members with a Mental Health Service Need Who Received Mental Health Services

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

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

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

- Receipt of any psychotropic medication listed in the Psychotropic-National Drug Code (NDC) code set.

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

Measurement Periods:

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

Baseline Reporting

CCO	Numerator	Denominator	Rate
Advanced Health	5,300	9,592	55.3%
AllCare Health	8,162	16,530	49.4%
Cascade Health Alliance	4,556	7,642	59.6%
Columbia Pacific CCO	5,855	10,672	54.9%
Eastern Oregon CCO	12,272	20,963	58.5%
Health Share of Oregon	78,806	136,599	57.7%
Intercommunity Health Network	14,118	24,527	57.6%
Jackson Care Connect	11,817	20,088	58.8%

PacificSource Community Solutions–Central Oregon	16,040	25,312	63.4%
PacificSource Community Solutions–Columbia Gorge	2,476	4,442	55.7%
PacificSource Community Solutions–Lane	18,815	29,183	64.5%
PacificSource Community Solutions–Marion	22,699	39,155	57.97%
Trillium Community Health Plan	1,138	1,863	61.1%
Trillium Community Health Plan	6,880	11,672	58.9%
Umpqua Health Alliance	7,638	12,689	60.2%
Yamhill Community Care	6,189	10,610	58.3%

Organization			
TOTAL-Statewide	222,761	381,539	58.4%

Interventions

Interventions across CCOs varied from workforce capacity, workforce training, to development of data exchange processes to increase data accuracy. Several CCOs increased funding and/or increased outreach and engagement to expand access for members. Many expanded telehealth providers and/or utilization of telehealth amongst existing provider networks. Additionally, OHA worked to expand BH workforce through several policy levers including loan repayment and qualified direct payment (QDP) initiatives to support improvement in network adequacy.

Initiation Engagement and Treatment (IET)

In April 2021, CMS approved Oregon's SUD 1115 waiver with the inclusion of a SUD statewide PIP. The SUD statewide PIP topic design work began in March 2022 through July 2022. Access to care for OUD/SUD services and Initiation, Engagement, and Treatment (IET) was selected as the SUD statewide PIP topic.

Measurement:
OHA will be aligned with the NCQA HEDIS measurement year (MY) 2022 specifications for the *IET* measure indicators to support performance and quality improvement efforts with CMS Medicaid Adult Core set.

Indicator 1	**The percentage of newly identified SUD episodes that were followed by treatment initiation within 14 days**
Numerator Description	Total number of newly identified SUD episodes that were followed by treatment initiation within 14 days
Denominator Description	Total number of newly identified SUD episodes in the 12-month intake period that meet the population eligibility criteria
Indicator 2	**The percentage of newly identified SUD episodes that were followed by treatment engagement within 34 days after treatment initiation**
Numerator Description	Total number of newly identified SUD episodes that were followed by treatment engagement within 34 days after treatment initiation
Denominator Description	Total number of newly identified SUD episodes in the 12-month intake period that meet the population eligibility criteria

Measurement Periods:

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

Extracted from External Quality Review (EQR) validation report:

12 of the 16 CCOs received *Met* scores for 100 percent of the evaluation elements in the PIP validation tool and an overall *Met* validation status. The remaining four CCOs (AllCare, EOCCO, IHN, and YCCO) received a *Partially Met* validation status, with the percentage of evaluation elements receiving a *Met* score ranging from 71 percent to 86 percent. Among the four PIPs that received a *Partially Met* validation status, common opportunities for improvement were identified in Step 7: Data Analysis and Interpretation of Results. For each of the four PIPs receiving a *Partially Met* validation status, the CCO reported baseline indicator results that differed from the final, corrected baseline indicator data that OHA provided to the CCOs and OHA. The CCOs will have an opportunity to correct the baseline indicator results for the next annual PIP validation.

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

E. Complaints, grievances, and hearings

1. CCO and FFS complaints and grievances

Provided in the chart below is a compilation of data showing the number of OHP member grievances from October 1, 2022 to September 30, 2023. These numbers were sourced through fee-for-service (FFS) data and via 16 CCOs.

Trends

	Oct – Dec 2022	Jan – Mar 2023	Apr – Jun 2023	Jul -Sep 2023
Total complaints received	4,402	5,103	4,563	4,970
Total average enrollment	1,533,995	1,537,181	1,621,449	1,664,830

Rate per 1,000 members	2.87	3.32	2.81	2.99

Barriers

The rise in complaints that CCOs reported from October 1, 2022 to September 30, 2023, indicates that grievance levels are returning to a more steady rate from lower numbers during the Public Health Emergency. There is a 7.26% increase from the last reporting period.

The Access to Care category continues to have the highest number of complaints with a 4.31% increase from the previous annual reporting period. The Interaction with Provider or Plan category increased 17.13%, compared to the previous annual reporting period. Quality of Care continues to be the third highest category of complaints, but had a .4% decrease from the previous annual reporting period. For FFS, data shows the highest number of complaints remains in the Quality of Care category; billing issues are the next highest category.

Interventions

CCOs: CCOs reported that the highest numbers of complaints are with non-emergency medica transportation (NEMT). CCOs relayed they are working closely with their NEMT providers and meeting with them on a regular basis to improve services. Some CCOs have taken direct action to improve NEMT, including:

- Implementing new ride software
- changing NEMT providers and
- reporting driver shortages

CCOs also worked on interventions related to dental care. Solutions included:

- working directly with dental offices to help resolve scheduling and communication issues to improve services.
- promoting Tele-Dentistry to improve availability of services
- establishing committees and taskforces to address provider capacity within their networks.
- using committees to focus on improving the member experience

FFS: During this annual reporting period, there were 571 complaints from members with FFS coverage. This represents a 27.81% decrease from the previous reporting period. From July –

September 2023, 345 calls were received from members enrolled in CCOs and referred to the appropriate CCO. There were also 7,417 informational calls received for the July – September 2023 quarter, where people were asking for information about member coverage, CCO enrollment, and accessing ID cards.

Statewide complaints totals – Oct. 2022 – Sept. 2023

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

Complaint category	Oct – Dec 2022	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023
Access to care	1,676	1,894	1,588	1,687
Client billing issues	392	435	397	457
Consumer rights	314	376	419	399
Interaction with provider or plan	1,329	1,585	1,475	1,561
Quality of care	496	610	473	605
Quality of service	195	203	211	261
Other	0	0	0	0
Grand Total	4,402	5,103	4,563	4,970

Related data

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

Notices of Adverse Benefit Determinations (NOABD)

The following table lists the total number of NOABDs issued by CCOs between October 1, 2022 through September 30, 2023. The NOABDs are listed by reason, per 42 CFR 438.400(b) (1-7) and are the total number of NOABDs issued, regardless of whether or not an appeal was filed. Over the past four quarters, CCOs reported that categories with the highest number of NOABDs issued were pharmacy, dental, outpatient, specialty care and diagnostics. 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 plain language and with appropriate citations. CCOs report they are tracking for timeliness, as well as reviewing for utilization and appropriateness of care are processes to ensure NOABDs are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	Oct – Dec 2022	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023
a) Denial or limited authorization of a requested service.	25,077	58,595	32,277	29,722
b) Single PHP service area, denial to obtain services outside the PHP panel	709	1,455	1,028	1,157
c) Termination, suspension, or reduction of previously authorized covered services	79	136	67	61
d) Failure to act within the timeframes provided in § 438.408(b)	19	6	3	6
e) Failure to provide services in a timely manner, as defined by the State	60	60	99	144
f) Denial of payment, at the time of any action affecting the claim.	57,162	83,280	125,305	133,919
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	83,106	143,532	158,779	165,009
Number per 1000 members	66.00	107.8	117.7	117.9

CCO Appeals

The table below shows the number of appeals that CCOs received over the past four quarters.

CCO Appeals	Oct – Dec 2022	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023
a) Denial or limited authorization of a requested service.	1,016	1,045	Data unavailable	Data unavailable
b) Single PHP service area, denial to obtain services outside the PHP panel.	16	14	Data unavailable	Data unavailable
c) Termination, suspension, or reduction of previously authorized covered services.	0	0	Data unavailable	Data unavailable
d) Failure to act within the timeframes provided in § 438.408(b).	0	0	Data unavailable	Data unavailable
e) Failure to provide services in a timely manner, as defined by the State.	3	0	Data unavailable	Data unavailable
f) Denial of payment, at the time of any action affecting the claim.	396	243	Data unavailable	Data unavailable
g) Denial of a member's request to dispute a financial liability.	0	0	Data unavailable	Data unavailable
Total	1,431	1,302	Data unavailable	Data unavailable
Number per 1000 members	1.14	.98	Data unavailable	Data unavailable
Number overturned at plan level	471	602	Data unavailable	Data unavailable
Appeal decisions pending	5	19	Data unavailable	Data unavailable
Overturn rate at plan level	32.91%	46.24%	Data unavailable	Data unavailable

F. CCO activities

1. New plans

Oregon awarded 15 CCO contracts under a procurement conducted in 2019. Current CCOs are previously existing plans, and one expanded into two new service areas. CCOs began serving members under the terms of the new contract effective January 1, 2020.

