Oregon Health Plan

Section 1115 Quarterly Report

10/1/2019 – 12/31/2019
Demonstration Year (DY): 18 (7/1/2019 – 6/30/2020)
Demonstration Quarter (DQ): 2/2020
Federal Fiscal Quarter (FQ): 1/2020

Oregon Health Authority

Oregon HEALTH PLAN

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I. Introduction

A. Letter from the State Medicaid Director

During this quarter, the Oregon Health Authority (OHA) continued to make progress toward our waiver goals, while preparing Coordinated Care Organizations (CCOs) for the new operational requirements that begin in 2020 and transitioning members to new CCOs.

OHA performed a readiness review of each of the CCOs that were chosen through the request for applications (RFA) process. The readiness review ensures that CCOs have the resources, capacity, provider networks, and community relationships necessary to provide quality care to the full volume of Medicaid members that they claimed in their application materials. The readiness review was thorough, and instilled confidence in all parties that CCOs are prepared to

OHA also engaged in a remediation process with four CCOs whose submissions to the RFA process only merited receiving one-year contracts. This process highlighted areas in which each of the four CCOs needed to improve, and each CCO successfully demonstrated improvements in all the necessary areas of policy, operations, and planning. As a result, each CCO successfully completed the remediation process, and all 15 CCOs now have 5-year contracts.

OHA also engaged with CCOs and other stakeholders through the rulemaking process for Oregon's Administrative Rules governing CCO activities. During this reporting period, CCOs, tribes, member advocates, providers, and community organizations submitted comments on proposed rules and OHA made adjustments to rules where appropriate. A rule hearing report is scheduled to be published in early 2020.

OHA continued to work with to expand the use of Health-Related Services. In November, OHA convened CCO representatives for a day-long event focused on Health-Related Services (HRS). CCO's appreciated the opportunity to ask candid questions and exchanged advice on successes and best practices.

OHA also developed a number of HRS guidance documents to complement previously published guidance documents. The guidance addresses questions that CCOs have raised during the course of their work in this innovative area. The guidance scheduled for release in early 2020, and will be accompanied by in-person meetings wherein CCOs can ask questions of OHA and of each other.

Lori Coyner, State Medicaid Director

B. Demonstration description

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

Oregon Health Authority

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

Under the demonstration, Oregon strives to promote the objectives of Title XIX by:

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

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

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

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

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

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II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 10/1/2019 – 12/31/2019
Demonstration Year (DY): 18– Quarter 2
Demonstration Quarter (DQ): 2/2020
Federal Fiscal Quarter (FQ): 1/2020

III. Overview of the current quarter

A. Enrollment progress

1. Oregon Health Plan eligibility

Oregon is preparing to implement a combined eligibility system this year, staff have started training on the new system and new programs which has taken significant resources away from daily processing at times. Therefore, some backlogs of work have begun to build. In addition, the annual Federal Marketplace open enrollment period also increased referrals to the state during that period. Coupled with the increased referrals, the Marketplace also recently replaced their enrollment system which has caused some unintended downstream impacts to how data is being received and mapped into the state's Medicaid eligibility system. Because of the discrepancies, more of the Marketplace referrals have required follow-up this year, thus further increasing processing times and workloads. There is an aggressive effort underway to reduce backlogs of work in order to be as current as possible when the new eligibility system is implemented.

2. Coordinated care organization enrollment

The passive enrollment of Medicaid and Medicare dual-eligible members concluded during the preceding reporting period. This reporting period represents the first quarter in which CCO enrollment figures will reflect that population remaining enrolled in their assigned CCOs. OHA continues to work with CCOs to ensure that members have access to quality care during the transition.

Also during this reporting period, OHA prepared enrollment transitions for members who were enrolled in CCOs that are terminating at the end of 2019, as well as for members who will have a new CCO in their service are as of January 1, 2020.

B. Benefits

The Pharmacy and Therapeutic (P&T) Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: rifamycin; amikacin liposome inhalation suspension; targeted therapies for Gaucher disease; amifampridine; cholic acid; dupilumab; tricyclic antidepressant (TCA) therapy in children younger than the FDA-approved minimum age limit; and removed the PA requirement for all opioid use disorder (OUD) products, except for the dose limit of 24 mg buprenorphine per day for transmucosal products.

The committee also recommended changes to the preferred drug list (PDL): make rifamycin non-preferred; make amikacin liposome inhalation suspension non-preferred; add class for lysosomal storage disorder drugs and make miglustat and eliglustat non-preferred; make taliglucerase alfa preferred and all other agents for Gaucher disease non-preferred; add class for Lambert-Eaton Myasthenic Syndrome (LEMS) agents and make Ruzurgi® preferred and Firdapse® non-preferred; make cholic acid non-preferred; and make buprenorphine injection (Sublocade™) preferred.

The Health Evidence Review Commission:

A new interim modification of the January 1, 2018 prioritized list went into effect on October 1, 2019 and remained in effect through December 31, 2019. Errata were published on 10/11/19, 11/18/2019 and 12/2/2019.

These, along with interim modifications approved 11/14/2019 by the Health Evidence Review Commission, were reported in the Notification of Interim Changes for the January 1, 2020 Prioritized List.

C. Access to care (ANNUAL)

D. Quality of care (ANNUAL)

E. Complaints, grievances, and hearings

1. CCO and FFS complaints and grievances

The information provided is a compilation of data from 15 coordinated care organizations (CCO) and fee-for-service (FFS) data. This quarterly reporting period covers Oct 1, 2019 through Dec 31, 2019.

Trends

	Jan – Mar 2019	Apr – Jun 2019	Jul – Sep 2019	Oct – Dec 2019
Total complaints received	5,683	6,875	6776	5954
Total average enrollment	1,190,032	1,131,954	1,203,531	1,183,310
Rate per 1,000 members	4.78	6.07	5.63	5.03

Barriers

CCO complaints showed a slight decrease overall during this quarter over the previous quarter. Access to Care category continues to receive the highest number of complaints, however the data shows a 11.8% decrease from the previous quarter. The Interaction with Provider/Plan category shows a decrease of 13.8% this quarter, over the previous quarter and Quality of Care issues increased by 8.9%. FFS data shows the highest number of complaints are in the Quality of Care category, with the Client Billing category the next highest.

Interventions

CCOs – CCOs report they are continuing to work with providers and internal customer service staff to ensure all expressions of dissatisfaction are recorded as complaints. Some CCOs report they have established committees and taskforces specifically to address provider capacity within their networks. CCOs report they are continuing work to reduce issues, such as disconnects between the provider and the front office, which can cause delays in scheduling and misinformation for the member. CCOs report that Peer Review committees are showing improvements in provider services which helps to reduce numbers of complaints. Some CCOs are continuing to report staff is being added internally as well at sub-contractor offices. One CCO reports they have client service excellence coordinators that focus on interactions between providers and members to improve services. Including blank complaint forms with customer satisfaction surveys for some providers has provided additional feedback for improving services. Rural area CCOs are continuing to report issues with bringing on more providers, which has increased complaints in some areas. NEMT continues to be an issue with several CCOs and report they are continuing to work bi-weekly and monthly with NEMT providers to improve transportation services.

Fee-For-Service – The DHS/OHA Member Services data shows complaint calls increased slightly from the previous quarter for Fee for Service member complaints and complaints from members enrolled in a CCO. The number of complaints from members who were on Fee for Service coverage during the quarter was 659. Member Services reported an additional 468 records identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 456 calls regarding complaints about Dental Care Organizations. There were 5450 informational calls received asking for a variety of information, such as information about their coverage, CCO enrollment, request ID cards, etc.

Statewide rolling 12-month Complaints totals

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

Complaint category	Jan – Mar 2019	Apr– Jun 2019	Jul – Sep 2019	Oct – Dec 2019
Access to care	2,865	3,127	2687	2370
Client billing issues	522	600	586	604
Consumer rights	221	202	248	175
Interaction with provider or plan	1,184	1,958	2161	1863
Quality of care	443	514	660	719
Quality of service	420	456	434	223
Other	28	18	0	0
Grand Total	5,683	6875	6776	5954

Related data

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

2. CCO and FFS appeals and hearings

Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs during the quarter. The NOABDs are listed by reason, as per 42 CFR 438.400(b)(1-7) and are the total number of NOABDs issued, regardless of whether an appeal was filed. For the Oct – December 2019 quarter CCOs report that the highest number of NOABDs were issued for pharmacy related denials. Specialty care was the next highest and outpatient care was the third highest. Some CCOs continue to monitor NOABDs to ensure written notices are sent to members in easily understood language and includes the appropriate citations. Tracking for timeliness, as well as reviewing for utilization and appropriateness of care are processes CCOs report they are doing to ensure NOABDs are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	Jan-Mar 2019	Apr – Jun 2019	Jul – Sep 2019	Oct – Dec 2019
a) Denial or limited authorization of a requested service.	32,590	36,276	33,609	33,906
b) Single PHP service area, denial to obtain services outside the PHP panel	112	132	149	325
c) Termination, suspension, or reduction of previously authorized covered services	144	149	143	138

d) Failure to act within the timeframes provided in § 438.408(b)	36	41	26	8
e) Failure to provide services in a timely manner, as defined by the State	288	263	234	49
f) Denial of payment, at the time of any action affecting the claim.	22,935	18,986	19,823	19,581
g) Denial of a member's request to dispute a financial liability.	N/A	0	0	0
Total	56,105	55,847	53,984	54,007
Number per 1000 members	64	47	45	46

CCO Appeals

The table below shows the number of appeals the CCOs received during the quarter. There was a 1.6% decrease this quarter over the previous quarter. CCOs reported the highest number of appeals were related to outpatient care. Pharmacy appeals were the next highest and specialty care was the third highest. CCOs report they review the overturn rates which leads to more in-depth discussions and reviews, monitoring and process changes. Some CCOs are reporting that Peer Reviews with Providers is resulting in improvements to services. CCOs report they are continuing to do activities such as site visits, staff education and monitoring for providers to improve understanding of the appeal process. CCOs also work with members to assist them in finding services they need or assist them with finding alternative covered options.

