Oregon Health Plan

Section 1115 Quarterly Report

7/1/2020 – 9/30/2020
Demonstration Year (DY): 19 (7/1/2020 – 6/30/2021)
Demonstration Quarter (DQ): 1/2021
Federal Fiscal Quarter (FQ): 4/2020

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I. Introduction

A. Letter from the State Medicaid Director

During this reporting period, Oregon continued to progress toward achieving the goals of the Medicaid demonstration waiver. As the state continued to respond to the to the COVID-19 pandemic, Oregon also experienced wildfires constituting a second public health emergency.

The wildfires affected state staff, CCO staff, healthcare providers, and many recipients of Medicaid benefits. OHA worked with community partners throughout the state to ensure that new streams of federal funding were used efficiently to complement ongoing CCO efforts.

Community Advisory Councils continue to be a valuable forum for highlighting emerging issues that are unique to each community, while Innovator Agents continue to create connections between the work of those groups and state priorities such as the State Health Improvement Plan, and Transformation Plans.

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.

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: 7/1/2020 – 9/30/2020
Demonstration Year (DY): 19
Demonstration Quarter (DQ): 1
Federal Fiscal Quarter (FQ): 4/2019

III. Overview of the current quarter

Oregon has experienced increased demands for enrollment due to the COVID-19 pandemic and the public health emergency created by wildfires. A recently implemented integrated eligibility system has helped coordinate enrollment in Medicaid and related services.

The increase in enrollment has corresponded to an increase in complaints as more members are needing care due to the pandemic and restrictions on in office visits were modified. The increase in this quarter however is still not to the level of complaints that were being reported prior to the shutdown of services due to the pandemic.

During this quarter, OHA approved the expansion of an existing CCO into an additional service area. This expansion is subject to a Corrective Action Plan related to provider network adequacy.

Also during this quarter, OHA continued to engage with CCOs, members, advocates, providers, and tribes through a number of public forums to address the emerging issues in our Medicaid program.

A. Enrollment progress

This section refers to Appendix A (Enrollment Reports), and the narrative includes information about each of the tables in that appendix.

1. Oregon Health Plan eligibility

Title XIX enrollment has continued to steadily increase over the past several months which can be attributed to coverage protections and simplified eligibility requirements provided under H.R.6201 Families First Coronavirus Response Act as well as to economic disruptions resulting from Oregon's extreme wildfire season. Title XXI enrollment remains fairly steady also due to COVID-19-related eligibility protections. Oregon has now completed an initial launch of its integrated eligibility system to a portion of the state and is now in the middle of a 9-month waved roll-out to convert remaining cases and offices into the upgraded system.

2. Coordinated care organization enrollment

CCO enrollment has continued to grow steadily since the COVID-19 pandemic. Enrollment and disenrollment policies continue to follow federal guidance in response to the Public Health Emergency. OHA continues to work with CCOs to address the challenges with enrolling new members during the pandemic.

B. Benefits

Errata to the March 13, 2020 Prioritized List were posted 8/4/2020. The August 14, 2020 prioritized list went into effect on August 14, 2020 and were reported in a Notification of Interim Changes. Errata to the August 14, 2020 list were published on August 20, 2020.

C. Access to care (ANNUAL)

D. Quality of care (ANNUAL)

E. Complaints, grievances, and hearings

1. CCO and FFS complaints and grievances

The information provided in the charts below is a compilation of data from the current 15 coordinated care organizations (CCO) and fee-for-service (FFS) data. The quarterly reporting period covers July 1, 2020 through September 30, 2020.

Trends

	Oct – Dec 2019	Jan – Mar 2020	Apr – Jun 2020	Jul – Sep 2020
Total complaints received	5,954	4,233	2,503	3,181
Total average enrollment	1,183,310	1,050,851	1,046,476	1,093,854

Rate per 1,000 members	5.03	4.03	2.39	2.91

Barriers

The third quarter reporting period shows an increase in the number of complaints. The CCOs indicate the increase in complaints come as more members are needing care due to the pandemic and restrictions on in office visits were modified. The increase in this quarter however is still not to the level of complaints that were being reported prior to the shutdown of services due to the pandemic. The Interaction with Provider/Plan category received the highest number of complaints with an increase of 56.4% from the previous quarter. The Access to Care category shows a 27% increase this quarter. Over the previous quarter Quality of Care issues increased by 32.3%. FFS data shows the highest number of complaints are in the Billing issues, with Quality of Care the next highest category.

Interventions

CCOs –CCOs are reporting the increase in complaints in this last quarter is attributed to modifications of services for in-office visits and services related to the pandemic. CCOs continue to report they have established committees and taskforces specifically to address provider capacity within their networks. Some CCOs report they have increased care coordination and communication with providers, such as in-office visits with members, to ensure care coordination is open and on-going for members. CCOs report they are continuing to monitor on a regular basis any trends and working to reduce the numbers of issues related to members requesting to change providers. CCOs are continuing to report staff is being added internally as well as at sub-contractor offices to focus on specific problem areas. Rural area CCOs are continuing to report issues with bringing on more providers, which has increased complaints in some areas. Some CCOs report their continued efforts are working to reduce NEMT complaints.

Fee-For-Service – The number of complaints from members who were on Fee for Service coverage during the Jul – Sep quarter was 202. An additional 436 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 151 complaints from members enrolled in Dental Care Organizations. 6541 informational calls were received asking for a variety of information, such as information about their coverage, CCO enrollment, request ID cards, etc.

Statewide rolling 12-month Complaints totals

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

Complaint category	Oct – Dec 2019	Jan – Mar 2020	Apr – Jun 2020	Jul – Sep 2020
Access to care	2370	1566	667	847
Client billing issues	604	293	446	343
Consumer rights	175	277	168	256
Interaction with provider or plan	1863	1464	690	1079
Quality of care	719	397	344	455
Quality of service	223	223	188	201
Other	0	13	0	0
Grand Total	5954	4233	2503	3181

Related data

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

CCO Notices of Adverse Benefit Determinations and Appeals

Notices of Adverse Benefit Determination (NOABD)

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

Notice of Adverse Benefit Determination (NOABD)	Oct – Dec 2019	Jan – Mar 2020	Apr – Jun 2020	Jul – Sep 2020
a) Denial or limited authorization of a requested service.	33,906	25,964	21,311	27,215
b) Single PHP service area, denial to obtain services outside the PHP panel	325	326	215	286
c) Termination, suspension, or reduction of previously authorized covered services	138	267	62	81
d) Failure to act within the timeframes provided in § 438.408(b)	8	47	11	10
e) Failure to provide services in a timely manner, as defined by the State	49	111	21	40
f) Denial of payment, at the time of any action affecting the claim.	19,581	41,912	40,779	58,588
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	54,007	68,627	62,399	86,220
Number per 1000 members	46	65	60	86

CCO Appeals

The table below shows the number of appeals the CCOs received over the past year. There has been a 27.13% increase in the number of appeals this quarter over last quarter. The increase is attributed to the services provided related to the pandemic and modifications made to in-office visits. CCOs reported the highest number of appeals for Outpatient services. Appeals related to Pharmacy 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 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	Oct – Dec 2019	Jan – Mar 2020	Apr – Jun 2020	Jul – Sep 2020
a) Denial or limited authorization of a requested service.	1,273	811	766	1,055
b) Single PHP service area, denial to obtain services outside the PHP panel.	3	4	7	6
c) Termination, suspension, or reduction of previously authorized covered services.	12	6	1	3
d) Failure to act within the timeframes provided in § 438.408(b).	3	4	0	0
e) Failure to provide services in a timely manner, as defined by the State.	0	0	0	2
f) Denial of payment, at the time of any action affecting the claim.	303	353	409	438
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	1,594	1,178	1,183	1,504
Number per 1000 members	1.35	1.1	1.13	1.5
Number overturned at plan level	537	379	308	475
Appeal decisions pending	8	9	12	5
Overturn rate at plan level	33.69%	32.17%	26%	31.58%

2. CCO and FFS appeals and hearings

The following information is a compilation of data from 15 coordinated care organizations (CCOs), 6 dental care organizations (DCOs) and fee-for-service (FFS). FFS members may be enrolled with a DCO for dental coverage.

The Oregon Health Authority (OHA) received 417 hearing requests related to the denial of medical, dental and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 371 were from CCO-enrolled members and 46 were from FFS members.