One of the previously existing plans – Trillium Community Health Plan –serves Lane County and applied to expand into Clackamas, Multnomah, and Washington counties (the Tri-County). OHA

denied the request and gave Trillium until June 30, 2020 to demonstrate a sufficient provider network. OHA's denial informed that without further action, the Tri-County service area would be removed from Trillium's contract. On August 14, 2020, OHA approved Trillium's expansion into the Tri-County, effective September 1, 2020. This expansion was subject to a Corrective Action Plan (CAP) effective March 5, 2021; the CAP was closed on May 31, 2022.

In the spring of 2023, the state legislature extended existing CCO contracts by 2 years. The new end date for the contracts is December 31, 2026.

2. Provider networks

Nothing to report for this Demonstration Year.

3. Rate certifications

OHA has contracted with health entities, known as Coordinated Care Organizations or CCOs, to manage and deliver health care for most OHP members. OHA pays CCOs to cover these individuals with capitation rates, a predetermined payment that depends on the individual's OHP eligibility status and is paid to CCOs on a monthly basis, dependent on enrollment numbers.

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

Part of OHA's planning efforts around HRSN services implementation has included refining CCO contract language to allow non-risk payments and evaluating the changes needed for MMIS system design. A survey is in development to gather more information about fee schedules and cost data to inform the HRSN fee schedule.

To prepare for the CY24 Rate Development year, OHA provided CCOs with an annual rates package, which outlined the deadlines and data grouping process utilized by OHA and Mercer for categories of services. OHA also uploaded several items to assist CCOs in their data validation for CY22 activities.

CCOs then submitted their completed Exhibit L's to OHA to begin the CY2024 rate development and data validation process. OHA met with each CCO to discuss the validation process of financial data for CY2023 rates. The goal of these meetings was to cross-compare data and ensure there is a consensus. Discussions centered around encounter data validation and CY2022 financials.

OHA held follow-up meetings with CCOs in June and July 2023 to discuss CY2024 rate development progress, as well as the HRSN survey and templates, which were released in August 2023. CY2024 rates were delivered to CCOs in August 2023.

In September 2023, OHA met with CCOs in a rates workgroup to discuss a number of topics, including HRSN payment flows, administrative costs, capacity funding, Designate State Health Program Funds, contract amendments, and the HRSN climate and admin survey results.

OHA delivered the final CY23 CCO rate package to CMS, which included the Oregon CY23 rate certifications and contract rate sheets. OHA continues to monitor the COVID-19 pandemic closely and working with CCOs in a partnership in maintaining our healthcare system.

4. Enrollment/disenrollment

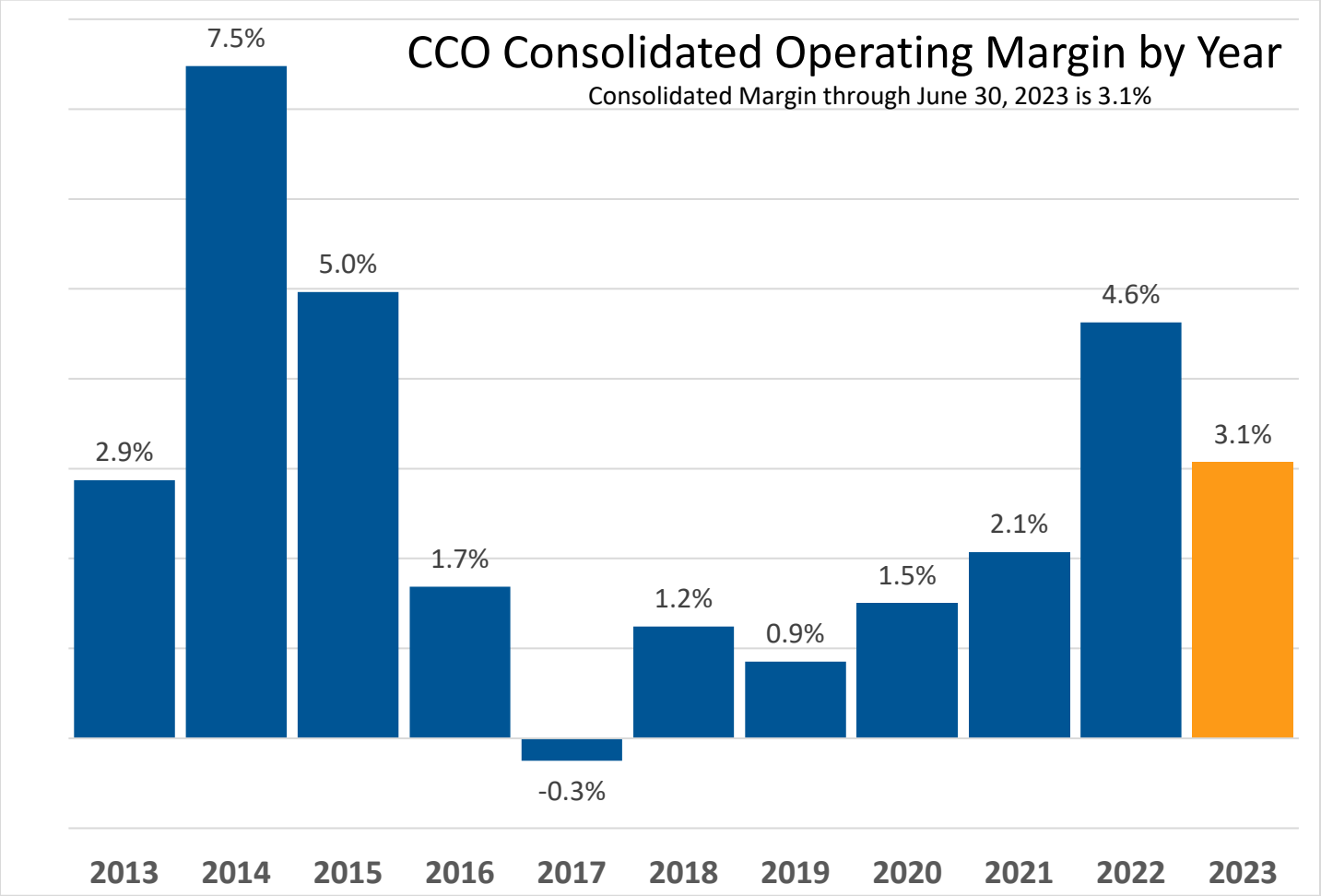
Enrollment highlights are noted throughout this report, particularly in section, "A. Enrollment progress."

5. Contract compliance

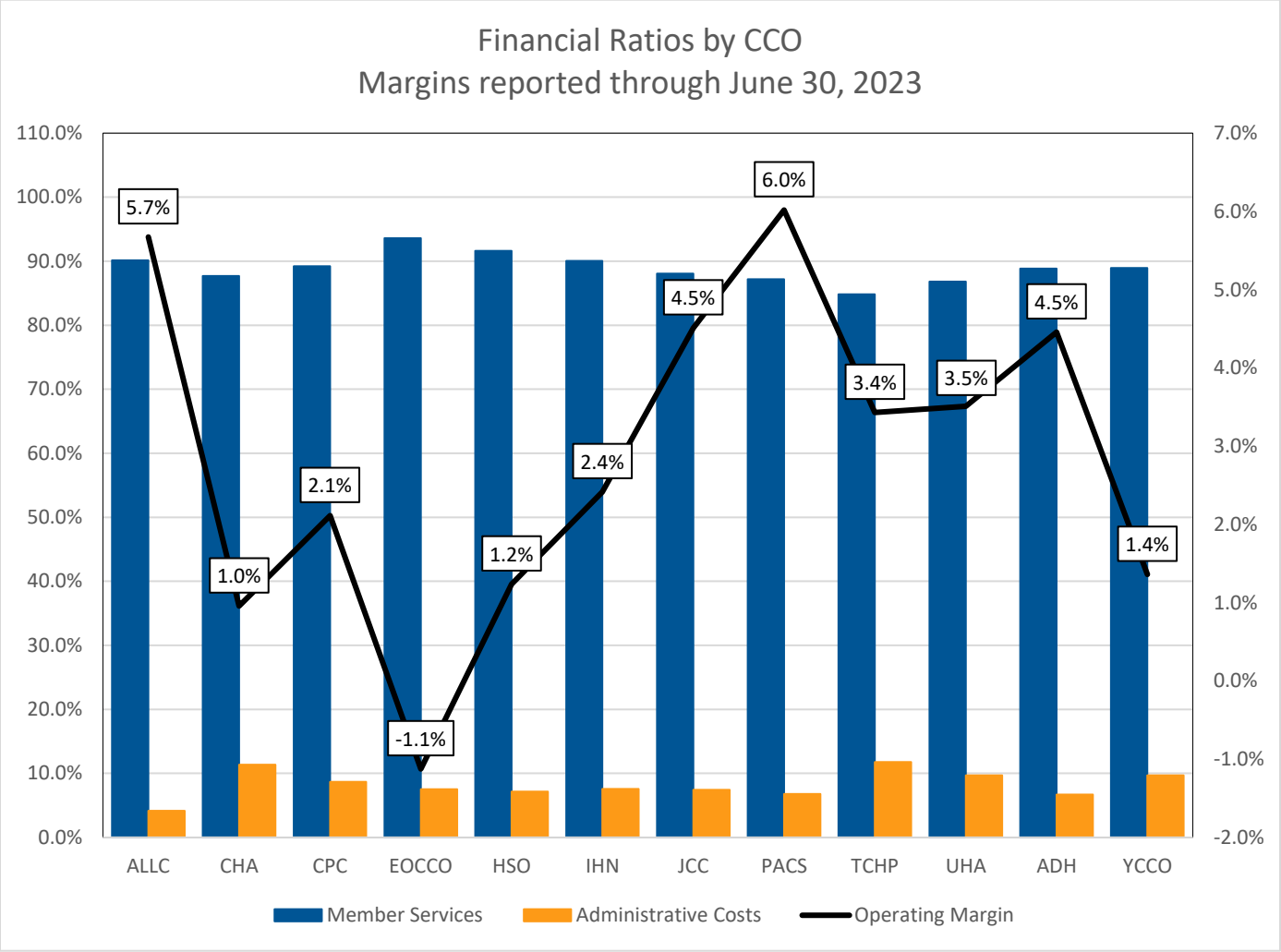
There are no issues with CCO contract compliance other than as described in the Corrective Action Plans section.