CCO Appeals	Jan-Mar 2019	Apr – Jun 2019	Jul – Sep 2019	Oct – Dec 2019
a) Denial or limited authorization of a requested service.	1,281	1,358	1,236	1,273
b) Single PHP service area, denial to obtain services outside the PHP panel.	8	2	17	3
c) Termination, suspension, or reduction of previously authorized covered services.	8	2	11	12
d) Failure to act within the timeframes provided in § 438.408(b).	1	1	1	3
e) Failure to provide services in a timely manner, as defined by the State.	0	0	0	0
f) Denial of payment, at the time of any action affecting the claim.	363	387	355	303
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	1,661	1,750	1,620	1,594

Number per 1000 members	1.89	1.95	1.35	1.35
Number overturned at plan level	514	573	495	537
Appeal decisions pending	12	12	8	8
Overturn rate at plan level	30.94%	32.74%	30.56%	33.69

CCO and FFS Contested Case Hearings

The following information is a compilation of data from 15 coordinated care organizations (CCO), 6 dental care organizations (DCO) and fee-for-service (FFS).

The Oregon Health Authority (OHA) received 362 hearing requests related to the denial of medical, dental and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 330 were from CCO-enrolled members and 32 were from FFS members.

During the second quarter, 417 cases were processed and resolved. In each quarter there is an overlap of processed cases with those received. For instance, cases resolved in January of 2020 may be cases OHA received as far back as August and September of 2019. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. There were 21 cases approved prior to hearing. Members withdrew from 45 cases after an informal conference with an OHA hearing representative and OHA dismissed 291 cases that were determined not hearable cases.

Of the not-hearable cases, 221 were forwarded to their respective CCO's to process as an appeal. Oregon Health Plan (OHP) members must exhaust their appeal rights at the CCO level and receive notice of appeal resolution (NOAR) before they can request a contested case hearing at the state level. Hearing requests received by OHA prior to the appeal being exhausted are dismissed as not hearable with a letter to the member explaining their appeal rights through the CCO and their hearing rights after receiving an NOAR.

Fifty-nine cases went to hearing, where an administrative law judge upheld the OHA or CCO decision in 41 cases and dismissed 18 cases for the members failure to appear. One case was dismissed due to a member requesting a hearing after the allowed time frames without good cause for the late request.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	21	5%
Client withdrew request after pre-hearing conference	45	8%
Dismissed by OHA as not hearable	291	75%
Decision affirmed*	41	8%
Client failed to appear*	18	4%
Dismissed as non-timely	1	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	0	0%

Set Aside	0	0%
Total	417	

* Resolution after an administrative hearing.

Related data

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

F. CCO activities

1. New plans

In the report for the preceding quarter (7/1/2019 – 9/30/2019) Oregon stated that of the 15 CCO contracts awarded for 2020, four of them were 1-year contracts. The Oregon Health Authority (OHA) required these four CCOs to complete remediation plans in order for their contracts to be extended for the full 5-year term of the contract award. During the current quarter (10/1/2019-12/31/2019) quarter, all four CCOs successfully completed their remediation plans, and OHA executed amendments to extend their contracts for the full 5-year term.

Also, in the report for the preceding quarter (7/1/2019 – 9/30/2019) Oregon identified Trillium Community Health Plan as one of two CCOs with expanded service areas for 2020. Trillium's contract application included an expansion of its service area into Clackamas, Multnomah, and Washington Counties in the Portland Metro region. As a condition of the 2020 contract award, Trillium was required to demonstrate the sufficiency of the provider networks in both its historical Lane County service area and its expanded service area in the Portland Metro region. Trillium was not able to demonstrate a sufficient provider network for the Portland Metro region. As a result, OHA denied Trillium a notice to proceed in the Portland Metro region. CCO members that would have been enrolled with Trillium in this service area for services beginning in 2020 have instead been enrolled with the other CCO in the Portland Metro region, Health Share of Oregon. Trillium has until June 30, 2020, to demonstrate a sufficient provider network in the Portland Metro region or this service area will be removed from its CCO contract.

Lastly, in the report for the preceding quarter (7/1/2019 – 9/30/2019) Oregon noted the closure of two CCOs and one DCO (closed to FFS members) at the end of 2019. OHA's contract with the last remaining Mental Health Organization (MHO) also ended on December 31, 2019. Members of this MHO – Greater Oregon Behavioral Health, Inc. (GOBHI) – were transitioned to the CCO its in service area. GOBHI continues to operate in Oregon, including as a partial owner and subcontractor of a CCO, but no longer has a direct managed care contract with OHA.

2. Provider networks

There were no relevant changes in provider networks for physical health, oral health, or behavioral health during this reporting period.

3. Rate certifications

The Oregon Health Authority (OHA) contracts with Coordinated Care Organizations (CCOs) to manage and deliver integrated services that include Physical Health, Behavioral Health, and Dental Services to the majority of Oregon's Medicaid population. OHA pays CCOs with Actuarially Sound capitation rates that are developed on an annual basis. Capitation rates pay an amount per month depending on the individual's age and OHP eligibility category. In addition to CCOs, OHA also retains seven Dental Only (DCO) contracts and a Mental Health Only (MHO) contract where capitation rates are developed separately.

In October 2019, OHA submitted the final CY2020 CCO Rates Certifications CMS which effective as of January 1st, 2020 through December 31st, 2020. However, a mid-year revision was submitted to CMS on January 28, 2020. This amendment reflects an update in the qualified directed payment amounts (QDP), provider contracting, and new information that was added on by the CCOs regarding rate add-ons. OHA has also submitted the CCO CY2020 Expenditure Report and the Contract Rate Sheet by Plan and by CCO.

In November 2019, OHA held various Rates Workgroup meetings to discuss the distribution of the quality pool as well as providing CCO's with 2019 Exhibit L and MLR instructions and templates. Each CCO had until November 20th, 2019 to submit their Exhibit L Reports for Q3.

4. Enrollment/disenrollment

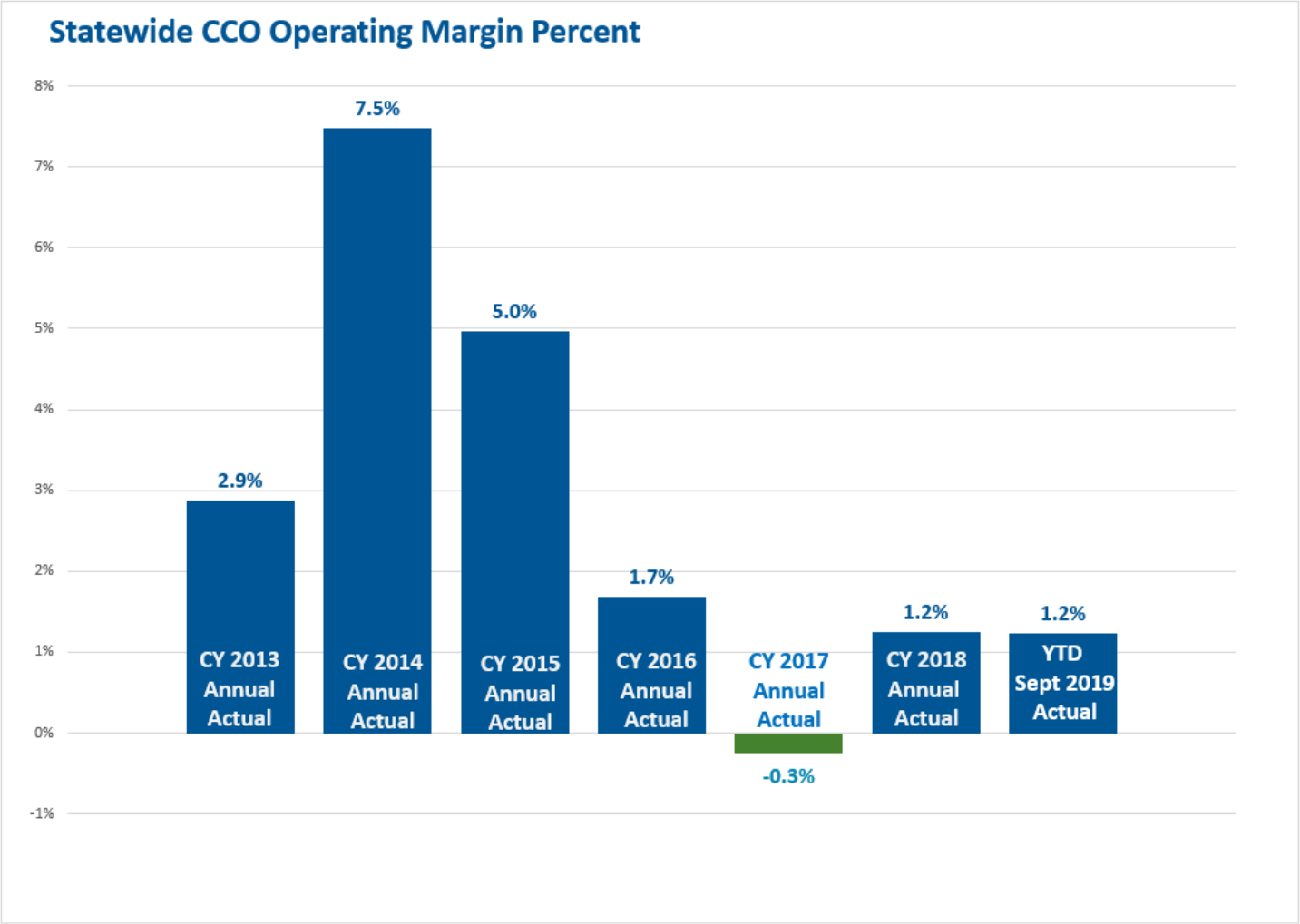
During this reporting period, OHA has taken many steps in anticipation of the new managed care contracts for CCO that start January 1, 2020. Some enrollment changes were instituted to stop enrollment into managed care plans that are terminating at the end of 2019 and to prepare members for enrollment in new managed care plans. There will be some decreases in managed care enrollment counts in December as a result.