During the third quarter, 409* cases were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing.

OHA dismissed 314 cases that were determined not hearable cases. Of the not-hearable cases, 280 were forwarded to the member's respective CCO to process as an appeal. Per Oregon Administrative Rule, Oregon Health Plan (OHP) members must exhaust their appeal rights at the CCO level and receive notice of appeal resolution (NOAR) before they can request a contested case hearing at the state level. Hearing requests received by OHA prior to the appeal being exhausted are dismissed as not hearable with a letter to the member explaining their appeal rights through the CCO and their hearing rights after receiving an NOAR.

Of the 95 cases that were determined to be hearable, 12 were approved prior to hearing. Members withdrew from 38 cases after an informal conference with an OHA hearing representative. 26 cases went to hearing, where an administrative law judge upheld the OHA or CCO decision and 15 cases were dismissed for the members failure to appear. In 3 cases the administrative law judge reversed the decision stated in the denial notice.

1 case was dismissed due to a member requesting a hearing after the allowed time frames without good cause for the late request.

* In every quarter there is an overlap of processed cases with those received. For instance, cases processed and resolved in July of 2020 may be cases OHA received as far back as May and June of 2020.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	12	2%
Client withdrew request after pre-hearing conference	38	9%
Dismissed by OHA as not hearable	314	77%
Decision affirmed*	26	8%
Client failed to appear*	15	3%
Dismissed as non-timely	1	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	3	1%
Set Aside	0	0%
Total	409	

* Resolution after an administrative hearing.

Related data

Reports are attached separately as Appendix C & D.

F. CCO activities

1. New plans

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

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

from its contract. On August 14, 2020, OHA approved Trillium's expansion into the Tri-County, effective September 1, 2020. This expansion is subject to a Corrective Action Plan.

2. Provider networks

There are no significant changes to provider networks during this reporting period.

3. Rate certifications

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

In 2019, OHA underwent a procurement process to determine participating CCOs which resulted in changes in service areas and member choice for some of the returning CCOs. These changes were effective January 2020 and resulted in a member choice period that inserted some uncertainty into the original 2020 capitation rate development.

During the time period of July through September 2020, OHA conducted a mid-year review of capitation rates to ensure that the final member attribution was reflected within the CY2020 rates. This mid-year rate review is retrospective back to 1/1/2020 and was anticipated to impact analyses such as regional factors and health-based risk adjustment, both of which are budget-neutral rate adjustments from a statewide perspective.

OHA also considered impacts of the COVID-19 pandemic when conducting the mid-year review of the CY20 capitation rates and developed two adjustments in response to the disenrollment freeze resulting from the Families First Coronavirus Relief Act.

OHA delivered the final revised CY20 retroactive rate package and the CY21 rate packages to CCOs in August 2020 and met with each CCO individually to discuss their rates and request feedback. In addition, OHA also hosted a Dental Rates Workgroup meeting to further discuss the CY21 Dental rates with both Dental Organizations and the CCOs present. Lastly, In September 2020, the new Trillium Community Health Plan was introduced into the TriCounty region (Portland metro area), OHA began working with affected CCOs to establish initial payment models as well as retroactive rate changes for 2020 through 2022.

OHA continues to monitor the COVID-19 pandemic closely and working with CCOs in a partnership in maintaining our healthcare system.

4. Enrollment/disenrollment

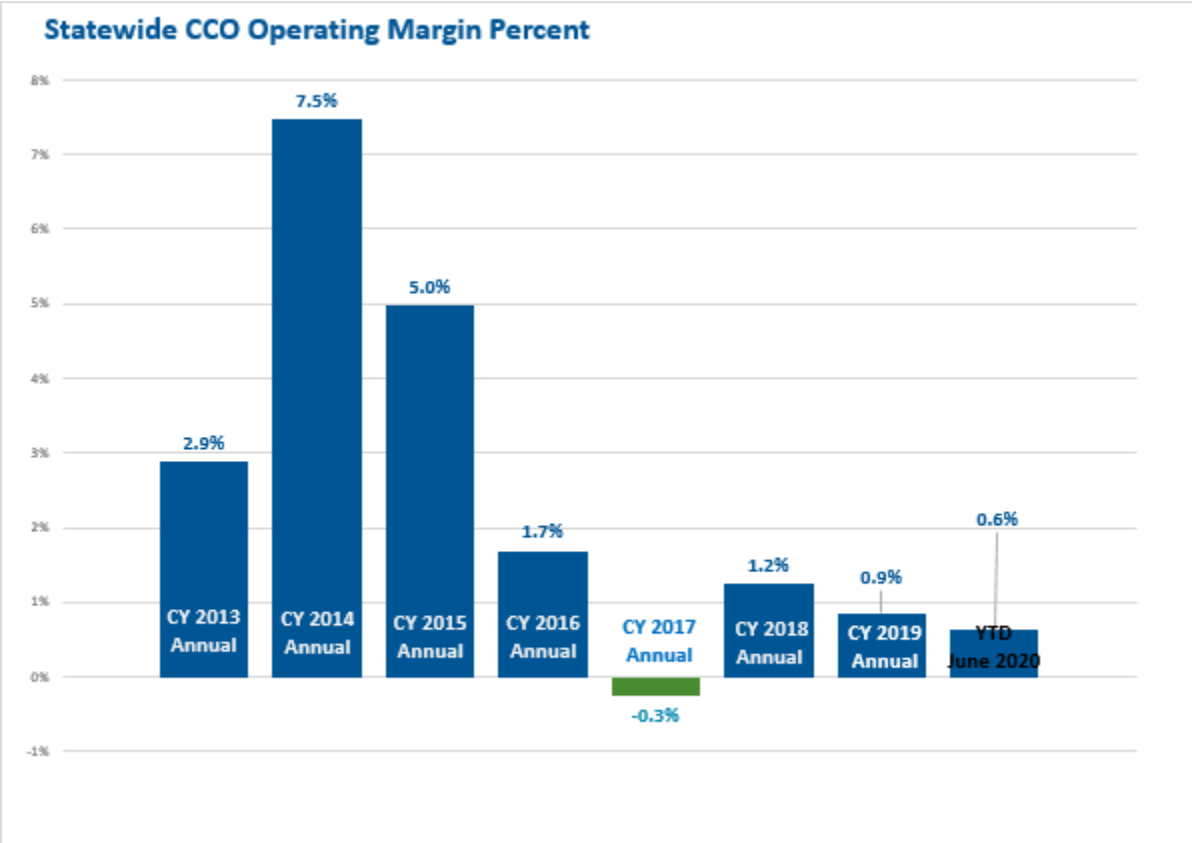
Enrollment has continued to grow steadily since the COVID-19 pandemic. Enrollment and disenrollment policies continue to follow federal guidance in response to the Public Health Emergency.