6. Relevant financial performance

In summarizing the financial results of our 16 CCO entities, there are a few items to highlight for this reporting period. CCOs achieved a statewide operating margin of 3.1%, or $119 million operating net income on $3.882 billion of operating revenue. In 2022, CCOs achieved the highest net operating margins for Oregon Medicaid since 2015. The 2022 statewide operating margin was 4.6%, or $328 million operating net income on $7.088 billion of operating revenue. CCOs in turn, reinvested $31 million of their Operating Net Income in their communities through the Supporting Health for All through Reinvestment (SHARE) Program.



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services that 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 the member services component has remained relatively consistent over the last two years. Through the first six months of 2023, spending on member services was at 89.5% and administrative costs were at 7.5%; this is in-line with the 2022 CCO-wide average, which was also 7.5%.



For the six months ending in June 30, 2023, a majority of the 16 CCOs met or exceeded the 85% target for MSR, a key indicator for the medical loss ratio (MLR). One CCO was below the 85% MSRs, and 4 of the CCOs had MSRs above 90%.

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

7. Corrective action plans

In Demonstration Year 21, the Oregon Health Authority held three Corrective Action Plans with three CCOs - Health Share of Oregon (HSO), Columbia Pacific CCO (CP CCO) and Jackson Care Connect CCO (JCC CCO).

The continuing CAP for the Health Share of Oregon (HSO) addressed noncompliance with a CCO contract and Oregon Administrative Rule. Specifically, the HSO did not provide reliable NEMT services to covered appointments, resulting in disruption to members' access to care. This CAP started on October 14, 2019, and ended on February 1, 2023.

On February 16, 2023, OHA initiated three new CAPs with the following entities: The HSO, Columbia Pacific CCO (CP CCO) and Jackson Care Connect CCOs did not require providers to use PA for intensive in-home behavioral health treatment (IIBHT) services and were consequently noncompliant with the CCO contract and Oregon Administrative Rule. The start date of the CAP was February 16, 2023, and the CAP will remain in effect until OHA determines it can be closed. The CCOs were asked to demonstrate that they have established a PA process for IIBHT services and provide evidence of compliant behavioral health policies and procedures, provider communications, and trainings regarding the process.

On March 3, 2023, the CCO appealed the Notice & Order by submitting a request for Administrative Review. After review, OHA decided that IIBHT services should not be subject to prior authorization, and enforcement of that requirement is therefore not warranted. On May 4, 2023, OHA provided notice to all CCOs and to providers of IIBHT services for fee-for-service members of the decision to remove this requirement from the 2024 CCO contracts and revise the applicable Oregon Administrative Rules. On May 10, 2023, the CAP was revoked.

8. One-percent withhold

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of April 2022 through March 2023.

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

G. Health Information Technology

OHA's health IT team spent October 2022 through September 2023 preparing for the 1115 waiver implementation, primarily around the closed loop requirement in the community information exchange (CIE).

CIE is used in all Oregon counties and sponsored by CCOs and health systems; however, Oregon's Medicaid FFS program has not participated. OHA engaged in various planning activities to prepare to request CMS Medicaid Enterprise Services funding and procuring CIE to support the FFS program to meet the closed loop referral requirements under the waiver. OHA has no plans to disrupt the current CIE environment and expects CCOs to use the tools they have invested in to meet their requirements under the waiver.

OHA engaged CCOs in various forums, including waiver specific forums and the Health IT Advisory Group, around requirements for closed loop referrals and CIE. CCOs provided feedback that informed the CMS waiver deliverables and 2024 CCO contract definitions and requirements.

Oregon Health Authority

OHA wrapped up a public CIE Workgroup of diverse partners under the Health IT Oversight Council (HITOC) to meet the requirements for HB 4150 (2022). The CIE Workgroup and HITOC provided recommendations on strategies to build on current CIE networks to accelerate, support, and improve secure, statewide CIE. Recommendations were informed by interviews and survey responses from 99 community-based organizations (CBOs). The recommendations were strongly aligned to move statewide CIE efforts forward in support of health equity and improved service coordination. The critical next steps to accomplish this are financial investment for participants, particularly CBOs, and statewide governance. The end product was an executive summary and a full report to the Oregon legislature, submitted in January 2023.

- Using the HB 4150 input, especially from CBOs, and engagements with CCOs, OHA developed a proposed phased-in approach to using CIE to meet the waiver closed loop requirements. CBOs have shared that adopting and using CIE takes significant time, training, and human resources. OHA understands that increase in use of technology like CIE for closed loop referrals should happen over the five-year waiver demonstration period and need to allow time and provide support for CBOs to participate especially those serving priority populations. Regardless of supports that may be provided, some may require or desire exceptions to participating in technology like CIE. Members will always have the right to not include their data in technology like CIE. Based on this, OHA has determined that:

    - Throughout 2024-2027, CCOs and OHA will provide support and incentives to CBOs to help with adoption and use of CIE including through grants, technical assistance, outreach, and forums for feedback.
    - For the first two years (2024-2025), CCOs and OHA will engage CBOs participating in HRSN to assess and incentivize CIE use, rather than making it a requirement.
    - Over the next two years (2026-2027), OHA expects that most referrals for HRSN services will be sent through CIE to CBOs participating as HRSN service providers. Exceptions may be made for CBOs that play a critical role in their communities including those serving priority populations.
    - Every year, CCOs will report on their plans and progress to support CBOs in their use of CIE. In addition, for years 2025-2027 CCOs will have a progressive measurement of CIE use that will focus on incentivizing equity and meeting OHP Member's needs.

H. Metrics development

Metrics Development

In alignment with the objectives of the waiver and OHA's goal of eliminating health inequities by 2030, the CCO Quality Incentive Program (QIP) is prioritizing upstream metrics that address social issues impacting health, such as access to healthy foods and safe, affordable housing. Development for two upstream metrics are summarized below.

1. **System-level social-emotional health measure: kindergarten readiness**

This metric focuses on identifying and connecting young children with social, emotional health needs to services. As of January 2022, this was included in the quality incentive measure set as an incentivized measure, as well as included in the challenge pool for 2022. Measure specifications and benchmarks can be found here. In 2023, this measure was still included in the quality incentive measure set, but it was removed from the challenge pool for 2023. The four components to this metric are:

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

Throughout 2022 and the beginning of 2023, the OHA Transformation Center facilitated a virtual learning collaborative to support the implementation of this measure. Materials from that learning collaborative can be found here.

In fall 2022, the OHA Transformation Center provided technical assistance to CCOs for implementing this measure. Links to slides and recordings from webinars can be found here.

Beginning in fall of 2023, the Transformation Center is contracted with OHSU-OPRN (Oregon Rural Practice-Based Research Network) to facilitate technical assistance and to support implementation of this measure with a focus on communication for parents and providers, understanding the system and making improvements and engaging new health partners within the health system. More details about that effort can be found here.

In 2025, the system-level social emotional health metric will be replaced by a child-level metric, which will measure incentivized improvements based on child-level receipt of clinically recommended behavioral health care services provided by CCO-contracted providers. OHA is partnering with the Oregon Pediatric Improvement Partnership (OPIP) to gather input from providers, CCOs and communities in 2024.

2. Social determinants of health: Social needs screening and referral

After a multi-year development strategy, the OHA Metrics and Scoring Committee voted in May 2022 to include this measure in the 2023 CCO incentive measure set. The goal is that CCO members will have their social needs acknowledged and addressed. CCOs began measure implementation in January 2023.

The measure has two components: Component 1 assesses CCO action plans to ensure social needs screening and referral is implemented in an equitable and trauma-informed manner. It also ensures that CCOs lay the groundwork for data sharing and reporting as required in Component 2. CCOs will complete a self-assessment that includes questions about social needs screening tools and methods, data collection mechanisms, trauma-informed practices, and protocols for referring CCO members to community resources.

For each measurement year, the CCO must answer all self-assessment questions and attest to having accomplished all "must-pass" elements required for that year. These elements assess how well CCOs identify and coordinate services for members with social needs in the domains of food insecurity, housing insecurity and transportation needs.

Component 2 is intended to measure the percentage of CCO members screened and, as appropriate, referred for services for three domains: (1) housing insecurity, (2) food insecurity, and (3) transportation needs. Reporting on Component 2 will begin in 2024 with benchmarks anticipated no earlier than 2025. Measure specifications can be found here.

Beginning in fall 2023, the OHA Transformation Center has partnered with OHSU's ORPRN to support CCOs and their partners to implement the social needs screening measure. More details about these efforts can be found here.