5. Contract compliance

There are no issues with Coordinated Care Organization contract compliance during this reporting period.

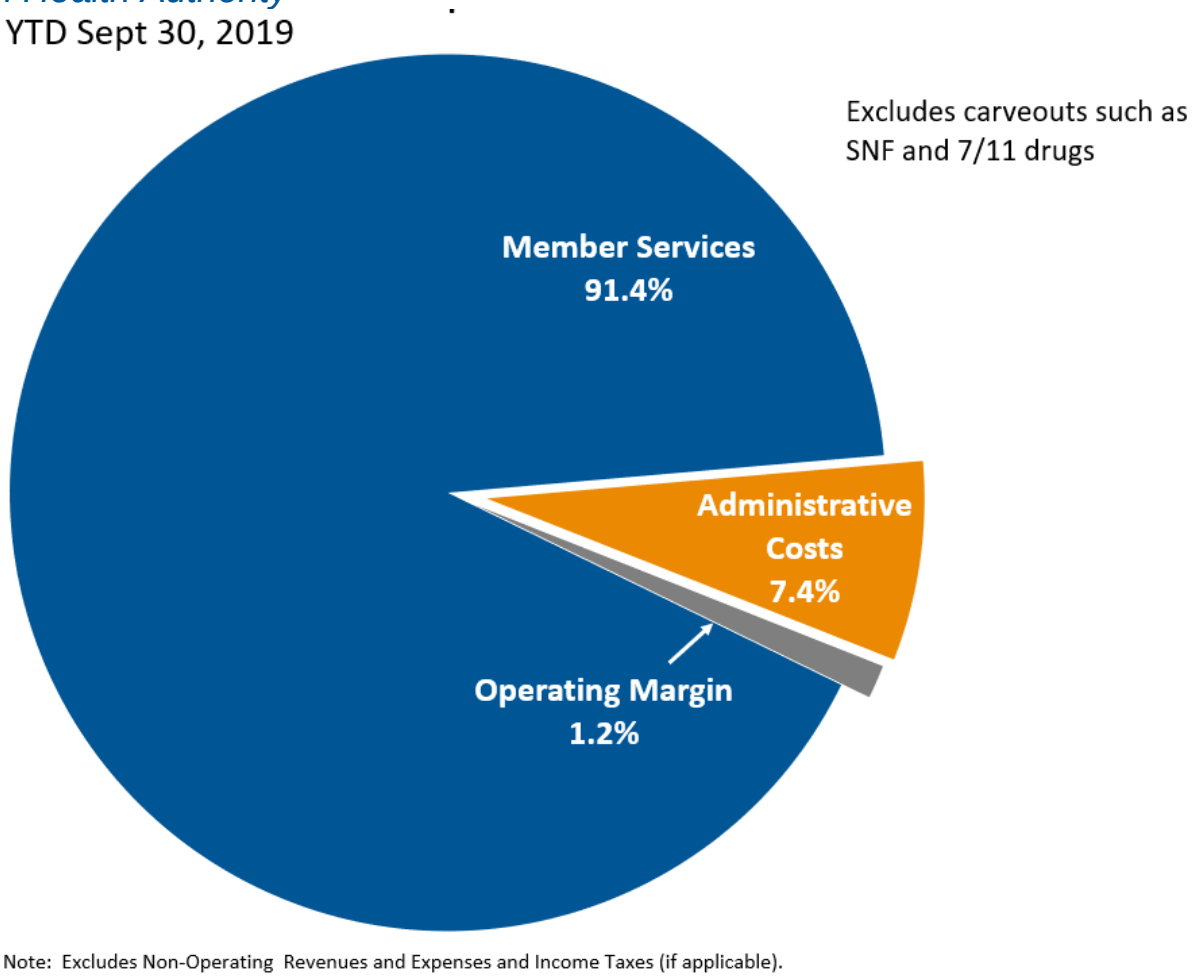
6. Relevant financial performance

For the 9-months ended September 30, 2019, the statewide CCO operating margin was at 1.2% compared to 1.2% for the year ended December 31, 2018. For reference, the capitation rates include a 1% profit margin. CCO operating margins returned to a slightly profitable status after trending downward during 2015-2017 period.



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (this includes medical, behavioral, dental and health-related services, reinsurance premiums and recoveries, and other adjustments) as a percentage of total revenue. For the 9-months ended September 30, 2019, the MSR for all CCOs in aggregate was 91.4%. Administrative Services accounted for 7.4% of total CCO revenue, leaving 1.2% as operating margin.

For the 9-months ended September 30, 2019, 13 out of the 15 CCOs met or exceeded the 85% target for MSR, a key indicator for MLR (Seven of the CCOs had MSRs above 90%). Two CCOs reported MSR below 85%, Umpqua Health Alliance at 83.3% and Cascade Health Alliance 84.4%.



As of September 30, 2019, all CCOs met their net worth requirement. Net Assets of the CCOs ranged from a low of $230 per member (Willamette Valley Community Health, LLC and Health Share of Oregon) to a high of $1,288 per member (Intercommunity Health Network), averaging $475 per member for the state.

For additional CCO financial information and audited financials are posted on OHA's website (http://www.oregon.gov/oha/FOD/Pages/CCO-Financial.aspx)

7. Corrective action plans

For the current quarter, one CCO continues to be on a Corrective Action Plan (CAP) and a different CCO was newly placed on a CAP:

CONTINUING CAP

• Entity name: Cascade Health Alliance (CHA)
• Purpose and type of CAP: Non-compliance with CCO contract and Hepatitis C Risk Corridor, OAR and CFR. CCO was not timely responding to authorization requests, not determining approvals and denials timely or appropriately, not providing notice to members and providers, and not providing authorized medication timely or at all to members who qualified for treatment for Hepatitis C.
• Start date of CAP: May 20, 2019
• End date of CAP: May 20, 2020; updated to December 31, 2019
• Action sought: Immediate correction of non-compliance; development and implementation of a plan for correcting the issues identify by OHA; submission of quarterly reports to OHA for a period of at least one (1) year.

• Progress during current quarter: CHA is compliant with the requirements. Its reports for Q4 CY2019 indicate that: all authorization requests were decided within the required timeframe; members and providers were notified about the decisions; and authorized medications were provided timely. No requests were denied. OHA agreed to close the CAP early; the final required report is for December 2019.

NEW CAP
• Entity name: Health Share of Oregon (HSO)
• Purpose and type of CAP: Non-compliance with CCO contract and OAR. CCO was not providing reliable non-emergency medical transportation (NEMT) services to covered appointments, resulting in disruption to members' access to care.
• Start date of CAP: October 14, 2019
• End date of CAP: April 14, 2020
• Action sought: Development and implementation of a plan for correcting the issues identified by OHA; submission of weekly reports to OHA for a period of at least six (6) months.
• Progress during current quarter: HSO's reports for November and December 2019 show small improvements in driver no-show rates, late pick-up for rides, and call wait times. HSO notified OHA that its NEMT vendor had gone into receivership and that HSO has contracted with a new vendor for NEMT services, with the new vendor's provider contracts going into effect on February 1, 2020.

8. One-percent withhold

During this quarter of 2019, HSD analyzed encounter data received for completeness and accuracy for the subject months of March 2019 through May 2019. All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

9. Other significant activities

During this reporting period OHA engaged with CCOs and other stakeholders in the final stages of development of policies that will be implemented during the five-year contracting period from 2020-2024. The broad scope and volume of changes taking place beginning in 2020 have engendered robust engagement from numerous stakeholders. OHA used this opportunity to remind all organizations interested in Oregon's Medicaid program of our key waiver goals, and to highlight how those goals are reflected in the new five-year contracts.

Many of the topics discussed during contracting and rules will carry forward into operational collaboratives and other avenues of dialogues with CCOs, to ensure CCOs are fully equipped to achieve those goals.

G. Health Information Technology

Medicaid Electronic Health Record (EHR) Incentive Program

Through the Medicaid EHR Incentive Programs (also known as the Promoting Interoperability Programs), eligible Oregon providers and hospitals can receive federally-funded financial incentives for adopting, implementing, upgrading, or meaningfully using certified electronic health records technology (CEHRT). Since the Medicaid EHR Incentive Program's inception in 2011, 3,834 Oregon providers and 60 hospitals have received over $205 million in federal incentive payments (as of December 31, 2019). Between October and December 2019, 133 Oregon providers received $1 million in Medicaid EHR incentive payments. The program sunsets at the end of 2021.