5. Contract compliance

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

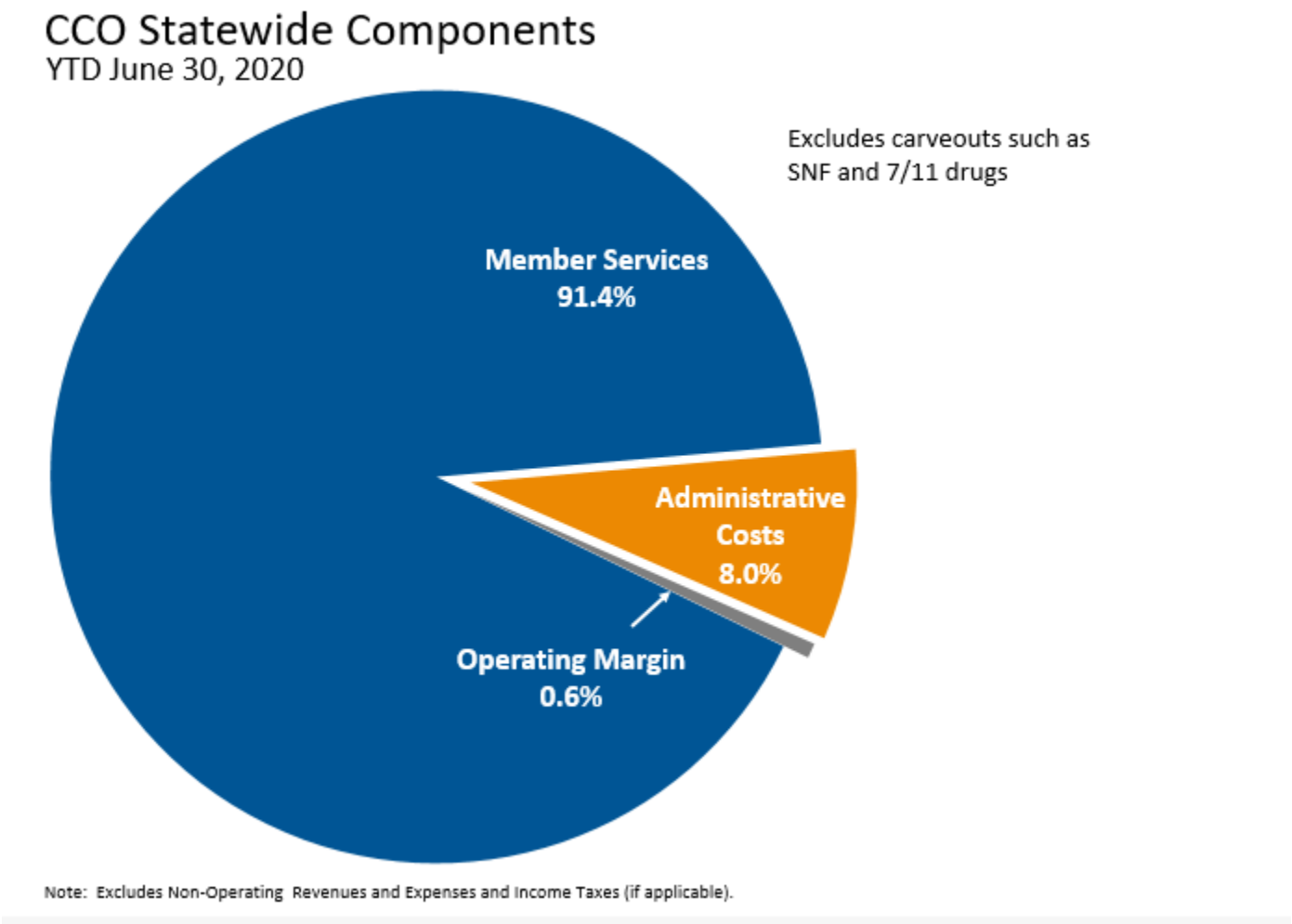
6. Relevant financial performance

For the six-months ended June 30, 2020, the statewide CCO operating margin was at 0.6% compared to 0.9% for the year ended December 31, 2019. 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 6-months ended June 30, 2020, the MSR for all CCOs in aggregate was 91.4%. Administrative Services accounted for 8% of total CCO revenue, leaving 0.6% as operating margin.

For the 6-months ended June 30, 2020, all of the 15 CCOs met or exceeded the 85% target for MSR, a key indicator for MLR (14 of the CCOs had MSRs above 90%).



At end of June 30, 2020, Net Assets of the CCOs ranged from a low of $186 per member (Health Share of Oregon) to a high of $1,639 per member (Trillium Comm. Health Plan), averaging $446 per member for the state.

For additional CCO financial information and audited financials please follow the link below -

http://www.oregon.gov/oha/FOD/Pages/CCO-Financial.aspx. Also refer to reporting on Lever 2.

7. Corrective action plans

For the current quarter, one CCO continues to be on a Corrective Action Plan (CAP) and another CCO has been placed on a new CAP:

Continuing CAP

• Entity name: Health Share of Oregon (HSO)

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

• Start date of CAP: October 14, 2019

• End date of CAP: Original end date: April 14, 2020. First extended end date: October 31, 2020. Second extended due date: April 30, 2021.

• Action sought: Development and implementation of a plan for correcting the issues identified by OHA; submission of weekly reports to OHA for the duration of the CAP.

• Progress during current quarter: The areas for improvement identified in the CAP are provider (driver) no-shows, on-time (pick-up) performance, call wait times, call abandonment, and member grievances. The performance in each area for July-September 2020 is as follows:

- Provider (driver) no-shows: The first two months of this quarter had the highest no-show rates since the CAP began. The third month's rate was in line with the prior quarter but still outside the performance target.

- On-time (pick-up) performance: This quarter was about the same as the prior two quarters, not including the one month in the prior quarter with marked improved performance. This quarter's rates remain considerably below the performance target.

- Call wait times & call abandonment: Both remain significantly better than when the CAP began, although HSO acknowledges that this improvement is the result of lower call volume due to members receiving fewer face-to-face healthcare services because of the COVID-19 Emergency and thus making fewer calls to arrange for NEMT services. There was some increase in call volume during this quarter. Same as the prior quarter, the performance target for each area was met in this quarter.

- Member grievances: HSO continued to exceed the performance target for this metric.

The major factor affecting HSO's performance in this quarter continued to be the COVID-19 Emergency.

New CAP

• Entity name: Trillium Community Health Plan

• Purpose and type of CAP: Insufficient compliance with CCO contract, Oregon Administrative Rule, and federal regulations regarding network adequacy, language access, health equity, and community engagement for the Tri-County service area.

• Start date of CAP: To be determined. OHA issued the CAP notice to Trillium on September 2, 2020, and received the proposed CAP from Trillium on October 15, 2020. The proposed CAP is under review by OHA.

• End date of CAP: Six months from the TBD start date.

• Action sought: Development and implementation of a plan for correcting the issues identified by OHA; submission of monthly reports to OHA for a period of at least six (6) months.

• Progress during current quarter: n/a

8. One-percent withhold

This quarterly report is for data from July 1, 2020 through September 30, 2020. OHA analyzed encounter data received for completeness and accuracy for the subject months finalized for December 2019 through February 2020. 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 continued to produce guidance for CCOs and Medicaid providers on how to respond to the simultaneous public health emergencies. OHA sends out weekly newsletters and holds weekly and biweekly operations phone calls to address concerns including access issues, network capacity concerns, and policies intended to address emerging public health concerns.

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, 3,845 Oregon providers and 60 hospitals have received over $209 million in federal incentive payments (as of September 30, 2020). Between July and September 2020, 42 providers received $357,000 in incentive payments. The program sunsets at the end of 2021.

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.

- As of 2nd quarter (Q2) 2020, integrated queries are up overall by 112.5% over Q2 2019. Within pharmacists, integrated queries are up by 415.6% over last year.
- As of 9/30/2020, 20,852 (this number cannot be deduplicated and may reflect duplicate prescriber counts) prescribers across 189 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), eight retail pharmacy chains (across 664 sites) and one rural pharmacy are also live.
- 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.

Community Information Exchange

Community Information Exchange (CIE) includes 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, reporting, and data analysis. CIE adoption and spread has continued organically in Oregon during the pandemic, with CIE efforts launched or planned in 23 counties. Aunt Bertha is now live in four Oregon counties and Unite Us is now live in 11 Oregon counties. OHA has two parallel bodies of work which it supports/is engaged with:

HIT Commons activities: HIT Commons supported work (funded by OHA) around CIE include:

- An environmental scan of CIE efforts in Oregon was completed in fall 2019 and included 20 meetings/interviews.
- A mapping of CIE activities in Oregon continues to be updated.
- An Oregon CIE Advisory Group was chartered to engage stakeholders statewide to discuss components of an effective CIE, assess opportunities for alignment of regional CIE efforts, and to develop a CIE Roadmap for Oregon by the end of 2020. The Advisory Group was on pause due to COVID-19 and re-engaged in September 2020. COVID-19 has been an accelerator in Oregon for health care organizations to lean into contracting discussions with CIE vendors on an expedited timeline. Because of that, and the CIE efforts are unfolding in real-time, the Oregon Advisory Group is considering rescoping and determining the critical areas of focus where there may be value for statewide alignment/work. The roadmap is expected to be completed by the end of 2020.

OHA/ODHS activities: OHA has been exploring how CIE tools can assist with the COVID-19 response by leveraging existing CIE implementations. In summer 2020, OHA began exploratory work in coordination with the Oregon Department of Human Services. After engaging with internal and external stakeholders, OHA is sharing support for interested community-based organizations, local public health authorities, and Tribes to join existing CIEs offered by CCOs and health plans. Communication around this support and engagement will start in late 2020.

Clinical Quality Metrics Registry (CQMR)

As shared in the last Annual Report, the CQMR service will be suspended at the end of 2020. OHA will work with stakeholders on setting a path forward as new FHIR-based quality reporting approaches become more ready for implementation.