I. Budget neutrality

OHA is unable to report on the current waiver new Budget Neutrality Workbook template. The agency is working to have 1115 system configurations implemented by 1/1/24 to align with the current waiver reporting requirements; however, system configuration data is dependent on other system change requests including continuous eligibility (CE) indicators and may not be ready by 1/1/24. We hope to submit a report by February 2024 with available data retroactive to the beginning of the waiver.

J. Legislative activities

The Oregon Legislature convened on June 25, 2023, with the passage of the state budget and several bills that impact the Oregon Medicaid program. Funding for OHA's 2023 – 2025 budget

increased and the major health bills that passed, underscored that the agency and its programs will continue to be a focal point for legislators and the public throughout the next two years. A summary table below outlines key legislation. The full OHA end-of-session 2023 Legislative Report can be found here.

2023 Oregon Legislative Session Enrolled Bill Number	Bill Summary	OHA Division Implementation Lead	Impacts Related to the Medicaid Program and/or Medicaid Members
HB 2002 Enrolled	Modifies provisions relating to reproductive health rights. Modifies provisions relating to access to reproductive health care and gender-affirming treatment. Modifies provisions relating to protections for providers of and individuals receiving reproductive and gender-affirming health care services. Creates crime of interfering with a health care facility. Punishes by maximum of 364 days' imprisonment, $6,250 fine, or both. Creates right of action for person or health care provider aggrieved by interference with health care facility. Repeals criminal	Public Health Division	This bill expands access to reproductive health and gender-affirming care (GAC) and establishes protections for both those seeking and those providing care. Legislation establishes further protections for groups that have been economically and socially marginalized regarding reproductive health and gender-affirming care.

	provisions relating to concealing birth. Declares emergency, effective on passage.		
HB 2107 Enrolled	Extends automatic voter registration to Oregon Health Authority in certain circumstances.	Health Systems Division	Directs OHA to work with the Secretary of State to develop a secure record-sharing process for people who are on OHP and eligible, but not yet registered to vote in Oregon by June 1, 2026. If this process is eventually allowed by the Center for Medicare & Medicaid Services (CMS), it would increase the number of people who vote in Oregon elections and would expand representation, particularly for marginalized and rural community members who are not reached by County Clerk voter registration efforts.
HB 2278 Enrolled	Authorizes pharmacists to administer influenza vaccine to persons 6 months old or older.	Public Health Division	Expands the range of locations where young children can get a flu vaccine by lowering the age at which a pharmacist can administer the flu vaccine from 7 years old to 6 months old.
HB 2286 Enrolled	Relating to health care services provided to Native Americans: 100% Tribal federal medical assistance percentage (FMAP) Program.	Health Systems Division	Codifies the 100% Medicaid federal match for Federally Recognized Tribes, making it an established program in Oregon with resources that Tribes can depend on for health-related programs.

HB 2395 Enrolled	Omnibus opioid	Public Health Division and Health Systems Division	Increases access to the overdose reversal drug naloxone by adding law enforcement officers, firefighters and emergency medical services (EMS) providers as persons who may administer naloxone and distribute multiple kits to people who have experienced overdose or are at increased risk, as well as their family members. The bill would also allow minors to receive outpatient treatment for substance use disorders without parental consent, among other dispensing changes for pharmacies.
HB 2446 Enrolled	CCO contracts	Health Systems Division and Health Policy and Analytics	Extends CCO contracts by two years, delaying the next procurement process. This will free up resources for OHA and CCOs to implement several major initiatives, including OHP redeterminations, the 1115 Medicaid Waiver and the Basic Health Program, without needing to simultaneously work on new CCO contract procurement.
HB 2757 Enrolled	Expands and provides funding for coordinated crisis services systems including 9-8-8 suicide prevention and the	Health Systems Division	Creates a 40-cent tax on phone lines to fund the 9-8-8 crisis line and mobile crisis centers. Establishes a trust fund for the monies collected.

	behavioral health crisis hotline.		This dedicated funding stream will ensure that people who are experiencing a mental health crisis can connect to counseling and support, 24/7, everywhere in Oregon. The tax sunsets in 2030.
HB 2994 Enrolled	Modifies requirements for health insurance coverage of hearing-related items and services. Requires OHA, through medical assistance programs, and Public Employees' Benefit Board and Oregon Educators Benefit Board, through health benefit plans offered by boards, to provide hearing-related items and services specified for health insurance coverage.	Health Systems Division and Health Policy and Analytics	Expands coverage of hearing-related equipment and services across health insurance programs including public employees' benefit board (PEBB), Oregon educators benefit board (OEBB) and OHP. This will give all patients access to the assistive listening devices or other hearing technologies they need.
HB 3320 Enrolled	Imposes new requirements on hospitals with respect to financial assistance policies and processes. Requires OHA to impose civil penalties for violation of requirements.	Health Policy and Analytics	Changes existing hospital financial assistance regulations by requiring a hospital to pre-screen for financial assistance eligibility to determine if the patient is uninsured, is a Medicaid beneficiary or owes the hospital at least $500. The bill specifies the criteria for a patient to apply for financial assistance and requires OHA to create rules for a presumptive eligibility

			screening process. Includes provisions to improve accessibility of financial assistance, which could greatly help low-income people seeking care in Oregon, bringing the state one step closer to eliminating medical debt, which disproportionately burdens people of color.
SB 232 Enrolled	Allows out-of-state physicians or physician assistants to provide specified care to patients located in Oregon. Clarifies that practice of medicine using telemedicine occurs where patients are physically located. Takes effect on 91st day following adjournment sine die.	Health Systems Division and Health Policy and Analytics	The bill will have a general and significant policy impact on access and availability to health services for patients with an established provider-patient relationship with providers out of state. This bill allows Oregon patients to access and maintain continuity of care with an established out-of-state provider, particularly specialists and other culturally and linguistically appropriate providers that are not readily available within the patient's service area.

K. Litigation status

Connecticut v. Generic Drug Manufacturers and Wisconsin v. Indivior

These multi-state antitrust suits include the state of Oregon in its enforcement capacity, but 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 due to purchases and reimbursements of the drugs; the state is working with necessary agencies to collect applicable data.

Sarepta Therapeutics Inc. v. OHA

This case concerns a petition for judicial review of OHA's prior authorization criteria for the prescription medication Exondys 51. Petitioner, Sarepta Therapeutics, Inc., argued that OHA exceeded its authority in adopting the criteria because it conflicted with drug-coverage requirements under the federal Medicaid Act, specifically the Medicaid Drug Rebate Program. 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. In April 2023, the Court of Appeals issued a decision affirming the validity of the prior authorization criteria for Exondys 51. The court held that OHA's prior authorization criteria for Exondys did not contravene the Medicaid Act. Sarepta Therapeutics, Inc. petitioned for the Oregon Supreme Court to take review of this case, but the request was denied.

L. Public forums

Post-Award Forum OHA has designed and participated in a number of public forums regarding the waiver in this reporting period. Waiver team members have frequently presented to and engaged with the Oregon Health Policy Board, the Medicaid Advisory Committee, Health Equity Committee, and the Public Health Advisory Board. The agency also held "Waiver Days" meetings to meet the requirements to hold a public forum to accept comment on implementation on 10/25/22 and 11/21/22. OHA also held monthly, public webinars from April to December in English and Spanish.

10/25/22 - Waiver Days: A presentation of the 1115 Medicaid Waiver. Open to the public. Presented by Lori Coyner, Senior Medicaid Policy Advisor, OHA. Coyner shared the new authorities contained within in the waiver, with a particular emphasis on continuous eligibility, EPSDT, and HRSN benefits. Community questions and feedback were received under the following headings:

- Eligibility. Questions focused on: continuous enrollment, Medicare/Medicaid eligibility**,** income requirements**,** continuous enrollment effective dates
- HRSNs. Questions focused on standardization across CCOs / FFS, spending limits/benefit limits, provider referrals and payment, contracting with CCOs, estimated eligible population, homeless definition, housing benefits, workforce, carceral settings, timeline, CCO referrals, engagement with CBOs and community engagement planning.
- EPSDT. Questions focused on coding notifications for providers
- Waiver implementation. Questions focused on timeline, timing of new CCO contracts
- Information and Resources. Questions focused on Website location, HRSN information, slide deck and the engagement schedule.

11/21/22 - Waiver Days: A presentation of the 1115 Medicaid Waiver. Open to the public. Presented by Lori Coyner, Senior Medicaid Policy Advisor, OHA. Coyner shared the new authorities contained within in the waiver with a particular emphasis on continuous eligibility, EPSDT, and the health-related social needs benefits. This session meets the Federal regulations that require OHA to hold a public forum to accept comment on implementation. Community questions and feedback were received under the following headings:

- Eligibility. Questions focused on age of siblings, continuous enrollment, carceral settings, family enrollment scenarios, meal services, CAWEM / HRSN eligibility, estimated number of people who will receive new benefits, FFS and kids in foster care.
- HRSNs. Questions focused on examples of program types, “at-risk for extreme weather,” definition of “special health care needs, “clarification on “at-risk for homelessness,” payment allocation, CCO roles, carceral settings, supportive services at Permanent Supportive Housing (coverage, rental assistance caps, housing supports and existing program integration), workforce concerns, role for Community Action Agencies, non-profit housing providers, engagement in rule making, timeline for receiving HRSN services, case management roles, overlap of 3-5 year housing vouchers, role of CCOs with managing housing, CCO feedback, housing navigation, screening tools, interface with Coordinated Entry System and recourse for failure to provide services.
- EPSDT. Questions focused on coding notifications for providers.