HIT Commons

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

The HIT Commons Governance Board met six times in 2019. The Board approved support through the HIT Commons for adoption and spread activities in support of the Oregon Provider Directory and directed staff to begin exploration and conceptual development of a statewide social determinants of health (SDOH) "Community Information Exchange" effort (see below for more information).

EDie/PreManage

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

PreManage is a companion software tool to EDie. PreManage brings the same real-time hospital event notifications (ED and Inpatient Admit, Discharge, and Transfer [ADT] data) to those outside of the hospital system, such as health plans, Coordinated Care Organizations (CCOs), providers, and care coordinators. EDie and PreManage are in use statewide and adoption for PreManage continues to grow.

In 2019, Oregon worked towards improving and enhancing EDie/PreManage for users. Highlights included:

- A 2019 Technical Assistance calendar was created for the year, and a six-part series held. The series supported basic, intermediate, and advanced use of the platform for primary care, behavioral health clinic use and workflows, and technical workflows.
- 66% of Oregon's hospitals are receiving PDMP data (see below) within their EDie alert.
- Physician Orders for Lifesaving Treatment (POLST) forms are available to view for clinics, Skilled Nursing Facilities (SNFs), payers, and hospitals who receive EDie alerts through paper/fax. PreManage began to roll out to Skilled Nursing Facilities (SNFs) across Oregon in 2019. 93 out of nearly 200 are live. SNFs are also now contributing admission and discharge encounter information into the platform to further support transitions of care and care coordination.
- To support children under the Medicaid program, a Complex Care Coordinator in OHAs Human Services Division onboarded onto PreManage on October 2019.
- The remaining Department of Human Services Intellectual & Developmental Disabilities (IDD) field offices went live with PreManage, bringing participation to 100% by IDD field offices in early winter 2019.

Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative

Oregon's Prescription Drug Monitoring Program (PDMP) Integration initiative connects EDie, HIEs, EHRs, and pharmacy management systems to Oregon's PDMP, which includes prescription fill information on controlled substances, and is administered by OHA's Public Health Division. HIT Commons oversees the PDMP Integration work with guidance from the Oregon PDMP Integration Steering Committee and in coordination with OHA's Public Health PDMP program.

PDMP Integration capabilities went live in summer of 2017 and the statewide subscription funding officially launched through the HIT Commons in Spring 2018. As of the December PDMP Integration report:

- 20,461 (this number cannot be deduplicated and may reflect duplicate prescriber counts) prescribers across 158 organizations have integrated access to Oregon's PDMP data– either through their EDie alerts, or through one-click access at the point of care (EHR or HIE), 7 retail pharmacy chains (across 368 sites) and 1 rural pharmacy are also live.
- 6.6% reduction in acute opioid prescribing since 2018.
- Interstate data sharing is established with PDMPs in Idaho, Kansas, Nevada, Texas, North Dakota, and Washington (WA for web portal only). Alaska, Wyoming and California are in progress.

Social Determinants of Health (SDOH) and HIT: Community Information Exchange

The HIT Commons has chartered an Oregon Community Information Exchange (CIE) Advisory Group to engage stakeholders statewide to discuss components of an effective CIE, assess opportunities for alignment of regional CIE efforts, and to develop a CIE Roadmap for Oregon by the end of 2020. In general, CIEs include a data repository of shared community resources that connects health care, human and social services partners to improve the health and well-being of communities. A technology platform supporting a CIE could provide many functions, including statewide social services directory, shared SDOH assessments, real-time closed loop referral management, collaborative care plans and standardized outcomes and data analysis. HIT Commons activities around CIE thus far have included:

- An environmental scan of CIE efforts underway in Oregon was completed in fall 2019 and included 20 meetings/interviews.
- The first Oregon CIE Advisory Group meeting was held in December 2019. Monthly meetings are anticipated to go through 2020 as the group engages stakeholders and develops a proposed roadmap for the HIT Commons Governance Board to consider in late fall/early winter.

Oregon Provider Directory (OPD)

The OPD will serve as Oregon's directory of accurate, trusted provider data. It will support care coordination, HIE, administrative efficiencies, and serve as a resource for heath analytics. Authoritative data sources that feed the OPD will be matched and aggregated and data stewards will oversee management of the data to ensure the OPD maintains initial and long-term quality information. The Provider Directory Advisory Committee provides stakeholder input and oversight to OHA's development of this program.

The OPD will benefit CCOs by supporting care coordination/HIE, administrative efficiencies, and serve as a resource for heath analytics in the following ways:

- Having one place to go for accurate and complete provider data
- Reducing burden on providers and staff time spent on data maintenance activities
- Enabling better care coordination for patients and ability to meet certain meaningful use objectives by supplying complete information on providers and how to contact them
- Improving the ability to calculate quality metrics that require detailed provider and practice information

HIT Commons is working with OHA staff and stakeholder volunteers to develop initial use case testing for the soft launch. Additional users will be added in later phases as data become more robust.

Clinical Quality Metrics Registry (CQMR)

Oregon's CQMR collects, aggregates, and provides clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting. The CQMR went live in early 2019 for Medicaid EHR Incentive Program/Promoting Interoperability electronic clinical quality measure (eCQM) reporting and the option for

reporting eCQMs to CMS for the Merit-based Incentive Payment System (MIPS) and Comprehensive Primary Care Plus (CPC+). Starting with the 2019 measurement year, the CQMR will support eCQMs and some state-specific measures for the CCO incentive measure program.

OHA engaged with stakeholders through a subject matter expert workgroup and other outreach. The SME workgroup wrapped up its work of advising on initial implementation and user acceptance testing, and a new CQMR user group will launch in the spring. In the fall of 2019, OHA worked with its vendor to implement and test system enhancements that were planned in response to stakeholder feedback. CQMR program staff engaged with CCOs to ensure successful onboarding, provided a communications toolkit, offered training webinars, and prepared written training materials to help users get ready for reporting that is due in the first quarter of 2020. In addition, ongoing technical assistance is offered through a contract with Oregon Health & Science University (OHSU), to help clinics prepare for patient-level eCQM reporting.

Health Information Exchange (HIE) Onboarding Program

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

Reliance eHealth Collaborative was the selected community-based HIE to onboard priority physical, oral, and behavioral health Medicaid providers according to a work plan developed in consultation with CCOs. OHA launched the onboarding program in January 2019. Through December of 2019, Reliance has been approved to start the process to onboard providers contracted with eight current CCOs in twelve Oregon counties.

Behavioral Health and HIT

The Behavioral Health HIT Workgroup was formed in August 2018 under the direction of HITOC to review the draft Behavioral Health HIT Scan and provide recommendations and priorities. The BH HIT Workgroup met again in November 2019 to provide input to the COMPASS team that is working on modernizing the Public Health reporting system. The modernization of the reporting system had been included in the August 2019 approved behavioral health HIT work plan that was developed based in part on Workgroup recommendations.

In November 2019 OHA received approval for $250,000 in grant funds through the SAMHSA Block Grant application to support behavioral health providers working with patients with substance use disorders to receive technical assistance on the adoption and use of EHRs. This application was submitted as part of a larger Block Grant application in September 2019.

A portion of the SUPPORT Act referred to as the “Improving Access to Behavioral Health Information Technology Act” authorized CMMI to create a demonstration project to incentivize the adoption and use of CEHRT for behavioral health care providers. The goals are to decrease the gap in behavioral health EHR adoption and improve the coordination and quality of care for Americans with mental health, Substance Use Disorder, and other behavioral health care needs. There has been no public information about this effort moving forward. OHA submitted a letter of interest to CMMI on July 10, 2019 expressing Oregon’s interest and highlighting our commitment to improving behavioral health as well as the technology gap that exists for Oregon behavioral health providers. OHA is in strong support of this demonstration project moving forward and hopes to see CMMI movement on this in the near future.

Health IT Stakeholder Groups

Health IT Oversight Council (HITOC)

The HITOC HIT 2017-2020 Strategic Plan was approved by the Oregon Health Policy Board in October 2017 and provides a roadmap for Oregon's HIT work ahead, including strategies for a "network of networks" approach to statewide health information exchange and the HIT Commons public/private partnership model of governance.

In February 2019, OHPB approved HITOC's major 2019 priorities (under the approved Strategic Plan): exploratory work in SDOH/health equity and patient engagement, next steps for statewide health information sharing ("network of networks") efforts (includes physical, behavioral, oral, and other information), wrapping up planning for behavioral health and HIT work, showing Oregon's HIT progress via dashboards and milestones, and potentially updating the Strategic Plan in fall 2019. Ongoing priorities include continued oversight work on partnerships/programs and new landscape assessment as appropriate.

HITOC meets six times a year. Highlights from HITOC's October and December 2019 meetings include:

- Receiving information on how certified EHR technology (CEHRT) and federal interoperability standards align with REAL+D in some areas and what information related to sexual orientation and gender identity is included in those federal standards
- Providing feedback on the 2019 Health IT Report, a report that includes trends, impacts, and outcomes of HIT, HIE, and EHR efforts in Oregon
- Finalizing a work plan to guide HITOC work through 2020

The work to update the Strategic Plan will begin in 2020.

CCO Health IT Advisory Group (HITAG)

HITAG did not meet during this reporting period.