Behavioral Health and HIT

The Behavioral Health HIT Workgroup was formed in August 2018 and continues to meet periodically under the direction of HITOC to review the draft Behavioral Health HIT Scan and provide recommendations and priorities. The Workgroup met in February 2020 to provide input to OHA on how to use the SAMHSA Block Grant funding for technical assistance to substance use disorder providers around EHR and HIE adoption and use. As a result of the collaboration with the Workgroup, OHA planned and hosted two virtual behavioral health learning collaborative events in September 2020 to provide an opportunity for behavioral health providers and organizations to collaborate and share best practices, lessons learned, and challenges around EHR adoption/upgrade and HIE. Both events featured topics or content that aligned with recommendations included in the Behavioral Health HIT Workplan.

The first event, offered September 1, featured presentations on behavioral health EHR adoption/upgrade, behavioral health EHR utilization in Oregon, and the collection and use of Race, Ethnicity, Language, and Disability (REALD) data. Additionally, the even offered breakout sessions for a few specific EHRs, telehealth, and decision-making in EHR adoption/upgrade. Nearly 200 individuals across 100 different organizations attended the event.

The second event, offered September 21, presented in collaboration with the HIT Commons, centered on HIE tools and privacy and confidentiality. Attendees received guidance for using the finalized OHA Provider Confidentiality Tool Kit and cover letter, legal information, and updates to 42 CFR Part 2, and were able to participate in breakout sessions covering various HIT/HIE applications for BH information sharing. More than 80 individuals attended the event.

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 and has approved Reliance workplans to onboard providers contracted with eight current CCOs, covering 12 Oregon counties. As of September 30, 2020, there are nine behavioral health practices, one oral health clinic, 34 critical physical health entities, and two major trading partners (hospital/health system participating in the Program.

Health IT Stakeholder Groups

Health IT Oversight Council (HITOC)

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

Highlights from HITOC's August 2020 meeting:

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

H. Metrics development

1. Kindergarten Readiness

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

1) Adopt two metrics for 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 2022 for 2023 CCO incentive measure set).

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

In July 2019 the Metrics & Scoring Committee implemented the first part of the strategy by voting to include both Well-child visits for children ages 3-6 and Preventive dental visits for children ages 1-5 in the 2020 Quality Incentive Program.

OHA then continued its partnership with Children's Institute, with technical expertise from the Oregon Pediatric Improvement Partnership (OPIP), to develop the other components of the multi-year-multi-measure strategy.

In the last quarter, the multi-partner workgroup developing the second component of the strategy (a CCO-level measure to improve the social-emotional health of young children) continued meeting monthly as a team (consisting of Children's Institute, OPIP, and OHA). The team also continued engagement with technical advisors from the Robert Wood Johnson Foundation funded Aligning Early Childhood and Medicaid initiative, of which Oregon is receiving technical assistance to support development of this measure. Oregon continued working with the AECM team, which kindly made additional technical assistance available through the end of the year. The Oregon team also presented on its work at the AECM convening of all grantee states in September.

In the last quarter the team worked in three areas:

- **Strategic Planning for Measure Specification Development.** Including engagement with partner agencies and governing boards, reviewing specifications and tools for equity impact; and securing presentation/engagement with Oregon metrics committees.
- **Measure Analytics.** Creating data analysis plan and running initial data pull for behavioral health reach metric; and researching consultants to aid in developing recommendations and tools for attestation scoring.
- **Communications.** Drafting communications tools explaining what social emotional health is and why it is important.

2. SDOH/Health-related Social Needs Measure

The public Workgroup initially planned to begin meeting on April 1, 2020 (see Workgroup webpage here: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx). However, given the pandemic, the Workgroup's meeting was paused. OHA implemented a plan to ensure the Workgroup can accomplish its goal of providing a social needs screening metric concept by the end of the year, while balancing the current priorities of OHA and our partners to address the COVID-19 pandemic.

Therefore, the full Workgroup will not convene until October 2020, and will have fewer, more targeted meetings. A smaller Expanded Planning Team met (virtually) in the interim and created a set of options for the Workgroup to consider. This group includes representatives from: OHA; consultants from Nancy Goff & Associates and the Oregon Rural Practice-based Research Network (ORPRN); DHS; the Oregon Community Information Exchange; and, our national advisors from the National Committee for Quality Assurance. The Expanded Planning Team first met in May 2020, with monthly meetings set through September 2020.

The Expanded Planning Team met in each month of the last quarter, with the charge of reviewing the Oregon context, national context, other states work, background research, measurement and feasibility aspects, and finally recommending 3-5 measure concepts for the Workgroup to consider. As the Expanded Planning Team's work neared completion in the last quarter, a smaller subgroup also met to consider the feasibility of the concepts under consideration. In addition, in this quarter initial plans were made for a smaller group to review tools which might be included in the final metric. In the end the Expanded Planning Team sent four high level measure concepts to the Workgroup for consideration (see: https://www.oregon.gov/oha/HPA/ANALYTICS/SDOHDocs/SDOH-measure-concepts-FINAL-10.7v2.pdf).

Finally, the internal core team planned for handing the baton from the Expanded Planning Team to the formal Workgroup, which first meets in the next quarter. This included solidifying the four measure concepts from the Expanded Planning team noted above, as well as finalizing a set of resources in which to ground the Workgroup, including: Workgroup Charter; Guiding Principles; completion of a series of three webinars on social needs screening and measurement from Bailit Health; completion of a crosswalk of social needs screening measurement across states by Bailit Health; completion of an background research and an environmental scan and supporting documents from the Oregon Rural Practice Research Network (see https://www.oregon.gov/oha/HPA/ANALYTICS/SDOHDocs/Resources-for-OHA-SDOH-Measurement-Concept-Workgroup.pdf).

3. 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 using evidence-based strategies. 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 evidence-based obesity measure has two-parts. Part One addresses obesity prevention and reducing the prevalence of obesity through evidence-based multisector community interventions. Part Two, an outcome measure, will rely on BMI measurement and interventions completed to assess the decrease in obesity prevalence. Part Two is currently on hold.

At the July 2020 Metrics and Scoring Committee meeting, the multi-sector community intervention part of the measure was recommended by the OHA to be included in the 2021 CCO incentive measure set. After much discussion, the committee ultimately did not select the it for 2021. The workgroup plans to redesign the measure and will bring it back to the committee at a later date.

4. 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 workgroup is co-chaired by the Director of OHA's Equity and Inclusion Division, and the Director of the OHA Office of Health Analytics.

The workgroup has met continuously since October 2018 to develop the measure for inclusion in the CCO incentive measure set. The 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. The measure title is: Meaningful Language Access for Culturally Responsive and Quality Health Care.

At the July 2020 Metrics and Scoring Committee meeting, the measure was recommended by the OHA to be included in the 2021 CCO incentive measure set. The committee selected the measure for the 2021 measure set. Effective January 2021, Oregon will be the first state to use a Medicaid pay for performance measure focused on health equity.

I. Budget neutrality

No significant developments/issues/problems with financial accounting, budget neutrality, or CMS 64 reporting for the current quarter.

J. Legislative activities

No significant legislative activity specific to achieving demonstration goals or impacting the demonstration occurred during this reporting period.

K. Litigation status

No significant litigation activity during this reporting period.

L. Public forums

Health Evidence Review Commission (HERC)

August 13, 2020

This testimony concerned coverage of Cologuard, a product used for colon cancer screening.

Melissa Wood from Exact Sciences joined the meeting. She said she was unaware that HERC would be taking up this topic in the afternoon. She thought the decision this morning was to table discussion. She added that the cost information the Commission was working with needed to be updated. She said that everyone in the state of Oregon is covered for Cologuard except Medicaid.

This testimony concerned the Guideline Note 60 for Opioids for Conditions of the Back and Spine.

Amara M. is a volunteer advocate for the Oregon Pain Action group and declared no conflicts of interest. She said she is a persistent pain patient recently diagnosed with Ehlers-Danlos syndrome (EDS). She said Oregon is

now one of the worst states to live in for someone on Medicaid who lives in intractable pain. She said Guideline Note 60 is an over-reach. She urged HERC to delve into this further.