- Implementation. Questions focused on referrals for overpayment, effective dates, timelines, timing of CCO contracts, OHP workforce and provider shortages,
- Information and Resources. Questions focused on the engagement schedule.

Public Webinars:

- 4/5/2023: Community Engagement Webinar. Jessica Deas, Engagement Manager at OHA, provided an overview about equity and engagement, Oregon's 1115 Medicaid Waiver, what's changing in OHP as a result of the waiver, a timeline, and opportunities for communities to provide feedback.
- 4/5/2023: Seminario Web para la participación comunitaria. Suly Rosales, Engagement Lead at OHA, provided an overview in Spanish about equity and engagement, Oregon's 1115 Medicaid Waiver, what's changing in OHP as a result of the waiver, a timeline, and opportunities for communities to provide feedback.
- 5/3/2023: Community Engagement Webinar. Jessica Deas, Engagement Manager at OHA, shared information about health equity and community engagement, an overview of OHP and Medicaid in Oregon, how to get and keep benefits, special rules unwinding with the end of the federal COVID-19 public health emergency, an overview of continuous eligibility overview, and the timeline, then took feedback and questions.
- 5/3/2023: Exención de Medicaid OHP 1115 2022-2027 Actualization: Suly Rosales, Engagement Lead, OHA, shared information in Spanish about health equity and community engagement, an overview of OHP and Medicaid in Oregon, how to get and keep benefits, special rules unwinding with the end of the federal COVID-19 public health emergency, an overview of continuous eligibility overview, and the timeline, then took feedback and questions.
- 6/7/2023: OHP 1115 Medicaid Waiver 2022-2027 Community Engagement Webinar: Jessica Deas, Engagement Manager, OHA, shared information about health equity and community engagement, an overview of the 1115 Medicaid Waiver in Oregon, and an updated waiver implementation timeline, then took feedback and questions.
- 6/7/2023: Exención de Medicaid OHP 1115 2022-2027 Seminario web sobre la participación comunitaria, Suly Rosales, Engagement Lead, OHA, shared information in Spanish about health equity and community engagement, an overview of the 1115 Medicaid Waiver in Oregon, and an updated waiver implementation timeline, then took feedback and questions.
- 7/5/2023: OHP 1115 Medicaid Waiver 2022-2027 Community Engagement Webinar: Jessica Deas, Rebecca Donell, and LaNae Bowles from OHA shared information about health equity and community engagement, an overview of terms, and the HRSN housing benefit, then took feedback and questions.

- 7/5/2023: Exención de Medicaid OHP 1115 2022-2027 Seminario web sobre la participación comunitaria: Suly Rosales, Engagement Lead, OHA, shared information in Spanish about health equity and community engagement, an overview of terms, and the HRSN housing benefit, then took feedback and questions.
- 8/2/2023: OHP 1115 Medicaid Waiver 2022-2027 Community Engagement Webinar: Jessica Deas, Engagement Manager, and Josh Thompson, OHA Climate Policy Specialist, from OHA shared information about health equity and community engagement, and overview of terms, and the HRSN climate benefit, then took feedback and questions.
- 8/16/2023: Exención de Medicaid OHP 1115 2022-2027 Seminario web sobre la participación comunitaria: Suly Rosales, Engagement Lead, OHA, shared information in Spanish about health equity and community engagement, and overview of terms, and the HRSN climate benefit, then took feedback and questions.
- 9/6/23: 1115 Medicaid Waiver public webinar: Dave Baden, Interim Director, OHA, shared updates about the design and implementation plans for the HRSN benefits.
- 9/20/23: 1115 Medicaid Waiver public webinar for Spanish speakers: Steph Jarem, 1115 Waiver Policy Director, OHA, shared updates about the design and implementation plans for the HRSN benefits.

Oregon Health Policy Board:

- 10/3/22: Patrick Allen, Director, OHA presented the overall 2022-2027 Waiver goal, authorities, projected funding and next steps. OHPB members commented on support for the expanded coverage for children and support for financial resources to community organizations and prioritizing health equity. No public comments were received on the OHP waiver.
- 4/4/23: Dana Hittle, Medicaid Director, OHA gave an overview of the 2022-2027 1115 Waiver and funding, an update on the implementation and shared strategies for community engagement and health equity. Questions were answered from the Oregon Health Policy Board members. No public comments were received on the OHP waiver.
- 9/12/23: Steph Jarem, 1115 Waiver Policy Director and David Baden, Interim Director, OHA gave an overview on the 1115 Waiver. They reviewed the scope of the waiver changes, updates on protocol and plan development in partnership with CMS, work sessions with community partners and Coordinated Care Organizations. Feedback on the housing benefit was summarized. The timeline for the role out of HRSN services was shared and there was time allotted for questions and answers. No public comments were received on the OHP waiver.

Medicaid Advisory Committee

Oregon Health Authority

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 10 times between 10/1/2022 and 9/30/2023 and the waiver was a key point of discussion in the following nine MAC meetings:

- October 26, 2022: 1115 Waiver update provided.
- December 7, 2022: 1115 Medicaid Waiver summary provided. MAC members asked questions about housing supports for outpatient substance use disorders (SUDs) for people transferring from Medicaid to Medicare and climate supports available in 2024.
- January 25, 2023: 1115 Medicaid Waiver summary presented. MAC members provided input about implementation plans.
- February 22, 2023: Retreat. Public comments included waiver-related questions about social screening work and connections to the deaf community. Questions were also posed about screening concerns at the provider level, and the process for housing applications for incarcerated members. MAC member Lisa Pierson suggested that a clinic or provider should have a questionnaire when a person comes in for screening.
- April 26, 2023: public health emergency unwinding and Community Partner Workgroup updates.
- June 13, 2023: educational meeting on CMS proposed rules.
- June 28, 2023: 1115 Waiver update – evaluation opportunity. Public comments addressed access to housing for persons with disabilities.
- July 26, 2023: educational meeting on Supporting Health for All through Reinvestment (SHARE), Health-Related Services (HRS), Health Related Social Needs (HRSN), and other social determinants of health spending at CCOs. Public comments addressed the process for members to receive rental assistance, guidance on CCO involvement with CACs, and collaboration with other social services when determining eligibility criteria.
- September 27, 2023: 1115 Waiver evaluation next steps and CORE work on Evaluation Design.

Health Equity Committee:

- On Nov. 10, 2022, Lori Coyner, Senior Medicaid Policy Advisor at OHA, provided an overview of the 1115 Medicaid Waiver to the HEC. Lori relayed how the waiver relates to OHA's goal of advancing health equity. She specifically covered:
  - An overview of the populations that will be eligible for HRSN benefits
  - HRSN benefits
  - Comprehensive investments in children's health to advance health equity
  - What is not included in the waiver

  HEC members asked questions about long-term funding for the HRSN benefits and informational awareness campaigns related to the HRSN benefits.

Health Information Technology Oversight Council
On Feb. 2, 2023, Lori Coyner, Senior Medicaid Policy Advisor at OHA, presented on the four components of the waiver that support the primary focus of advancing health equity in Oregon, specifically:

- Continuous Medicaid enrollment
- HRSN benefits
- Smart, flexible spending for health equity through extra federal funding dollars called DSHP Funding
- Creating a more equitable, culturally and linguistically responsive health care system through creation of community investment collaboratives; approval of this component was still pending

The group discussed opportunities for Health IT through the waiver work, specifically Health Information and Community Information Exchanges.

- HITOC Member Panel on Waiver Implications: Susan Otter, Director of Health Information Technology & Analytics Infrastructure, OHA, facilitated a panel of four HITOC members who volunteered to speak about the waiver implications on their organizations' work and about how they believe it will help reduce health inequities.

House Committee on Behavioral Health and Health Care:
On May 15, 2023, David Baden, Interim Director of OHA, and Dana Hittle, Medicaid Director at OHA, presented an overview of the waiver to the Oregon House Committee on Behavioral Health and Health Care. Their presentation included the goals of the waiver, the newly approved waiver authorities that need to be implemented, a high-level timeline for implementation of each benefit change, development processes, known challenges to benefit implementation, how external partners will be engaged during the development process, and when and where more information about how the program design is progressing will be released.

Housing Alliance:

On Aug. 8, 2023, Dana Hittle, Medicaid Director at OHA, Andrea Bell, Director of Oregon Housing and Community Services, and staff from Governor Kotek's office presented an overview of the HRSN Housing Services Proposed Design and Implementation.

Questions and concerns were raised about eligible populations, services, administrative requirements, capacity building and the autonomy of CCOs in decision-making related to capacity funds. Support was given for clear and streamlined eligibility requirements. There was request for an integrated coordinated entry and referral system.

Housing Service Providers:

On Sept. 4, 2023, David Baden, Interim Director at OHA, and Andrea Bell, Director of Oregon Housing and Community Services, presented at an OHA-hosted event with more than 100 direct housing service providers. The goal was to provide an introduction to the waiver and solicit feedback on eligibility, services and Community Capacity Building Funds (CCBFs). Questions were asked about data management, how CCOs will work with providers and how to become an HRSN service provider. There were concerns shared about the need to assess current CBO capacity, that CCOs might not know how to use the benefits, about the higher acuity of clients currently and what will happen at the end of the 6-month rental support.