Health IT & Health Information Exchange Community and Organizational Panel (HCOP)

HCOP did not meet during this reporting period.

Network of Networks Technical Definitions Workgroup

The planned Network of Networks is a critical part of HITOC's strategy for statewide HIE to support care coordination, population health, patient engagement, and value-based payment models. In its mature form, the Network of Networks may include: coordinating and convening key stakeholders; identifying and implementing needed infrastructure to facilitate exchange; ensuring interoperability; ensuring privacy and security practices; providing neutral issue resolution; and monitoring environmental, technical, and regulatory changes and adapting as needed. It will not include a state-run HIE.

In June 2018, after further study of the current Oregon HIE environment, HITOC chartered two workgroups to develop the Network of Networks concept: a technical definitions group to draft working definitions, and an advisory group to make recommendations to HITOC about key next steps after analyzing approaches and their relative merits in terms of effort, impact, and cost. After meeting with the technical definitions group several times, coordinating with the HIT Commons, and assessing major shifts at the federal level, including the

planned Trusted Exchange Framework (TEFCA) and Common Agreement and draft rules promulgated by CMS and ONC, HITOC decided to pause on network of networks efforts until the federal shifts are more clear, in order to avoid conflicting with national efforts. HITOC will continue to monitor the situation and will take action when appropriate.

The Network of Networks Technical Definitions Workgroup did not meet during October-December 2019.

H. Metrics development

Kindergarten Readiness

This developmental work comprises a four-part, multi-year measurement strategy:

1) Adopt two metrics for the 2020 CCO incentive measure set (for inclusion in the 2020 CCO incentive measure set):

- Well-child visits for children 3-6 years old
- Preventive dental visits for children 1-5 years old

2) Adopt a CCO-level attestation metric focused on children's social-emotional health once specifications are finalized (i.e., for the 2021 or 2022 CCO incentive measure set).

3) Replace the existing developmental screening metric with a new follow-up to developmental screening metric in 2022 or 2023.

Social Emotional Health Measure Development

During this same time, OHA continued its partnership with Children's Institute, with technical expertise from the Oregon Pediatric Improvement Partnership (OPIP), to develop the other components of the multi-year-multi-measure strategy. The workgroup developing the second component of the strategy (a CCO-level measure to improve the social-emotional health of young children) continued its bimonthly working sessions, which are now attended by members of OPIP. These meetings will continue through October 2020, with the goal of developing a measure that the Metrics & Scoring Committee could choose to include in the CCO quality incentive program in 2022.

Oregon is one of only eight states selected to participate in the Aligning Early Childhood and Medicaid (AECM) initiative, supported by the Robert Wood Johnson Foundation, and which aims to improve the health and social outcomes of low-income infants, young children, and families through cross-agency collaboration. This national program is led by the Center for Health Care Strategies in partnership with the National Association of Medicaid Directors and ZERO TO THREE. During this quarter OHA and partners from Children's Institute and OPIP continued to participate in monthly technical assistance meetings as a part of this initiative. In addition, the national AECM team conducted a site visit to Oregon in October, sponsoring a strategy session which included members of the Metrics & Scoring Committee and thought leaders in health and early learning from around the state. The strategy session was devoted to discussion and action planning about the developmental social emotional health measure (number 2 above).

To gather further input on the social emotional health measure, the workgroup fielded an online survey of stakeholders from across health and early learning sectors in November in December; 673 responses were received.

Follow-up to Developmental Screening Measure Development

OHA's partner, OPIP, is leading development of this measure. During this quarter OPIP continued to pilot the draft metric in various clinics with various EHRs across the state. Pilot findings demonstrate sensitivity and specificity to improvement efforts, face validity to pilot primary care sites. Detailed updates to be presented to the Metrics & Scoring Committee in later 2020.

SDOH/Health-Related Social Needs Measure

In this quarter the internal workgroup made plans for the recruiting members of the public workgroup which will consider and develop recommendations back to the Metrics & Scoring and Health Plan Quality Metrics Committees. This included creating application materials and a review process, as workgroup members will need to apply to participate. The solicitation for applications for workgroup membership will begin in January 2020, with appointments made by March 2020. The workgroup's first meeting will be on April 1, 2020.

During this quarter, the OHA internal planning also secured HITEC funding for contractor assistance in developing the measure related to screening for the Social Determinants of Health/Health-Related Social Needs. One contractor will be utilized as an independent facilitator of the public workgroup which will consider and develop recommendations back to the Metrics & Scoring and Health Plan Quality Metrics Committees. Another contractor made available by this funding will be an informaticist who will help in creating the technical specifications for the metric, and in pilot testing the metric with clinics. This contractor will also advise the to-be-formed workgroup on technical/electronic-health-records on topics to consider in its recommendations to the Metrics & Scoring & Health Plan Quality Metrics Committees.

Evidence-Based Obesity Measure Workgroup (Developmental measure workgroup)

In early 2018, the Metrics and Scoring Committee and Health Plan Quality Metrics Committee requested the development of an incentive metric focused on obesity, based on the prevalence and issue of obesity among Oregonians. Since May 2018, the Oregon Health Authority has been working on the development of an evidence-based obesity prevention measure for use in the state of Oregon. Workgroup membership includes Oregon Health Authority staff from the Public Health Division and the Health Policy and Analytics Division, and CCO and Local Public Health representatives.

The measure is being developed as a two-part measure. Part One addresses obesity prevention and reducing the prevalence of obesity through evidence-based multisector interventions. Part Two, an outcome measure including BMI measurement and interventions completed, is still in development and will be completed for anticipated implementation in 2023. The measure aligns with CCO 2.0 goals because it will increase a focus on issues outside the doctor's office that impact health and build stronger relationships with community partners.

Part One of the measure (multisector interventions) utilizes an attestation model with a point system across five areas. The areas are based on Oregon's Health Evidence Review Commission (HERC) evidence-review guidance document on obesity. The five areas are:

- Coverage and promotion to adult and pediatric intensive supports
- Root cause analysis and actions plans
- Community engagement
- Multisector interventions
- Foundational criteria

During the period of October 1 to December 31, 2019, the workgroup for Part One conducted a pilot test for the attestation point system of the measure. Ten of fifteen CCOs participated in this pilot project. The CCOs in this pilot were not expected to implement obesity MSI interventions during the pilot time period.

Purpose of the pilot:

- Test the attestation process for the Obesity Multisector Interventions component of the metric.
- Test the capability of CCOs to assess current obesity prevention and treatment work.

Results of the pilot:

- **Successes:** Existing relationships with community partners and local public health agencies; CCO leadership will help to make this measure a success.
- **Barriers:** Lack of resources; competing priorities; lack of local programs to promote multisector interventions.
- **Solutions:** Allocating CCO resources; identifying partnerships; ongoing technical assistance from OHA through the Transformation Center

Results of the pilot project will be presented to the Metrics and Scoring Committee in January 2020.

During the period of October 1 to December 31, 2019, the workgroup for Part Two (documentation and assessment of BMI) continued to work on developing measure specifications that maintain the intent of the measure while also being technically feasible with multiple EHR vendors.

Health Equity Measurement Workgroup (Development measure workgroup)

In early 2018, the Oregon Health Policy Board tasked the Oregon Health Authority with developing recommendations for measuring health equity in Oregon's healthcare system. The Health Equity Measurement Workgroup convened in October 2018.

The proposed health equity metric measures the proportion of visits with spoken and sign language interpreter needs that are provided by OHA qualified and certified interpreters. The goal of the measure is to ensure meaningful language access to health care services for all CCO members through quality language services and the delivery of culturally responsive care.

In May 2019 the measure proposal was presented to HPQMC for final decision to include in the 2020 menu set. The committee did not vote to include the measure for 2020. In June 2019, a requirement to report the total number of interpreters and type of interpreter services provided per quarter was included in CCO 2.0 contracts.

For the period of October 1 to December 31, 2019, the workgroup conducted a pilot project to test data reporting feasibility. Nine of fifteen CCOs participated in this pilot project.

Purpose of the pilot:

- Test the reporting template (reporting requirements begin Jan 1, 2020)
- Evaluate the quality of data
- Support CCOs in the reporting requirement

Results of the pilot:

- **Challenges:** Reporting turnaround time; matching records between data systems; workflows not in place to capture services by provider networks; not all CCOs have the ability to identify additional members needing interpreter services
- **Successful CCO practices in place:** Investment in language access services; provider education and frequent communication with network providers; matching patient with bilingual providers; workflows are in place for tracking certified and qualified providers

In the next quarter, January 1 to March 31, 2020, OHA will present the results of the pilot project and any recommended measure updates based on the pilot. Presentations will be made to the Metrics and Scoring Committee and the Health Plan Quality Metrics Committee. Also, in the next quarter these committees will make decisions about the inclusion of these measures in 2021 measure sets.

I. Budget neutrality

The Oregon Health Authority (OHA) provides two budget-neutrality reports: Oregon Health Plan Section 1115 Medicaid Demonstration Budget Neutrality report and Oregon's Children's Health Insurance Program (CHIP) Title XXI Allotment report. There are no significant current issues to address in these reports.

Reports are attached separately as Appendix D – Neutrality Reports.

J. Legislative activities

There are no legislative activities to report for this quarter.

K. Litigation status

Open lawsuits and legal actions related to the Oregon Health Plan (OHP), to which the State Medicaid agency (Oregon Health Authority) is a party to, are listed, in aggregate. Lawsuits and legal actions include anything that is currently open in court, excluding estate recovery, during the reporting period.