Koa Kai is an advocate and an ambassador for the chronic disease coalition and declared no conflicts of interest. She said Guideline Note 60 was created based on expert opinion and not on evidence. Many would argue it is a case-study in conflicts of interest and lack of ethics. HERC has never performed patient out-come research regarding Guideline Note 60. She said without this critical data we must rely on antidotal evidence, including public comments. According to the Oregon's Death with Dignity Act data, the number of patients who used this program in 2019 who cited inadequate pain control or had concerns about it increased 33% from the year prior. This shocking data alone should cause HERC to repudiate the guideline note. Although the clause "when clinically indicated" was added in the middle of aggressive taper language, the rest of the guideline note instructions are confusing for the providers and that clause is likely to be overlooked. The overall sentiment has not changed: Do not prescribe opioids and taper patients who are on them. The taskforce is exceeding its authority by essentially requiring physicians, through its aggressive policy language, to forego clinical judgement for a one-size-fits-all barrier to medically necessary treatment for the most vulnerable and medically complex patients. Complementary and medication treatments should both be offered to patients.

Stephen Hix is a chronic pain patient and an advocate for himself and others. He agreed with both speakers who came before him. He reminded the Commission that Dr. Beth Darnell offered to give HERC a free pain program and that wasn't taken advantage of. He said that the CDC said the guidelines have been drastically misinterpreted. He said he is praying for the day that doctors can practice medicine. He said he was functional on narcotics for a decade before it was taken away from him.

This testimony concerned the Coverage Guidance on Planned Out-of-Hospital Birth (OOHB) being recommended by the Evidence-based Guidelines Subcommittee and corresponding changes to the Prioritized List discussed by the Value-based Benefits Subcommittee (VbBS).

Silke Akerson CPM, LDM declared no conflicts of interest. She said the Evidence-based Guidelines Subcommittee (EbGS) process had been very robust. The revised coverage guidance and guideline will improve access to care and choice for patients. She said Oregon is one of the few states that has accurate data on outcomes for planned OOHB. Many of the studies quoted are nationwide studies and some show increased neonatal mortality; however, in Oregon, the data shows rate of perinatal mortality 2015-2018 was similar to planned hospital delivery. She said national data on risk of severe hemorrhage, evidence is not that there is increased risk of severe hemorrhage but that is only in states where midwives don't have access to anti-hemorrhagic medications.

HERC Value-based Benefits Subcommittee

August 13, 2020

This testimony concerned polydactyly of the foot, flat foot, and tarsal coalition.

Testimony was heard from Dr. Justin Roth, a pediatric orthopedist. He agrees with the staff proposed coding changes and guideline. He noted that polydactyly of the foot occurs in about 1 in 1,000 children. The older treatment was rubber band amputation, which can result in painful neuroma. Orthopedists now do surgical

correction of the condition to avoid nerve issues. Many of these patients are getting care currently at the Shriner's hospital, which is likely why this has not been brought to the HERC as an issue in the past.

Dr. Roth also addressed flat foot and tarsal coalition. The only way to get to a calcaneovalgus foot is to have a tarsal coalition that is untreated. Tarsal coalition "locks" the foot up and interferes with foot growth and development. Treatment of tarsal coalition is a more common procedure done by pediatric orthopedics. Calcaneovalgus repair is a large surgery that takes multiple hours of anesthesia. Tarsal coalition can be done in an ambulatory surgery center and is less invasive. He recommends coverage for children aged 14 or 15 and under. He noted that the foot becomes painful and more rigid about age 10 or so. After age 15, deformity becomes more rigid and person has learned to live with deformity. He will try to put together evidence regarding these conditions and bring this to HERC staff for consideration of these topics in the future. Olson wanted information on the data on rate of progression from calcaneouvalgus as part of that future review.

This testimony concerned the Guideline Note 60 for Opioids for Back and Neck Pain.

Amara M, Steven Hicks and Koa Kai offered similar testimony as they did at the Health Evidence Review Commission meeting held the same day.

This testimony concerned coverage of Cologuard.

Testimony was heard from Dr. Paul Limburg, from Exact Sciences, who receives royalties related to Cologuard. Colorectal cancer (CRC) is a major public health concern. MT-sDNA (also known as FIT-DNA) can increase the screening uptake in the population. Screening can result in treatment to prevent cancer or detection of a cancer diagnosis at a lower stage where there are better outcomes. Screening needs to be promoted. About one third of all screen eligible adults are not up to date on CRC screening. USPSTF and NCCN recommend choice and judge all screening modalities as equivalent. The Imperiale study found Cologuard outperformed FIT in all areas. Specificity for FIT is 95% per year, Cologuard is 87% per three years. At 3 years, the number of false positives is the same between Fit and Cologuard. He reported that there are additional costs with FIT testing of $153. Cologuard has navigation support that increases the adherence rate for follow up. About 71% of patients with a Cologuard order follows up on their order. Home based screening options are better than screening modalities requiring a provider visit during COVID times.

Limburg noted that Cologuard can be a completely home-based option, which is important in the COVID epidemic. The Medicare reimbursement rate is $508.87.

This testimony concerned the Coverage Guidance on Planned Out-of-Hospital Birth (OOHB) being recommended by the Evidence-based Guidelines Subcommittee.

Silke Akerson, CPM, LDM offered similar testimony as she did at the Health Evidence Review Commission meeting held the same day.

HERC Evidence-based Guidelines Subcommittee

September 10, 2020

Testimony concerning the Multicomponent Interventions to Improve Screening for Breast, Cervical or Colorectal Cancer was heard.

Melissa Wood, manager of the Government Relations, noted that her conflict of interest was working for the manufacturer, Exact Sciences, of Cologuard. Ms. Wood stated that she can take any questions regarding this report and the coverage of Cologuard for OHP. Gingerich said that the full HERC may reconsider Cologuard coverage at the time that the full HERC reviews this report. Kansagara thanked Ms. Wood for her comments.

Medicaid Advisory Committee

The Medicaid Advisory Committee met three times between July and October 2020. There was no public comment on both committee meetings.

Meeting Date: July 29, 2020
Agenda Items:

- MAC Charter Revisions
- DHS/OHA Update
- Ombuds Program Report
- MAC Workplan overview and discussion

Public Comment:
West Livaudais, livaudai@ohsu.edu, from Oregon Office on Disability and Health/OHPB Health Equity Committee. West was interested in having a conversation with individuals with expertise in asset/income limitations for people with disabilities for Medicaid to learn history and/or initiatives to consider replicating Washington's Apple Health for Workers with Disabilities legislation.

Meeting Date: Sept 30, 2020
Agenda Items:

- Screening for Social Needs Development
- Consumer Assessment of Health Providers and Systems (CAHPS) – 2019 Findings
- Senate Bill 1041: Overview and MAC Role
- DHS/OHA Update

There was no public comment

Meeting Date: Oct 28, 2020
Agenda Items:

- Review of MAC ByLaws
- State Health Improvement Program and PartnerSHIP
- Behavioral Health Supports & CARES Act Funding
- DHS/OHA Update
- Ombuds Program Quarterly Update
- MAC work plan - proposed subcommittee

There was no public comment

Metrics and Scoring Committee

Meeting Date: July 17, 2020

The Committee reviewed 22 pieces of written public testimony and heard oral testimony from 13 people. Written testimony is available on the Committee webpage: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx. Written testimony was received from:

- Children's Health Alliance
  - Re: 2020 and 2021 CCO Incentive Measure Benchmarks for Childhood and Adolescent Health
- Children's Health Alliance
  - Re: COVID-19 impact on 2020 CCO Incentive Program
- Children's Health Alliance
  - Depression Screening and Follow-up Benchmark Rebasing
- Central Oregon Health Council
  - Re: Decision-making timeline for matters related to the 2020 Quality Incentive Measure program in the context of the COVID-19 crisis
- Central Oregon Pediatric Associates
  - Re: Impact of COVID-19 on the 2020 Medicaid Quality Incentive Measure Program
- Rodney Todd, MD
  - Re: COVID-19 impact to 2020 metrics
- Mosaic Medical
  - Re: COVID-19 impact on 2020 CCO Incentive Program
- National Association of Chronic Disease Directors
  - Re: Support for Obesity prevention through multi-sector interventions measure
- Oregon Primary Care Association
  - Re: COVID-19 impact on 2020 CCO Incentive Program
- One Community Health
  - Re: COVID-19 impact on 2020 CCO Incentive Program
- Oregon Council on Health Care Interpreters
  - Re: Support for Equity measure: meaningful language access to culturally responsive health care services.
- Health Equity Committee
  - Re: Support for Equity measure: meaningful language access to culturally responsive health care services.
- Oregon Medical Association
  - Re: Support for Obesity prevention through multi-sector interventions measure
- Umpqua Community Health Center
  - Re: COVID-19 impact on 2020 CCO Incentive Program and 2020 benchmark achievement; 2021 incentive measures.
- Cascade Summit
  - Re: COVID-19 impact on CCO Incentive Program and benchmark achievement
- Healthy Active Oregon Coalition
  - Re: Support for Obesity prevention through multi-sector interventions measure and Equity measure: meaningful language access to culturally responsive health care services.
- Health Share
  - Re: continuing 2020 measures into 2021; delay Equity measure: meaningful language access to culturally responsive health care services and Obesity prevention through multi-sector interventions measure; select benchmarks and targets that account for impact of COVID-19; develop program contingency plan.
- Pacific Source
  - Re: Concerns about to using 2019 as baseline for 2021 improvement targets; suggested changes to Equity measure: meaningful language access to culturally responsive health care services specifications; support for Obesity prevention through multi-sector interventions measure.
- Care Oregon

    - Re: Concerns about Obesity prevention through multi-sector interventions measure
- CCO Oregon
    - Concern with using 2019 as baseline for 2021 improvement targets; workforce challenges and online resources; telehealth; preventive dental services.
- Coalition for a Healthy Oregon
    - Re: Concerns about Equity measure: meaningful language access to culturally responsive health care services.
- El Programa Hispano & Coalition of Community Health Agencies
    - Re: Support for Equity measure: meaningful language access to culturally responsive health care services.

Verbal public testimony provided during meeting:

- Ana Miramontes (OHP member from Jackson and Josephine County)
    - Importance of health care interpreters
- Yadira Gomez (OHP member from Jackson and Josephine County)
    - Importance of certified health care interpreters
- Stick Crosby (All Care Health – Director, Network and Health Equity, Oregon Health Care Interpreter Council)
    - Importance of health care interpreters and support for Equity measure: meaningful language access to culturally responsive health care services
- Krista Collins (Health Share of Oregon)
    - Referenced written testimony; asking that no new measures be added for 2021. If any added, of two proposed new measures, support addition of the Equity measure: meaningful language access to culturally responsive health care services over Obesity prevention through multi-sector interventions measure.
- Annie Valtierra-Sanchez (Equity Coalition Director, OHA Health Equity Committee)
    - Support for Equity measure: meaningful language access to culturally responsive health care services.
- Will Brake (COO for All Care CCO, former Metrics & Scoring Committee chair)
    - Support for Equity measure: meaningful language access to culturally responsive health care services.
- Ryan Bair (Rogue Community Health)
    - Support for Equity measure: meaningful language access to culturally responsive health care services.
- Felicity Ratway (Chair of Policy and Advocacy Workgroup, Certified Medical Interpreter)
    - Support for Equity measure: meaningful language access to culturally responsive health care services.
- Dr. Zeenia Junkeer (Director of Oregon Health Equity Alliance)
    - Support for Equity measure: meaningful language access to culturally responsive health care services; concerns about Obesity prevention through multi-sector interventions measure.
- Julie Harris (Children's Health Alliance)
    - Make both 2020 and 2021 reporting only; do not add any clinic-based improvement measures during pandemic.
- Samantha Shepherd (CCO Oregon)
    - Consider current workforce challenge; additional time may be needed to implement new metrics; trainings & certifications should be available online; ensure telehealth is counted; reconsider preventive dental measure numerator criteria in relation to services provided in primary care.
- Yesi Castro (Oregon Community Health Workers Association)

- Support for Equity measure: meaningful language access to culturally responsive health care services

- Ping (Immigrant & Refugee Community Organization)

Support for Equity measure: meaningful language access to culturally responsive health care services.

Meeting Date: August, 2020 (meeting canceled)

Meeting Date: September 18, 2020

Written public testimony was sent out to the committee members, and is available on the webpage:

- Felicity Ratway (not received in time for July meeting)
  - Support equity measure
- CCO Oregon
  - Preventive dental measure
- Children's Health Alliance
  - 2021 targets
- Health Share
  - 2021 targets
- Community Health Centers of Lane County
  - 2021 targets
- Oregon Primary Care Association
  - 2021 targets
- OHSU Family Medicine at Richmond
  - 2021 targets
- Yakima Valley Farm Workers clinic
  - 2021 targets

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

Health Plan Quality Metrics Committee

No public comment in July, August or September 2020. The Health Plan Quality Metrics Committee did not meet between July 1, 2020 and September 30, 2020 as a result of OHA suspending non-critical committee meetings while our health care partners focused on the COVID-19 response.

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

Due to the impact of COVID-19 on primary care practices in Oregon, the PCPCH program suspended all site visits to primary care clinics from March to July 2020. The program resumed site visits virtually in August 2020 and completed three virtual site visits 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 September 2020, 645 clinics were recognized as PCPCHs (nine fewer than the prior quarter). This is approximately three-quarters of all primary care practices in Oregon. Eighty-six PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model.

In January 2021 the Oregon Health Authority will implement revised PCPCH recognition standards, which were informed by the recommendations from the PCPCH Standards Advisory Committee, a multi-stakeholder body that provides OHA with policy and technical expertise for the PCPCH model of care, and input from other community partners and subject matter experts. Notable revisions include the addition of new measures to address oral health, social determinants of health and substance use disorders, as well as language to improve health equity in all standards. The revised PCPCH standards were scheduled be implemented in mid-2020, but the implementation was delayed because of Oregon's response to the COVID-19 pandemic.

Tribal Care Coordination

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

The claiming of 100% federal match is made possible by 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 third year.

OHA has been working with tribal health representatives from Oregon's nine Federally-recognized Tribes to support efforts to establish Indian Managed Care Entities. OHA has been working with the tribes since April 2019 to move this project forward. Four Tribes and one urban Indian health program will each establish their own Indian Managed Care Entities. Our projected go-live date is 7/1/2021.

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 (PMPM) care management fees and performance-based payments are key components of the CPC+ payment model. Process changes are moving forward so OHA can launch the Track 2 alternative comprehensive primary care payment in January 2021. This hybrid payment will include a prospectively paid PMPM payment (paid quarterly) and a corresponding FFS claims reduction on payments for specific claims submitted during the program year. Track 2 practices select their hybrid payment ratio for CMS. OHA will use the same payment ratio.

The Oregon CPC+ payers met in July and September to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers discussed telehealth, opportunities to reduce low-value care, evaluation, equity and opportunities to align with the Primary Care Payment Reform Collaborative.

Value-Based Payment Innovations and Technical Assistance

The Transformation Center conducted interviews on VBP with CCO leadership, per a CCO contractual requirement. Staff from the OHSU Center for Health Systems Effectiveness participated in the interviews and will be using information collected as part of a larger effort to evaluate the CCO 2.0 VBP Roadmap.

In addition, CCOs responded to written questions ahead of the interviews on successes and challenges of achieving the CCO 2.0 VBP requirements in 2020, which will be shared publicly, and included consideration of challenges associated to the COVID-19 public health emergency.

The center will use the information gathered from these interviews to develop technical assistance to support CCOs and their providers within the context of COVID-19 so they are able to continue to implement and adopt VBPs as designed within the OHA CCO VBP roadmap.

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. The collaborative's three work groups support work in the following areas: metrics, evaluation, and implementation/technical assistance.

The collaborative met in July to discuss the impact of COVID-19 on primary care payment reform and opportunities for the collaborative to promote VBPs. Members engaged in a robust discussion about how the collaborative could work collectively to promote equity. Ideas included 1) promote data collection and quality measures to help identify disparities; 2) integrate equity measures and funding for specific activities to improve equity into VBP models; 3) recruit BIPOC community members to join the collaborative; 4) pay parity for all visit types, including phone only; 5) support clinics to address health-related social needs; and 6) fund trainings on anti-oppression and systemic racism for providers and payers.