Health Evidence Review Commission (HERC)

Each meeting HERC meeting provided an opportunity to discuss issues related to the coverage of health services and the medical necessity criteria to be reflected in the Prioritized List of Health Services. Complete agendas, materials and minutes for each meeting are available here. Verbal and written comments from HERC meetings are included below:

October 6, 2022

- *Verbal comments:* Paul Terdal advocated for the end of using Quality-Adjusted Life Years (QALYs) in HERC decision making. Stephen Willis PA-C, Kimberly Cleveland, BSN, RN, DCES, Charlene Lai, MD, Julia Saltzgiver, RDN, Jessica Castle, MD and Alison O'Neill testified to advocate for broader coverage of continuous glucose monitors for patients with type 2 diabetes.
- *Written comments:* Seven written comments supported broader coverage for continuous glucose monitors for type 2 diabetes.

November 17, 2022

- *Verbal comments:* Paul Terdal, Mary Porter and Tony Coelho each spoke about advocating against the use of Quality-Adjusted Life Years (QALYs).
- *Written comments*

January 19, 2023

- *Verbal comments:* 2 People testified in support of coverage for chronic disease self-management programs for chronic pain.
- *Written comments part 1; Written comments part 2*

March 9, 2023

- *Written comments part 1; Written comments part 2*

April 10, 2023

No public comment.

May 18, 2023

- *Verbal comments:* Deb Brugman, a genetic counselor and laboratory employee, spoke in favor of coverage her company's FoundationOne genetic test.
- *Written comments*

August 17, 2023

- *Verbal comments:* Two advocates spoke supporting broader coverage of gender affirming treatments. One also advocated for coverage of hair removal for polycystic ovarian syndrome.
- *Written comments part 1; Written comments part 2*

September 28, 2023

- *Verbal comments:* Three people spoke advocating broader coverage of continuous glucose monitors.
- *Written comments part 1; Written comments part 2*

October 6, 2022

- *Verbal comments:* Three people spoke opposing the use of QALY's in HERC decisions. One spoke advocating expanded coverage for atopic dermatitis. Two spoke in support of coverage for chronic disease self-management programs. A laboratory representative spoke in favor of coverage of the FoundationOne test.
- *Written comments:* Five comments supported broader coverage of continuous glucose monitors. A manufacturer's representative spoke in favor of coverage of pneumatic compression devices for lymphedema.

November 17, 2022

- *Verbal comments:* Three physicians spoke in support for coverage of collagen cross linking.
- *Written comments:* Five comments supported broader coverage of continuous glucose monitors.

January 19, 2023

- *Verbal comments:* One physician spoke in favor of coverage of single-sided deafness for adults.
- *Written Public Comments part 1; Written Public Comments part 2*

March 9, 2023

- *Verbal comments:* A manufacturer's representative testified in support of FoundationOne test. Three providers advocated for removing restrictions on coverage of surgery for people who smoke.
- *Written Public Comment part 1; Written Public Comment part 2*

May 18, 2023

- *Verbal comments:* An audiologist and two otorhinolaryngologists spoke in favor or expanded coverage for cochlear implants. A dermatologist spoke in favor of coverage of lasers for hidradenitis supurativa.
- *Written Public Comment*

August 17, 2023

- *Verbal comments:* A manufacturer's representative spoke in favor of coverage of Freespira. A patient spoke in support of coverage of breast reduction surgery for patients with very large breasts. A patient's mother spoke in favor of coverage for services for fibromyalgia.
- *Written Public Comment part 1; Written Public Comment part 2*

September 28, 2023

- *Verbal comments:* Two industry representatives, an advocacy organization employee, an endocrinologist, a nurse and a clinical pharmacist spoke in favor of broader coverage of continuous glucose monitors.
- *Written Public Comment part 1; Written Public Comment part 2*

Evidence-based Guidelines Subcommittee (EbGS),

1/12/2023

No verbal comments. One written comment was received to advocate for broader coverage of bariatric surgery; another offered recommendation on a scope statement for chronic disease self-management programs.

2/2/2023

- *No verbal comments:*
- *Written Comment part 1; Written Comment part 2*

4/20/2023

- *Verbal comments:* Two industry representatives, and two endocrinologists spoke in favor of broader coverage of continuous glucose monitors. *Written comments:* There were seven written comments supported broader coverage of continuous glucose monitors

6/13/2023

- *No verbal comments*
- *Written comments:* There were eight written comments in support of expanding coverage of continuous glucose monitors; 1 opposed expansion

Association of Oregon Community Mental Health Programs:
On Jan. 24, 2023, Dana Hittle, Medicaid Director at OHA, shared the innovations in the waiver, especially concerning transitions of care, housing, other health-related social needs benefits and EPSDT services.

Public Health Advisory Board:
On Jan. 12, 2023, Lori Coyner, Senior Medicaid Policy Advisor at OHA, shared overarching goals, authorities and funding of the 1115 Medicaid Waiver and connections and opportunities for Oregon's public health system. PHAB members shared appreciation for focus on people in the carceral system and asked about connections between the CCOs and the Local Public Health Authorities related to the waiver benefits.

IV. Progress toward demonstration goals

A. Improvement strategies

Continuous Eligibility for Adults and Children

Technology updates to support new Continuous Eligibility (CE) for Adults and Children policies will be deployed to the Oregon Eligibility (ONE) system in two phases:

1. The first phase was deployed in July 2023 to create functionality to identify members to whom CE applies and establish applicable CE periods.
2. The second phase of the updates will be deployed in February 2024, and will include eligibility functionality to establish case renewal dates with consideration of CE policy, in addition to refinements and bug fixes.

Internal and external communication about Oregon's CE policies were coordinated between the Oregon Health Authority and Oregon Department of Human Services (ODHS) to develop and distribute learning materials and training opportunities. Development of updated materials is underway in preparation of phase 2 for February 2024.

Early and Periodic Screening, Diagnostic &Treatment

The Early and Periodic Screening, Diagnostic & Treatment (EPSDT) program did not renew the prior waiver. Oregon has fully implemented EPSDT services to OHP members between the ages of 0-21 beginning Jan. 1, 2023. The EPSDT rules have been updated and will be published Jan. 1, 2024 with a new division for EPSDT, as well as a state plan amendment that pertains more to the robust program Oregon is implementing. EPSDT continues to work with other waiver implementations and programs including: YSCHN, HRSN-nutrition and Youth in Carceral Settings.

Expand Access to Supports that Address Health Related Social Needs

Since receiving authority to provide HRSN services to eligible OHP members, Oregon has been planning the implementation of the HRSN climate, housing, and nutrition, and outreach and engagement services.

- **Climate-related services** aim to address the negative effects of extreme climate events on a member's health and well-being. These services include the provision, service delivery, and installation of one or more of the following home devices: air conditioners, heaters, air filtration devices, portable power supplies and mini refrigeration units. To be eligible for services, OHP members will need a device for medical treatment or prevention. During this reporting period, the fee schedule was drafted, along with minimum device specifications.

- **Nutrition services** will include medically tailored meals, pantry stocking, nutrition education and fruit and vegetable Rx. The eligible populations for each nutrition support, a corresponding fee schedule and detailed service plan are in development. Feedback from CCOs and CBOs will be collected in the first few months of 2024.

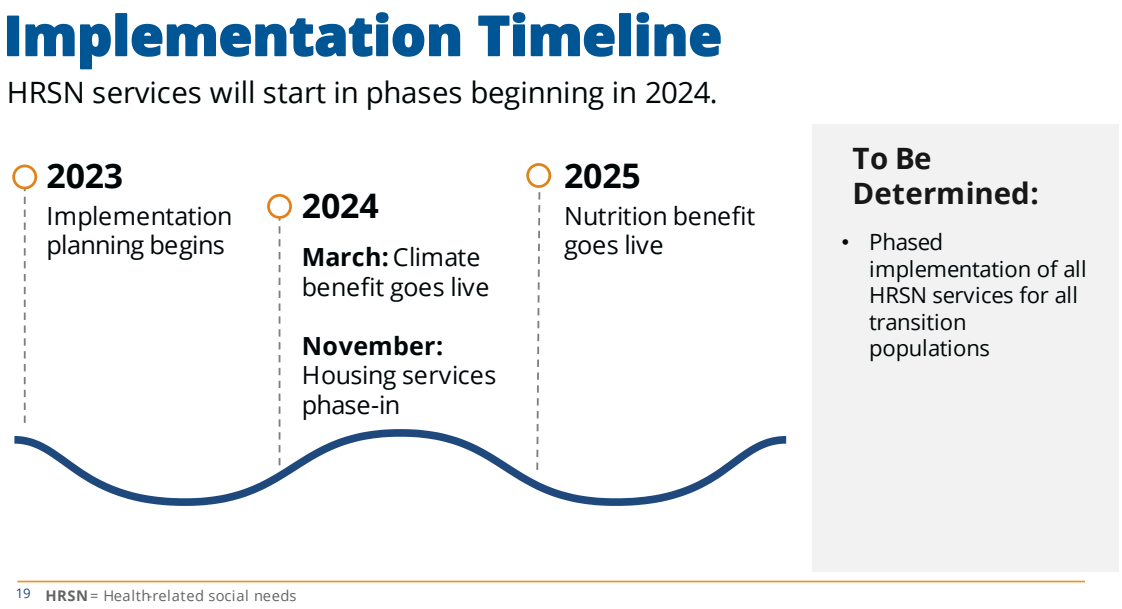
- **Housing services** will address a range of housing-related needs, in order to provide individuals and families with the support to obtain and/or maintain a safe, habitable place to live. Housing services will include: 1) Housing navigation and pre-tenancy support: obtaining identification and other documentation required to obtain housing, searching for housing and presenting different options, ensuring the living environment is safe and habitable, and communicating with the landlord 2) Tenancy sustaining services: engagement and communications with landlords, providing training on tenant obligations under lease agreements, providing support to secure and utilize entitlements and benefits 3) One-time transition and moving costs: deposits needed to secure housing, set up fees for utilities, and basic furniture 4) Rental support for six months for specific populations and 5) Medically necessary home modifications and remediation services. Also during this reporting period, the housing strategy was refined to focus on the at-risk of homelessness population with a greater focus on prevention.