Family Care v. OHA

A CCO, FamilyCare, has filed a lawsuit making the following claims against OHA and its current and former Directors. Some of the trial court's decisions have been taken up on immediate appeal, and the trial court action has been stayed pending the outcome of those appeals. There was no significant activity during the reporting period.

Bay Area Hospital v. Oregon Health Authority

In December of 2019, Bay Area Hospital, formed by a health district, filed an administrative appeal to challenge a supplemental assessment on hospital to support the Oregon Health Plan. The Oregon Tax Court ruled against

the Hospital on the issue of the assessment, in May of 2019. The Hospital appealed to the Oregon Supreme Court but later dismissed the appeal and an appellate judgment dismissing the appeal was issued December 27, 2019. A proposed order from the administrative law judge is expected to be issued by early July.

Sarepta Therapeutics Inc. v. OHA

This is a petition for judicial review of the agency's prior authorization criteria that are the rule for determination for Oregon Health Plan coverage of the prescription medication Exondys 51. There was no significant activity during the reporting period.

L. Public forums

Health Evidence Review Commission (HERC)

November 14, 2019
No public testimony.

HERC Value-based Benefits Subcommittee

November 14, 2019
This testimony concerned Lower Extremity Chronic Venous Disease (LECVD) interventions that could be used for cosmetic varicose veins, an unfunded condition, or to treat complicated varicose veins, a funded condition.

> **Dr. Ed Boyle** testified regarding the benefits of treatment on patients' quality of life. He noted that NICE coverage is much more expansive than the coverage contemplated by the HERC. He noted that treatment of CLEVD affects pain and quality of life. He felt that severe swelling should be included as an indication and would like to see severe pain as an indication as well. Boyle noted that private insurers manage benefits with pain as an indication, and that physicians are familiar with the documentation necessary to indicate the patient's pain. Boyle also was interested in expanding coverage to include stasis dermatitis. Boyle stated that the diagnosis of severe venous reflux is made by ultrasound findings. CMS and private insurers require the ultrasound findings when determining coverage. Boyle argued that the proposed guideline as written only covers severe end stage CLEVD. He again reiterated that CMS covers severe refractory edema and stasis dermatitis and advocated for inclusion of these indications, which would match the major private insurers.

This testimony concerned a stakeholder request to add coverage for vestibular rehabilitation, including canalith repositioning, for vestibular disorders.

> Public commenters, **Mary Hlady** and **Jamie Caulkey**, both physical therapists from Providence, expressed happiness that canalith repositioning would be moved to the funded region of the Prioritized List. They raised concern about the proposed limitation to those 65 years and older. Livingston clarified that while others may be at risk of falls, older adults were at higher risk based on the USPSTF review. Public comment discussed the importance of a variety of comorbidities, particularly neuromuscular conditions, that may increase morbidity of fall risk.

This testimony concerned adding coverage for codes related to wraparound services for autism. To qualify for wraparound services, a child must be involved in two or more child systems (e.g. foster care and medically fragile), and that OHA has rules regarding the level of severity a child must have before qualifying for these services. Not covering wraparound services can lead to non-coordinated care.

Nat Jacobs from OHA testified that these services are reserved for the top 5% of children with high needs to youth state programs. These services can reduce ER and other downstream costs. Adding wraparound service codes to the autism line creates consistency among mental health diagnoses.

HERC Evidence-based Guidelines Subcommittee

December 5, 2019

The committee heard more testimony related to updating the 2015 Coverage Guidance on Planned Out-of-hospital Births with committee discussion of the topic planned to continue through at least February.

Sharron Fuchs offered her comments, clarifying a written comment submitted by Vern Saboe, DC, prior to the meeting, supporting the coverage guidance. She clarified that his letter means that the HERC guidance constitutes the scope of practice and some of the standards of care for the chiropractic profession around out-of-hospital birth.

Silke Akerson, a licensed direct-entry midwife, and executive director of the Oregon Midwifery Association offered her comments. She said she has been sounding an alarm that the group is far into creating practice standards for midwifery that her concerns aren't being heard. She said it is inappropriate for HERC to create practice standards. She said she had reviewed other coverage guidance, such as the one for planned cesarean section and they are much less detailed and more based on evidence. They treat providers as professionals practicing within their own license and scope and practice standards.

She said that the EbGS had made practice guidelines for a broad profession, using personal opinion and professional expertise, not evidence, and said that if such guidelines are to be created there should be more midwife experts involved. She raised concern about decreased access to out-of-hospital birth and creating harm to all the professions and boards that have their own guidance.

She asked what the evidence is regarding several of the consultation/transfer requirements, including a history of postpartum psychosis. She said based on her professional expertise, for many women who have had postpartum psychosis, out-of-hospital birth is an excellent choice because they are able to have one-on-one individualized care with someone who can work with their team of mental health professionals to make a really specific plan. They don't have the interruption or fear of going to a facility they may have a lot of tension about. In addition, postpartum psychosis happens two days to two weeks postpartum, well after labor and delivery. It's not about what happens at the birth.

She also asked about the evidence for other factors, including that a midwife is not capable of assessing whether a 16-year-old or a woman with a prior 3rd degree tear, or cannabis use. She said that evidence-based standards should be restricted to factors we have clear evidence about such as breech, twins, gestational diabetes, pregnancy-induced hypertension and gestational diabetes. She also requested that the transfer and consult criteria be listed separately for ease of use.

Karen Dewitt spoke next. She is a naturopathic physician who attends out-of-hospital births and owns a birthing center. She believes in importance of evidence-based medicine and informed consent. While

she acknowledged HERC and OHA have had good intentions, she affirmed Akerson's comments that the criteria are not evidence-based and are too detailed. She said that from 2015 to 2017 there was a 75 percent decrease in out-of-hospital births covered by the Oregon Health Plan. She referenced the Strong Start data and said that we should be increasing access to midwifery because of lower cesarean rates, successful VBAC rates and other outcomes such as lower preterm birth rates. She said the issue isn't the list of risk factors in itself (though there needs to be more input from out-of-hospital birth providers in order for it to work well). Rather, there are a lot of situations where a woman shouldn't be giving birth outside a hospital but there is also a gray area where women have a right to make a choice.

She said the feedback from 95 percent of her patients is that the prior authorization process is discriminatory and traumatic and increases their overall anxiety about their prenatal care and their birth plan. This is because of how long the process takes. She does prior authorization every day for other services, but this is different in terms of the amount of medical records and the distinction that no approval is given until the third trimester. (Akerson interrupted to say that the policy has recently changed and there is now a hold on payment until after the birth records are sent. The midwife can go an entire course of care and not know whether she will be paid). Dewitt confirmed that she recently became aware that they had to send labor flow notes after the birth, and for a lot of women this feels like an invasion of privacy. She also expressed concerns about PA staff denying coverage for criteria not on the list, such as Ehlers-Danlos syndrome. Her birthing center has had to hire someone just to manage the prior authorizations. She said many midwives have stopped accepting Medicaid.

She gave an example of women who feel discriminated against, such as those with higher BMI. The majority feel the consultation doesn't add any more safety to their care and feel humiliated to have to have the approval of a hospital-based provider who doesn't know about out-of-hospital birth.

She recommended OHP consider process more like that used in Washington, with a one-or-two-page summary of the woman's overall health. It's straightforward and not humiliating or traumatizing and it doesn't make providers not want to accept Medicaid.

She also told of a woman whose Medicaid coverage for a home birth was denied due to mental illness. She was not comfortable in a hospital due to previous trauma experienced in a hospital, and so planned to wait to the last minute to go to the hospital. The baby came sooner than she expected, and she had an unattended home birth. Fortunately, she and the baby were OK, but she could have had a hemorrhage, or the baby could have needed resuscitation.

She expressed concern that many consulting providers say they don't know enough to say that out-of-hospital birth is safe, so they don't recommend it and coverage is denied based on the consultation.

Metrics and Scoring Committee

October 18, 2019

Public testimony at the meeting:

- Chandra Elser, of Health Share Oregon, asked if there would be discussion of potential changes to metrics, e.g., to address vaping health concerns, improve the depression screening mechanism, etc. She noted that there is limited time available to propose such changes before the next measure set is approved. A discussion followed on strategies for proposing and implementing changes to measures in the future. September 20, 2019

November 15, 2019

Public testimony at the meeting:

- Beth Englander and Kelsey Heilman of Oregon Law Center spoke about the need in Oregon for better testing for blood lead poisoning. Due to the damage to child development, and Oregon's relatively poor performance in this field, they advocated for development of a metric for pediatric blood lead testing. They also observed that low-income and minority children are disproportionately affected, making this a health equity issue as well.

The Metrics & Scoring Committee did not meet in December 2019.

Health Plan Quality Metrics Committee

No public comment in October, November or December.

IV. Progress toward demonstration goals

A. Improvement strategies

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

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

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

Patient-Centered Primary Care Homes

PCPCH program staff conducted 11 site visits to primary care clinics this quarter. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address barriers.

As of December 31, 2019, 648 clinics were recognized as PCPCHs (19 more than the prior quarter). This is approximately three-quarters of all primary care practices in Oregon. Seventy-one PCPCHs (six more than the prior quarter) have been designated as 5 STAR, the highest tier in the PCPCH model.