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

Statewide Performance Improvement Project

For the period of July 1, 2020 to September 30, 2020 OHA explored the trajectory for the statewide PIP due to the lessons gained from the COVID-19 epidemic. COVID-19 has further highlighted the needs and barriers in Oregon's behavioral health systems and therefore OHA is exploring changing the statewide PIP topic to center on behavioral health access under the physical health and behavioral health integration focus area in OHA's 1115 Waiver Quality Strategy. The previous statewide PIP topic, Acute Opioid Prescribing, will not move pass design phase as a statewide PIP and may be picked up individually by CCOs to implement interventions in their respective communities.

Additional conversations with internal and external stakeholders will be in the coming quarter. Regular updates with Oregon's external quality organization (EQRO), Health Services Advisory Group (HSAG), are discussed to ensure compliance with EQR expectations.

Roadmap to Oral Health

The OHA Public Health Division convened a workgroup of school oral health program stakeholders from June through August 2020 to develop guidelines for school oral health programs to continue to safely provide oral health services in the school setting during the COVID-19 pandemic. Participants developed OHA guidance documents applicable to any medical or dental programs interested in providing oral health services (e.g. dental screenings, fluoride varnish, silver diamine fluoride, dental sealants, etc.) in schools.

- OHA Guidance on Resumption of Dental Services in School Settings (posted here: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3318A.pdf)
- OHA Guidance for Certified School Dental Sealant Programs (posted here: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3318.pdf)

While these services are available to children beyond those served by OHP, the primary population receiving these services are OHP members. The new guidance will help keep OHA meet our Roadmap goal of increasing access to school oral health and dental sealant programs.

Sustainable Relationships for Community Health program

Activities: Sustainable Relationships for Community Health (SRCH) is a grant funded opportunity for clinical and community partners to address health disparities in the local community. This multi-sector approach to advance healthcare transformation in the state, provides space for teams of local public health authorities, clinical partners and community-based organizations, to determine and build together shared health systems change goals and infrastructure, to be sustained and spread beyond the grant period.

With the COVID-19 pandemic, OHA extended the SRCH grant year to December 2020 to continue to support the SRCH teams to implement and sustain their work. Due to staffing limitations related to the coronavirus response, two of the SRCH teams halted their work. OHA and contractors continued to provide technical assistance to the two remaining SRCH teams and each team met for their first virtual SRCH session. 3 additional virtual SRCH sessions for each team will be held in October/November and lastly in December 2020.

Progress and Findings: During this period, OHA provided technical assistance to the Tillamook and Regional Health Education Hub (RHEHub) SRCH team. The Tillamook SRCH continued to focus on integrating prediabetic screening and referrals to the National DPP in clinic workflows using PDSA cycles (Plan-Do-Study-Act). During their August SRCH convening, Tillamook developed a new cycle of PDSAs to test the most effective methods to identity and screen patients at risk for prediabetes in two different health systems. The RHEHub SRCH Team worked on reestablishing chronic disease self-management programming as in-person options were not feasible due to COVID-19. They also continued efforts to move electronic referral processes forward by piloting a community information exchange, Unite Us, referrals in several clinics and discussed health education billing efforts to ensure sustainability.

Trends, Successes, or Issues: OHA's pivot to extend the SRCH grant year to December 2020 and adapt the SRCH model in response to the COVID-19 pandemic led to new opportunities. The series of four virtual convenings between August and December 2020 for each SRCH team has allowed for greater customization of the SRCH model in order to meet teams' needs and capacity during the COVID-19 pandemic. With local public health, community and clinical partners having reduced capacity due to COVID-19 and operating in a constantly changing environment, this pivot has allowed for teams to continue SRCH work at their own pace, and the new virtual format has led to increased participation. However, two of the SRCH teams were unable to continue at this time. The Columbia Gorge team chose to pause SRCH work and will stay in communication with OHA about ability to re-start or continue SRCH work in the future as their capacity shifts. The Public Employees Benefit Board (PEBB) team focused on implementing National DPP with the Oregon Department of Corrections (DOC) employees also has chosen to pause their SRCH work as the DOC focuses its resources and capacity on responding to COVID-19 outbreaks and prevention in the inmate population. OHA and DOC will reassess readiness to continue this work in the future.

OHA has engaged an external evaluation firm, Rede Group, which is in the process of conducting preliminary evaluative activities including developing a theory of change, a functional model, and working with OHA to develop a relevant and use evaluation framework and supportive evaluation questions. The evaluation is planned to produce findings from the current SRCH cohort and also learnings and results from 5 years of the SRCH initiative.

Process Improvement (workflow) Technical Assistance

Technical assistance given by QI and Transformation Center technical assistance bank relating to process improvement (workflows). Not a significant amount of work to report but continuous throughout the year across health topics. Additional work out of HSD for simplification of reporting and meeting collaboration

Innovator Agents

- **Community Advisory Council (CAC) involvement and participation in work related to Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and Transformation Plan;**

  Community Advisory Councils (CACs) in the state of Oregon continued to meet remotely on a monthly basis. Chairs of the CACs participated in bi-monthly meetings with Oregon Health Authority (OHA) Transformation Center to be informed about the CAC process, CHAs, and CHIPs. CACs were provided access to training and technical assistance to improve health outcomes and to elevate the voice of Oregon Health Plan members. Additionally, they were provided with training on how to run effective CAC meetings, informed about state rules governing CACs, and learned how to increase Oregon Health Plan members participation on CCOs' (Coordinated Care Organization), Boards.

  Innovator Agents (IAs), were engaged with Community Advisory Councils and served as local experts to the CACs, CCOs, and community partners to ensure coordination across these groups. IAs served these groups by having increased knowledge of their local communities, gaps, strengths, and availability of health resources. They linked the needs of the CACs to the CCOs and OHA to develop community priorities and strategies. They participated in the completion and review of local Community Health Assessments, Community Health Improvement and Transformation plans.

  IAs connected CACs with OHA and statewide health priorities such as the State Health Improvement Plan. The State Health Improvement Plan has a staffed fully integrated workgroup including staff from multiple divisions of the OHA. One innovator agent has been assigned to the workgroup and will be bringing information from the various county-specific CHIPs back to the SHIP workgroup as well as sharing development of SHIP plans to the innovator agent team and to the CCO sponsored CHIPs to inform and develop statewide strategies.

  IAs continue to support CACs. through COVID-safe practices by providing ideas and experiences to make remote meetings more thoughtful and engaging. A few CACs have adapted by providing their members with delivery codes for food delivery services, allowing CAC members to enjoy a meal together virtually, as they would have in the past, when they met in person. Others have included personal time within the meeting agendas, providing an outlet for those who have been isolated and who have a need to share and talk about how COVID has affected their own lives and family. These adaptations have proven to support CAC engagement and be effective in helping members cope with the isolation and lack of socialization that COVID has created. This has also been a positive way in which CAC members can engage and see how they can assist each other in these difficult times.

- **Spread of best practices around health system transformation and innovation;**

IAs helped good news travel fast by sharing innovation and successful practices with CCOs and CACs. They played a key role in sharing concerns with OHA leadership. They offered feedback and solutions during the COVID global pandemic and Oregon's extreme wildfire emergency that involved several areas of the state. They identified the health, social, and behavioral needs of OHP members, and explored ways to address those needs. Gaps in health service delivery were shared with OHA leadership and CCOs. OHA resources to assist OHP members during times of crisis were identified and shared with CACS and CCOs.

They engaged with CACs and CCOs regarding community health transformation and innovation to ensure statewide and local coordination. IAs played a critical role in advancing health equity and addressing social determinates of health. They led OHA's strategic priority of eliminating health inequalities by working collaboratively with CACs, CCOs, and local community partners to assess areas of improvement. One IA continued to work with seasonal and migrant farmworker groups around COVID response and improvements.

- **Tracking of CCO questions, issues, and resolutions in order to identify systemic issues;**

IAs served as the single point of contact between OHA and CCOs. They continued to raise concerns with OHA regarding Oregon Health plan members, CACs, CCOs and local communities. They were involved in daily interactions and ongoing communications with OHA leadership and other agency staff regarding systemic concerns. They offered recommendations and solutions to OHA leadership to address systemic concerns and, or, breakdown barriers. Several IAs shared their expertise about emergency preparedness, immunizations, behavioral health, and community development with OHA and their CCOs to improve health outcomes.

IAs engaged with CCOs to increase access to health care and to eliminate health inequalities. They identified process improvements that allowed OHA to achieve its triple aim with a priority on health equity, behavioral health, and addressing social determinants of health.