Planning for HRSNs has been done in collaboration with Oregon Housing Community Services (OHCS), Oregon Department of Human Services (ODHS) Nine Federally Recognized Tribes, 16 CCOs, and other partners. Through this work, OHA has produced the following:

- HRSN Infrastructure Protocol: Details how community capacity building funding (infrastructure funding) will be used, the types of entities that will be eligible for funding and funding amounts. Oregon submitted this deliverable to CMS for review and approval in April 2023.

- HRSN Services Protocol: Details eligibility for services, service definitions, provider qualifications, and care management of HRSN Services. Oregon submitted this deliverable to CMS for review and approval in August 2023.
- New Initiatives Implementation Plan: Details data sharing and health information technology related to HRSN services, partnerships in implementing HRSN services and the plan for improving a percentage of Medicaid beneficiaries enrolled in certain programs. Oregon submitted the New Initiatives Implementation Plan to CMS for review and approval in August 2023.

The timeline for HRSN services as been determined and is detailed below:



Health-Related Services

In the first year of the waiver, CCOs continued to use Health-Related Services (HRS). First authorized under Oregon's 2012-2017 Oregon Health Plan waiver and expanded to include both Flexible Services and Community Benefit Initiatives under the renewed 2017-2022 waiver, HRS allows CCOs to develop innovative programs and services to serve some of the most medically and socially vulnerable Oregon Health Plan members.

CCOs are not required to use HRS, but in the first year of this waiver, all CCOs did continue to use HRS. A report summarizing CCO HRS spending for calendar year 2022 is posted publicly here: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2022-CCO-HRS-Spending-Summary.pdf. Some highlights include:

- Total accepted HRS spending for 2022 was $60.2 million and nearly double total accepted HRS spending for 2021.
- The top three areas of 2022 CCO HRS spending were in the health information technology category, including: community information exchange ($20.8 million), housing ($10.5 million), and prevention ($7.6 million).

Oregon Health Authority

- $2.06 million in HRS was allocated to Federally Recognized Tribes in Oregon in 2022 to allow Tribes to decide how best to use the funds to improve health.

Designated State Health Programs

Oregon will implement the Designated State Health Program (DSHP) once final approvals are provided by CMS. DSHP allows for limited federal matching funds on approved existing state-funded expenditures. The new funding will be used to help pay for:

- Medicaid coverage to Youth with Special Health Care Needs (YSHCN)
- HRSN services for eligible OHP members
- HRSN capacity building for community partners

Alignment with tribal partner priorities

Addressing social determinants of health is a priority for Oregon tribal partners. American Indians/Alaska Natives on OHP who meet eligibility criteria will be able to receive HRSN services. To ensure tribal systems will be able to deliver HRSN services to tribal communities, OHA is partnering with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program to plan and design the implementation of HRSN services. Tribal Consultations on HRSN services took place in August 2023 and again in September 2023. Consultations focused on HRSN community capacity building funding and the implementation of climate-related supports. To support Tribes in delivering HRSN services, OHA is setting aside $11.9 million in community capacity building funding (infrastructure funding). OHA and Tribes are planning biweekly work sessions to collaborate on HRSN service delivery.

C. Better care and better health (ANNUAL)

In alignment with OHA's goal of eliminating health inequities by 2030, the CCO Quality Incentive Program (QIP) is prioritizing upstream metrics that address social issues impacting health, such as access to healthy foods and safe, affordable housing.

Progress Reporting

Throughout the demonstration year, OHA produced regular reports with final calendar year 2022 data, showing CCOs incentive and state performance. All CCOs had performance data successfully reported for the year. While the report only shows a statewide average for CCO members as a whole, a new CCO Performance Metrics Dashboard expands on this report to describe in more detail the progress of Oregon's CCOs on quality measures. Viewers can search by metric and see individual CCO trends over time. The dashboard also has the option to explore breakouts of many measures, by Race, Ethnicity, Language and Disability (REALD) standards.

This report is available online here:
https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2022-CCO-Metrics-Annual-Report.pdf

The new metrics dashboard is available here: https://visual-data.dhsoha.state.or.us/t/OHA/views/CCOPerformanceMetrics/welcome?%3Aembed=y&%3AisGuestRedirectFromVizportal=y

Highlights from the demonstration year

- **Health Equity Measure** - This measure promotes high-quality language services for all Medicaid members. In 2021, the first year that the measure was incentivized, CCOs were required to conduct a self-assessment of language access. They were required to identify and assess communication needs; provide language assistance services; train staff and provide notice of language assistance services. This was incentivized following multi-year development work by a public workgroup and other partners.

  For 2022, CCOs had to meet two components: First, CCOs had to continue to improve the work identified in their self-attestation. Second, CCOs had to collect 80% of interpreter service data on a sample of members' physical, behavioral or dental health visits. This sample included 30% or up to 411 members per CCO, where OHA identified as needing an interpreter. CCOs could request to adjust or add members to this sample. Results showed that CCOs provided an OHA-qualified and certified interpreter for only 5.6% of members' visits and general interpretative services for 32.6% of members' visits. One CCO did not meet the requirement to collect 80% of interpreter service data on the sample.

- **Kindergarten readiness**: In the first year of this metric, CCOs were required to complete an attestation survey, asset map and action plan to show how they will improve the social-emotional health of young children. These efforts are part of a broader measurement strategy on the health sector's role in preparing children for kindergarten. Documentation requirements aimed to capture CCO progress on the following components:
  1. Social-emotional health reach metric data review and assessment
  2. Asset map of existing social-emotional health services and resources
  3. CCO-led cross-sector community engagement
  4. Action plan to improve social-emotional health service capacity and access.

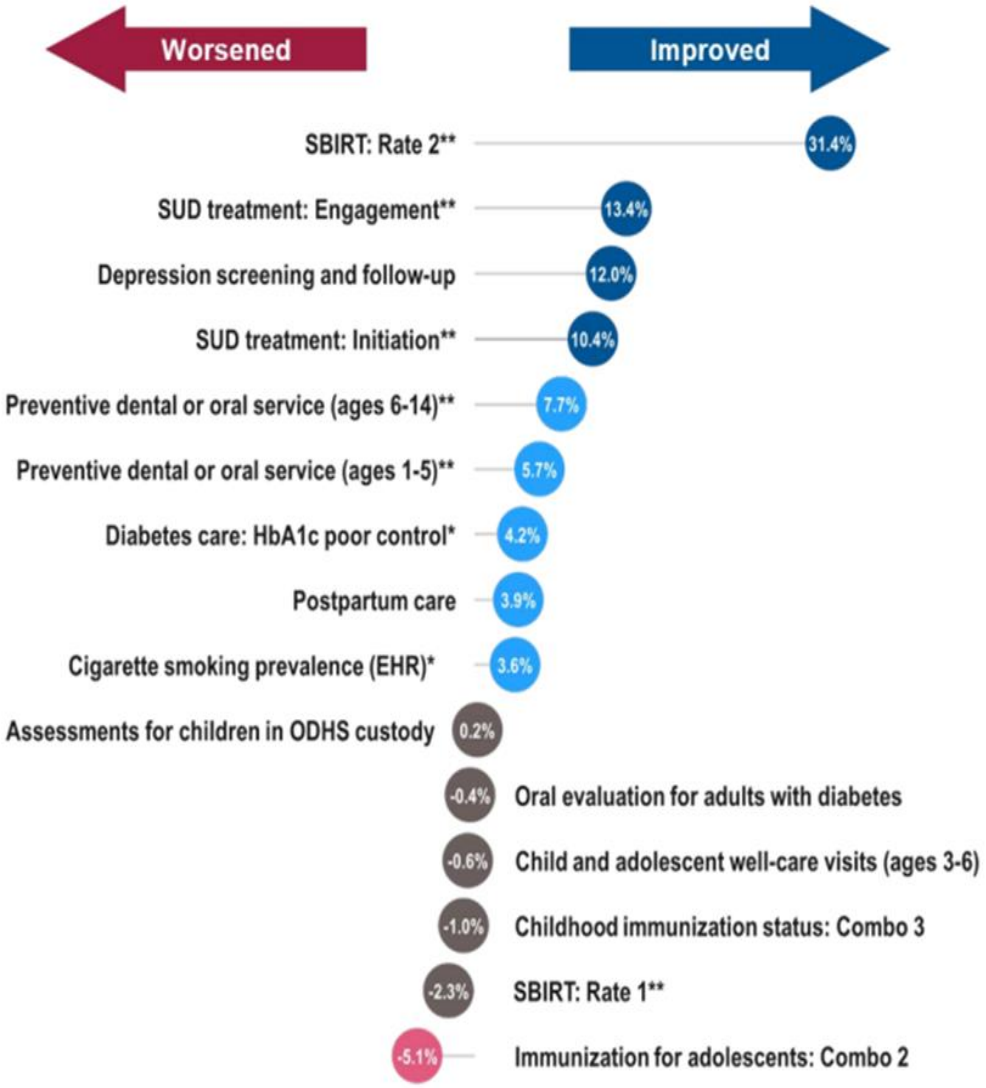
  The components intentionally work to build upon each other from year to year. They require community engagement and CCO-led collective work to improve the social-emotional health of young children. CCOs were required to complete all must-pass items for the measurement year, with no option for partial credit. In 2022, all CCOs met this measure.