The PCPCH Standards Advisory Committee is a multi-stakeholder body that provides OHA with policy and technical expertise for the PCPCH model of care. The committee convened monthly from July to December 2019 to review PCPCH implementation progress and advise on refining the model to further guide primary care delivery transformation. The committee provided recommendations to OHA on how to improve the model. Notable recommendations include the addition of new measures to address oral health, social determinants of health and substance use disorders. The revised PCPCH standards will be implemented in mid-2020.

Certified Community Behavioral Health Clinics

During this quarter, the Oregon Health Authority (OHA) was able to secure funding that allowed nine of the original 12 Certified Community Behavioral Health Clinics (CCBHCs) to continue participating in the current demonstration program for six months (Sept 2019 – Feb 2020). Oregon continued to pay a daily rate to participating clinics, using the selected Prospective Payment System (PPS-1) model. The rate for each CCBHC is unique to each organization and was developed based on analysis of cost reports submitted to OHA during the planning grant.

Following a one-year planning grant (2015- 2016), the CCBHC demonstration program was launched in Oregon on April 1, 2017 and originally set to end March 31 but had been extended to through June 30, 2019. Today, the demonstration and payment methodology continue to garner federal support that may allow for additional continuity. CCBHCs must meet numerous federal requirements, such as the ability to directly provide outpatient mental health and substance-use disorder (SUD) services to the full age range, regardless of payer. There are also nine Oregon CCBHC Standards, which enhance or expand on the federal requirements.

Among the key milestones for this quarter:

- Clinic-lead metrics for Demo Year 2 (April 2018- March 2019) report completed.
- Report to Congress, 2019 released by Mathematica/SAMHSA

Additional federal extensions grants to demonstration states through May 21, 2020.

Tribal Care Coordination

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

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

Services eligible for this program include any covered Medicaid services. These services are typically covered at 100% FMAP when provided at IHS/tribal facilities, but updated guidance allows 100% funding for services outside of IHS/tribal facilities as long as the care is coordinated by the IHS/tribal facility. The state then claims the enhanced federal match, subtracts a small administrative fee, and returns the difference to the IHS/tribal health program that coordinated the care.

To further assist in efforts to expand coordination of care for tribal members, the Oregon Health Authority has contracted with CareOregon to provide care coordination services for the roughly 17,000 AI/AN people enrolled in the Oregon Health Plan who are Fee-For-Service patients. CareOregon's model of care coordination was led and developed by the tribes during discussions taking place in 2016. The tribes requested establishment of a program that focused on culturally-responsive health care and took into account the unique nature of the AI/AN health care delivery system. During the first 11 months of the program 766 members enrolled in the program, and 1,336 calls were received by CareOregon's call center. 140 of these tribal members were enrolled

in one of Oregon's nine federally recognized tribes; 346 individuals were enrolled in an out of state tribe. CareOregon reports high rates of member satisfaction with the program, which has been renewed for a second year.

OHA has been working with tribal health representatives from Oregon's nine Federally-recognized Tribes to support efforts to establish one or more Indian Managed Care Entities. OHA has been hosting weekly meetings since April 2019 to move this project forward. It is expected that I/T/Us will establish five Indian Managed Care Entities.

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

Comprehensive Primary Care Plus (CPC+)

The Transformation Center manages the Medicaid fee-for-service implementation of CPC+. Per-member, per-month care management fees are a key component of the CPC+ payment model.

The Oregon CPC+ payers had monthly facilitated meetings to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers:

- Discussed the significant impact CCO 2.0 has had on their work, including changing the number of CPC+ practices in their networks, meaning a shift in organizational emphasis and interest.
- Collaborated with Comagine to produce two "Data Bytes" using the Oregon Data Collaborative; one focused on quality, and another on inpatient and ED utilization.
- Agreed on a vision for future work to identify, analyze, communicate and accelerate the drivers of improved performance in primary care, and to leverage aggregated claims data to examine the impact of the CPC+ program. The payers also want to share best practices to inform the spread of the model beyond CPC+ clinics. This includes providing tools for practices as they move beyond CPC+ to other VBP models.

Primary Care Payment Reform Collaborative

OHA convenes the Primary Care Payment Reform Collaborative, a legislatively required multi-stakeholder advisory group tasked with assisting OHA with the development and implementation of a Primary Care Transformation Initiative. In 2019 the collaborative formed four work groups to support work in the following areas: metrics, evaluation, implementation and technical assistance.

At the October meeting, members received updates on implementation progress, discussed the Primary Care First payment model, finalized the collaborative workplan and received updates from work groups to determine next steps.

Value-Based Payment Innovations and Technical Assistance

The Transformation Center is planning a robust technical support program for CCOs' VBP activities. Initial technical assistance will include:

- Support for care delivery area (CDA) VBP development in hospital care, maternity care and behavioral health care;

- Support for developing and sharing features and characteristics of VBPs that may more effectively achieve VBP goals; and
- Education on VBP models and characteristics for providers and others to facilitate adoption.

The center will convene CCOs in early 2020 to gather input that will inform VBP alignment approaches. The listening session will focus on CCOs' ideas to use VBP alignment as a lever to reduce provider reporting burden; reduce administrative costs; and improve quality of care for members.

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

Statewide Performance Improvement Project

The current statewide PIP, based upon calendar year (CY) 2019-2021, is in the design phase. OHA and CCOs selected the topic of opioid prescribing in acute situations.

Discussions with OHA and CCOs led to finalization of the statewide PIP direction. The following is the adopted structure for the statewide PIP.

Study Topic (Step 1): Acute Opioid Prescribing

Study Question (Step 2): Do targeted interventions decrease the percentage of members in the study population who received greater than seven days' supply for the first opioid prescription?

Study Population (Step 3): Population Definition: Oregon Health Plan (OHP) opioid naïve members 12 years of age and older who received an opioid prescription in the measurement year.

Opioid naïve is defined as no opioid prescription for six months prior to the first opioid prescription in the measurement year.

Study Indicator (Step 4): Study Indicator Title: The percentage of members whose first opioid prescription was filled for greater than seven days' supply.

Measurement:

The measure is currently defined as: *Percent of patients with at least one opioid prescription in one year, who have no opioids prescribed in the prior six months, among patients in the population by days' supply (i.e., ≤3, 4–7, 8–13, and ≥14).*

Measurement Periods:

Baseline: January 1, 2020, through December 31, 2020

Remeasurement 1: January 1, 2021, through December 31, 2021

Remeasurement 2: January 1, 2022, through December 31, 2022

As part of the CMS 1115 OHA waiver, attachment E, CCOs are expected to develop and implement three additional PIPs and/or focus study; outside the statewide integration PIP focus.

Additional information is posted publicly on OHA's website (https://www.oregon.gov/oha/HPA/DSI/QIDocs/CCO-PIP-Quarterly-Summary.pdf).

For the coming calendar year, 2020, OHA will be working with the external quality review organization, HSAG, on the review summary provided to OHA to better support rapid cycle improvement implementation. Prioritizing the areas of opportunities for CCOs to receive technical assistance will further move the CCOs to continuous quality improvement methods in ensuring health transformation and quality of care for OHP enrollees.

Behavioral Health Collaborative Implementation

The center staffed the Regional Behavioral Health Collaborative (RBHC), which is a partnership with behavioral health leaders and stakeholders in the Portland area to improve behavioral health outcomes through collective action across organizations responsible for behavioral health. The initial focus of the RBHC is peer-delivered services and substance use disorder activities that can make an impact in 12–24 months. Three topic-specific work groups are developing implementation plans and measures of success:

- The medical work group held a planning meeting with new stakeholder engagement to discuss content for the resource document to assist medical settings and recovery peer agencies add recovery peers to enhance medical responses to individuals with SUDs. Participants included peers, staff from medical settings that have engaged peers, and staff from medical settings who want to engage peers. The group identified topics to include in the resource document and lessons learned.
- The communities of color work group received funding for a two-year project to increase culturally specific peer-run recovery housing and culturally specific trainings for peers. The funding will support three new minority-specific recovery houses with integrated peer support.
- The youth and families work group submitted a proposal to provide peer-delivered services to youth in foster care. The proposal was not funded. The work group is meeting in February to identify opportunities to advance the work – such as new funding, ways to integrate the work into other activities and systemic changes to remove barriers.

Additionally, the center hosted a one-day event offering peer-to-peer learning on how CCOs, primary care practices and specialty behavioral health organizations are integrating behavioral health. Topics included the benefit of integration in reducing emergency department use amongst those with mental illness, effective use of data, and substance use disorder strategies. One hundred and twenty-one people attended, and 96% of evaluation respondents said the event was valuable or very valuable to their work. As one participant said, "I loved hearing patient stories and perspective. Great moderator; so wonderful to hear about successful programs."

Roadmap to Oral Health

OHA completed processes to allow dental professionals to bill Medicaid for two important procedures that encourage integration of dental and physical health. Starting on January 1, 2020, dentists will be able to administer vaccines their patients. They will also be able to be reimbursed for administering HbA1c tests.

To increase awareness and understanding of oral health among OHA staff and the general public (OHA Roadmap outcome), OHA sponsored a visit by the Assistant Surgeon General, Rear Admiral Tim Ricks, DMD, MPH on September 23, 2019. OHA and Dr. Ricks gave a public presentation on the upcoming Surgeon General's Report on Oral Health, Oregon's oral health metrics, and the successes and challenges of oral health integration nationally and in Oregon. Dr. Ricks also toured Multnomah County Health Department's Northeast

Dental Clinic to learn more about their work to serve inner-city, high-needs patients and reduce opioid prescribing.

Related to Dr. Ricks' visit, OHA was invited in November 2018 to give input to the Surgeon General's second-ever special report on oral health. In addition, the OHA dental director took part in a listening session with the Surgeon General to provide input on Oregon's efforts to encourage responsible opioid prescribing among dentists and to give input on the importance of community water fluoridation. Both topics that will be covered in the report, to be released in the fall of 2020.

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

Sustainable Relationships for Community Health Program

Activities: The goal of Sustainable Relationships for Community Health (SRCH) is to bring together different organizations and sectors within a community to complete a shared health systems change project sustained beyond the grant period. The four SRCH teams for 2019-2020 met in October 2019 for SRCH Institute 1, a two day in-person convening. During SRCH Institute 1, teams determined their priority populations and pilots for the SRCH grant year, co-designed strategies to formalize infrastructure between partners (e.g. closed loop referrals) and implemented quality improvement processes. The SRCH teams will continue their work through June 2020, with two more SRCH Institutes in February and May 2020. OHA staff provided technical assistance during SRCH Institute 1 and continue to support each team between Institutes.

Progress and Findings: During SRCH Institute 1, each SRCH team co-designed sustainable health systems strategies to improve health outcomes, promote equity and contain costs. This work included co-developing a shared goal, measurable outcomes, and specific actions with partners. All SRCH teams learned techniques that are critical to establishing, nurturing and sustaining partner relationships to improve health outcomes.

Trends, Successes, or Issues: This is the first time that the Public Employee Benefit Board, PEBB leadership, and the three health plans have participated in the SRCH process and Institutes. With the health plans participating, systems change improvements can be scaled beyond PEBB beneficiaries.

Public Health Modernization

Oregon's legislature allocated an additional $10 million for public health modernization during the 2019-21 biennium, for a total of approximately $15.6 million.

The majority of these funds were allocated to local public health authorities, federally-recognized tribes, the Urban Indian Program, and the Northwest Portland Area Indian Health Board. Funding directly supports Oregon communities to prevent and respond to communicable diseases and to implement new ways to eliminate health disparities. The success of interventions for communicable disease control is grounded in strong partnerships, including those with the health care sector. A description of partnerships established for 2019-2021 is also published on OHA's public web site (https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/2019-Regional-Partnerships.pdf).

Oregon Health Authority is using a portion of funds to modernize statewide population health surveillance systems and to make upgrades to the Oregon State Public Health Laboratory. Improvements to statewide health data and the public health lab ensure health care providers and others have the information they need to understand and respond to health threats. Funds also support annual reporting on public health accountability

metrics. This set of metrics, required in Oregon Revised Statutes, Chapter 431, track the efficiency and effectiveness of the public health system in improving population health outcomes and in some cases align with health system metrics used in the CCO Quality Pool Program.

Innovator Agents

The Innovator Agents assisted CCOs as they made final preparations for CCO 2.0. CCOs were required to conduct community engagement meetings to provide information about the CCO and its services to members and the community. Innovator agents attended these meetings to provide an OHA presence and answer questions when appropriate. Innovator agents assisted with readiness review for all CCOs and the four CCOs that received one- year contracts were provided technical assistance from OHA and Coraggio Group to enable them to obtain five- year contracts. The Innovator Agents helped arrange phone calls between the parties, made connections with subject matter experts, reviewed documents and provided feedback to the CCOs. Two CCOs ended their contracts with OHA and the Innovator Agents that supported those CCOs coordinated questions and meetings related to closing requirements, including member transition, financial close- out and reporting, and provider/stakeholder communications. The work in communities where there is more than one CCO has involved focus on the two CCOs creating a joint Community Advisory Council in order to best represent the community and to pool resources to meet community need and consumer involvement. Involvement with specific provider groups regarding member assignment, contracting changes and member communication has been a large issue and will continue to be in the near future. Innovator agents have continued to provide support to Community Advisory Councils (CACs) by attending meetings, giving OHA updates, and providing technical assistance as CACs begin to comply with new contract and rule requirements.

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

Health-Related Services

CCOs receive a global payment for each member, which provides CCOs the flexibility to offer health-related services (HRS) to improve the health of Oregon's Medicaid population.

In November, the Transformation Center hosted a peer learning event on how CCOs are implementing HRS and what HRS services or initiatives CCOs are funding. The Oregon Rural Practice-based Research Network (ORPRN) co-facilitated the event with Transformation Center staff and incorporated learnings from interviews with CCOs, clinics and health systems partners. OHA staff also shared HRS guidance updates. Seventy-nine people attended, representing 13 CCOs. Of evaluation respondents, 100% said they planned to take action as a result of attending, with the most helpful content being how to report HRS spending and using HRS for housing-related investments.

OHA staff reviewed CCOs' 2019 HRS policies and will share results with CCOs with an eye toward the updated requirements in the new 2020–2024 CCO contracts.

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

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

Community advisory council activities

The center continued to host monthly CAC learning collaborative calls on CAC member recruitment and engagement and other topics, and also prepared for two webinars in January focused on CACs and CCO contract and rule changes.

Community health assessment (CHA) and community health improvement plan (CHP)

Based on OHA's review of every CCO's second CHP, OHA provided written feedback to CCOs and requested additional information. The additional information received will highlight CCOs' gaps in CHP development and inform future CCO guidance and technical assistance. The guidance and technical assistance will include a CHP best practices session at the CCO 2.0 kickoff event in March 2020, a CCO CHA/CHP requirement guidance and checklist document, and an update to the CHA/CHP development training to address changes in CHA/CHP requirements.

CCO incentive metrics technical assistance

The Transformation Center is planning technical assistance to support several of the 2020 CCO incentive metrics.

Adolescent immunizations

The Transformation Center held needs assessment calls with CCO and clinic staff to help design technical assistance to increase adolescent immunizations.

Diabetes (HbA1C and a new oral health visit metric)

The Transformation Center held two peer-to-peer webinars to support system and clinic efforts to lower rates poor HbA1c control. The center also held needs assessment calls with CCO, dental care organization and clinic staff to support CCO efforts to improve the rate of dental exams for adults with diabetes.

Kindergarten readiness (well-child visits and preventive dental visits)

The Transformation Center held needs assessment calls with CCOs, clinics and referring partner organizations to inform future technical assistance to help CCOs improve on two metrics of kindergarten readiness: well child visits (ages 3-6) and preventive dental visits (ages 1-5). A top need identified is to better communicate with parents about why well-child visits and preventive dental services for children are important.

Screening, brief intervention and referral to treatment (SBIRT)

The Transformation Center is partnering with ORPRN to offer TA to primary care clinics in support of the SBIRT metric. The TA is a three-year study funded through the Agency for Healthcare Quality and Research. The project is designed to address unhealthy alcohol use, chronic pain management and opioid prescribing in primary care. Ten clinics across Oregon have signed up to participate so far.

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

The Transformation Center coordinated a statewide CCO learning collaborative session that focused on strategies to achieve timely health assessments for children in DHS custody. The session included data and notification and presentations from two CCOs about lessons learned and their strategies for success. Most evaluation respondents rated the sessions as valuable for supporting their work.

Six-month retrospective technical assistance evaluation

The Transformation Center has been evaluating the impact of key technical assistance activities six months afterward. Of respondents to date, 95% have rated the specific TA activity somewhat, very or extremely helpful (19% extremely, 44% very, 32% somewhat), and 87% indicated their CCO made at least one change as a result of the TA activity. Respondents have noted the following impacts of the TA:

- "We were able to build a shared understanding of how a successful, inclusive community health assessment process should occur, and connected with our local private hospital representatives in a way we likely would not have been able to otherwise."
- "Improved ability to identify and intervene to solve unique issues creating high ED use."
- "We met our OHA metric for hypertension, in part due to this program."
- "Our support for traditional health workers has improved and we have implemented better alternative payment models to support them."
- "I think I'm doing a better job of 'hearing' my patients and their concerns. I believe there is improvement in the outcomes based on how I share learned information."

B. Lower cost (ANNUAL)

C. Better care and Better health (ANNUAL)

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately as Appendix A – Enrollment Reports

2. State reported enrollment table

Enrollment	Month/Year	Month/Year	Month/Year
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	951,951	951,575	953,633
Title XXI funded State Plan	91,887	91,174	91,316
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
Enrollment current as of	October/31/2019	November/30/2019	December/31/2019

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%	0	0	0	0
		Pregnant women FPL > 170%	0	0	0	0
	Title XXI	SCHIP FPL > 170%	41,668	110,896	16.02%	44.60%
	Title XXI	SCHIP FPL < 170%	102,438	274,662	14.75%	15.97%
Mandatory	**Title XIX**	Other OHP Plus	158,781	455,355	11.71%	1.19%
		MAGI adults/children	736,616	2,074,959	12.82%	0.28%
		MAGI pregnant women	10,676	25,315	7.71%	9.86%
		QUARTER TOTALS	1,050,179			

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

OHP eligible and managed care enrollment

OHP eligible*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
October	992,559	895,595	656	45,353	1,058	299	10,644
November	990,553	889,004	434	43,932	1,036	279	10,617
December	994,215	891,351	513	44,210	1,089	280	10,688
Quarter average	992,442	891,983	534	44,498	1,061	286	10,650
		89.88%	0.05%	4.48%	0.11%	0.03%	1.07%

** 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

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

C. CCO appeals and hearings

Reports are attached separately as Appendix C – CCO Appeals and Hearings.

D. Neutrality reports

Reports are attached separately as Appendix D – Neutrality Reports.