  Specific successes include promising results on behavioral health, including improved screenings for depression and treatment of substance use disorders. CCOs also increased preventive dental services for youth 14 years and under. Areas for growth include around immunizations and well-care visits. During 2022, there were decreases in immunizations

and there is some evidence that vaccine hesitancy grew during the pandemic, which may have affected these rates.

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

At a glance: Statewide change in CCO performance from 2021



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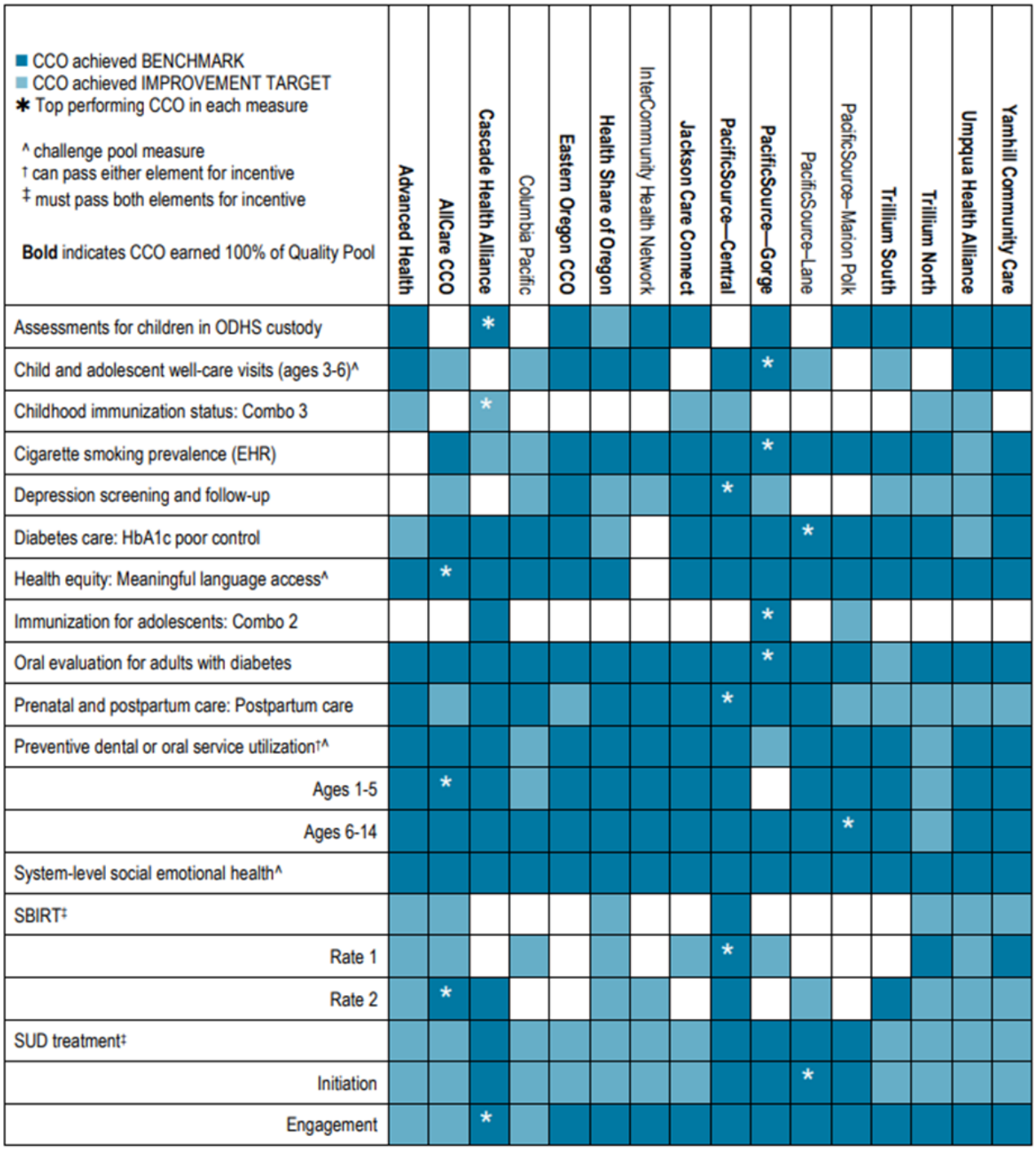
* For these measures, a lower rate indicates better performance. To enable easy comparison across the measure set, measures are listed in the chart based on whether performance moved in the desired direction. For example, performance on the cigarette smoking prevalence measure improved by 3.6%, meaning a 3.6% decrease in the rate of smoking.

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

*** In the chart, changes of less than 3% are color-coded and grouped as largely steady since 2021, 3-10% moderate change, and above 10% substantial change.

2022 incentive measure performance overview



❖ **Quality Pool:** Disbursement of the CCO quality pool funds continues to be contingent on CCO performance, relative to benchmark and improvement targets for measures. The 2022 Quality Pool for CCO incentive metrics was over $300 million, representing 4.25% of the total amount all CCOs were paid in 2022. This is the largest payment in the history of the program, which began at $47 million in 2013.

The share of funds that a CCO can earn, depends on the number of members it serves and its performance on 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. 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. These funds are earned in two stages:

- Phase one distribution: CCOs can earn 100% of their Quality Pool in the first phase of distribution by meeting the benchmark or improvement target on 75% of the incentive metrics (11 of 14 metrics). If a CCO does not meet this requirement, those unearned funds go into the Challenge Pool. No "must pass" metrics were selected for the 2022 Quality Pool. "Must pass" metrics have a benchmark or reporting requirement that CCOs must meet to be eligible to receive full Quality Pool payments. Historically, the Metrics and Scoring Committee has selected one to three "must pass" metrics each year.

- Phase two distribution The Challenge Pool contains any funds remaining after stage one distribution of the Quality Pool. For 2022, the Challenge Pool focused on measures for kindergarten readiness and MC
- health equity. Challenge Pool funds were distributed to CCOs according to their performance on each of the four Challenge Pool metrics:

1. Child and adolescent well-care visits (incentivized for ages 3-6)
2. System-Level Social Emotional Health
3. Preventive dental or oral health services, ages 1-5 and 6-14
4. Health equity measure: Meaningful language access to culturally responsive health care services

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately

2. State reported enrollment table

Enrollment	July/2023	August/2023	September/2023

Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,330,276	1,326,210	1,320,967	
Title XXI funded State Plan	138,990	139,026	139,203	
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%	315,509	2,813,460	2.76%	49.80%
	Title XXI	SCHIP FPL > 170%	88,233	695,319	0.40%	21.59%
Optional	**Title XIX**	PLM women FPL 133-170%	1	12	0.00%	-50.00%
	Title XXI	SCHIP FPL < 170%	207,075	1,631,225	-0.35%	14.98%
Mandatory	**Title XIX**	Other OHP Plus	3	36	0.00%	0.00%
		MAGI adults/children	1,171,467	11,915,831	1.41%	-9.85%
		MAGI pregnant women	35,002	227,598	16.49%	40.56%
		QUARTER TOTAL	1,817,290			
** Due to retroactive eligibility changes, the numbers should be considered preliminary*						

OHP eligible and managed care enrollment

OHP eligible*	Coordinated Care	Dental Care	Dental Only

		CCOA**	CCOB**	CCOE**	CCOG**	DCO	CCO F**
Oct. 2022	1,328,521	1,244,566	1,726	183	12,287	71,190	N/A
Nov. 2022	1,337,129	1,253,072	1,935	179	12,404	71,794	N/A
Dec. 2022	1,346,425	1,262,069	1,106	129	12,444	71,739	N/A
Jan. 2023	1,356,546	1,272,029	151	73	12,566	N/A	71,083
Feb. 2023	1,364,376	1,278,411	114	62	12,551	N/A	72,656
Mar. 2023	1,371,342	1,283,536	115	64	12,520	N/A	75,993
Apr. 2023	1,377,801	1,288,228	70	63	12,469	N/A	77,051
May 2023	1,386,833	1,297,580	66	66	12,338	N/A	77,250
Jun. 2023	1,391,633	1,301,001	67	64	12,128	N/A	77,943
Jul. 2023	1,434,111	1,342,941	64	61	11,918	N/A	78,358
Aug. 2023	1,432,303	1,338,914	69	63	11,718	N/A	81,783
Sept. 2023	1,429,379	1,334,558	68	65	11,455	N/A	82,456
Quarter average	1,379,700	1,291,409	463	89	12,233	71,574	77,175
	Average percentage	93.60%	0.03%	0.01%	0.89%	5.19%	5.59%

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

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

B. Complaints and grievances

Attached separately.

C. CCO appeals and hearings

Attached separately.

D. Neutrality reports (reported separately)