The extreme wildfire emergencies across the state, in addition to the COVID-related emergencies has proved to be a critical situation with the availability of culturally and linguistically appropriate behavioral health services in many parts of the state. The innovator agents have been working with community partners to identify the needs of those communities and inform OHA leadership about how the agency can best respond. Through a series of communications with community benefit organizations, innovator agents helped to identify other resources to consider in addition to the financial supports. These areas hit by wildfires have lengthy recovery timelines and the innovator agents play a key role in identifying where those needs are greatest, as well as communicating and coordinating supports from OHA and other local agencies.

Assistance to CCOs implementing innovative projects and pilots (e.g. stakeholder feedback, adapting innovation to improve adoption rate); and

IAs served as local experts providing feedback regarding the involvement of CACs, CCOs, and community organizations in the development of innovated projects. They engaged with CCOs to improve immunizations rates, increased adolescent well child screenings, addressed health inequities and social determinants of health.

- **Community partnerships supporting effective innovation.**

  IAs build and strengthen OHA and CCO relationships through increased engagement and participation across all OHA divisions. They supported the CACs and CCOs in the implementation of the Community Health Improvement Plans and Transformation Plans.

  They worked with their local CACs and CCOs to remove barriers that impeded innovation. They shared their knowledge about evidence-based practices, innovative projects, and strategies to support quality improvement and improved health outcomes. They assisted the CACs and CCOs with the development of community partnerships to advance coordination of innovative projects.

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.

Staff made a final determination about which 2019 spending met HRS criteria and completed an analysis of spending across CCOs, available here: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2019-HRS-Reporting-Summary.pdf

Staff held an HRS 101 webinar for CCOs and their contracted providers and organizations. Sixty-nine people attended, and 80% of evaluation respondents said it was valuable to their work (20% neutral).

To improve future use of and support potential increases to HRS spending, staff are updating guidance for HRS housing and community benefit initiatives and developing HRS traditional health worker guidance. All HRS guidance documents for CCOs and external partners are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx

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.

Behavioral health integration

The center hosted a virtual behavioral health learning collaborative to assist behavioral health organizations with their adoption or upgrade of electronic health record (EHR) systems and adoption of health information exchange tools. Funding was provided through a SAMHSA grant and content was developed through the recommendations of the Health Information Technology Oversight Council Behavioral Health HIT Workgroup. The event provided

an opportunity to hear from colleagues and experts on best practices, lessons learned, successes and challenges around EHR adoption and upgrade, and health information exchange.

The event drew 155 participants. Of evaluation respondents, 92% rated the event as valuable or very valuable to their work. The most helpful pieces were learning about others' work and information about race, ethnicity, language and disability (REALD) data collection.

Population health

Community advisory council activities
The center continued to host monthly peer-to-peer meetings with CAC members and CAC coordinators. Meeting topics included social needs screening, COVID-19 funding for community engagement, CAC's role in reviewing social determinants of health and equity spending, and CAC member recruitment strategies. The center also launched a new learning collaborative for CAC members serving on CCO governing boards, which will hold its first meeting in December.

Staff also updated a CAC 101 presentation for new and current CAC members.

Community health assessment (CHA) and community health improvement plan (CHP)
Staff continued to work with the consultant updating the CHA/CHP development curriculum to 1) shift curriculum to online modules with an emphasis on remote participant engagement, and 2) add activities to support a shift in CHP health priorities to support COVID-19 response and recovery efforts, based on community input.

CCO incentive metrics technical assistance
Much of the TA for supporting 2020 CCO incentive metrics was on hold due to COVID-19 response, though planning and designing technical assistance began to ramp up again.

Diabetes (HbA1C and a new oral health visit metric)
The Transformation Center held three webinars focused on implementing the National Diabetes Prevention Program. The webinars were tailored for CCOs (63 attendees), community-based organizations (46 attendees) and clinics (34 attendees).

OHA kicked off its work with the Oregon Rural Practice-based Research Network to increase quality improvement (QI) capacity in clinics by concentrating on two CCO incentive metrics: HbA1C poor control and dental exams for adults with diabetes. OHA anticipates training staff from 40 clinics on how to use QI tools and science to improve performance on the metrics. Technical assistance for clinic staff will include a remote four-hour interactive training and up to five hours of follow-up one-on-one calls with practice coaches.

Kindergarten readiness (well-child visits and preventive dental)
The Transformation Center is working with a contractor to develop communication tools for CCOs to use with their providers and Oregon Health Plan members to promote the value of well-child visits (ages 3–6) and preventive dental care for children (ages 1–14).

Meaningful language access to culturally responsive health care services

CCOs have a new incentive metric for 2021: meaningful language access to culturally responsive health care services. This will measure the provision of quality interpreter services and is based on the proportion of member visits with spoken and sign language interpreter needs provided with OHA qualified or certified health care interpreters. The Transformation Center held the first of three needs assessment calls with clinic and CCO staff. These conversations will help OHA prioritize future technical assistance provided.

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. Moving forward, the TA is also addressing ramifications COVID-19 may have on SBIRT workflows and concerns about a rise in unhealthy alcohol and drug use concurrent with the physical distancing needed to suppress COVID-19 morbidity and mortality. Thirty-seven clinics across Oregon have signed up to participate so far; additional recruitment strategies are planned for October as clinic recruitment slowed during the pandemic.

Cross-cutting supports

Children's health complexity

The Office of Health Analytics, in collaboration with the Oregon Pediatric Improvement Partnership (OPIP), released updated statewide-, CCO- and county-level data on children's health complexity. The Transformation Center is supporting TA to CCOs to use this data, provided through OPIP. One additional CCO signed up for technical assistance this quarter; technical assistance will take place over the fall and winter months.

Patient-centered counseling trainings

The Transformation Center held three patient-centered counseling virtual trainings for Medicaid providers. More than 60 people attended. Examples drew from CCO metric-related topics, and evidence-based health communication models included motivational interviewing, the FRAMES model and Five As for tobacco cessation counseling. No-cost continuing medical education credits were available. Evaluation results were extremely positive, with 98% of respondents indicating the training was valuable to their work and 100% planned to take some action as a result. Seven more trainings are scheduled through December.

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

OHA suspended the CCO learning collaborative while CCOs focused on COVID-19 response. In September, staff planned for the next collaborative session, which will resume in October.

Transformation and Quality Strategy (TQS) technical assistance

Staff finalized the TQS guidance documents and evaluation criteria for 2021 submissions and scheduled CCO technical assistance through topic-specific webinars and open office hours.

Social Determinants of Health Measurement Workgroup

The Transformation Center and Office of Health Analytics are continuing their partnership to develop a recommended social needs screening measure at the request of Oregon's Metrics and Scoring Committee. This

is in line with the Oregon Health Policy Board's CCO 2.0 policy recommendations, which included encouraging the Metrics and Scoring Committee to include population health, social determinants of health, and health equity measures in the CCO Quality Incentive Pool.

The SDOH Measurement Workgroup: Screening for Social Needs, a public work group, will convene beginning in October to develop a measure concept for consideration by the Metrics and Scoring and Health Plan Quality Metrics Committees. In preparation, OHA convened a smaller planning team including OHA and Department of Human Services staff, consultants and technical experts, including the National Center for Quality Assurance and Bailit Health. The partnership with Bailit Health is funded through the Robert Wood Johnson Foundation and State Health and Value Strategies. The planning team has developed four social needs screening measure concepts for consideration by the public work group when it convenes in October.

B. Lower cost

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

C. Better care and Better health (ANNUAL)

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately as Attachment A.

2. State reported enrollment table

Enrollment	July/2020	August/2020	September/2020
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,035,052	1,049,057	1,059,880
Title XXI funded State Plan	90,733	91,486	91,816
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	July 30, 2019	August 30, 2020	September 30, 2020

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%	41,297	114,452	2.80%	15.26%
	Title XXI	SCHIP FPL < 170%	102,676	283,300	-1.41%	14.94%
Mandatory	**Title XIX**	Other OHP Plus	163,102	466,499	2.13%	14.05%
		MAGI adults/children	814,457	2,332,098	7.34%	21.15%
		MAGI pregnant women	10,404	24,829	7.47%	5.3%
		QUARTER TOTALS	1,131,936			
** Due to retroactive eligibility changes, the numbers should be considered preliminary*						

OHP eligible and managed care enrollment

OHP eligible*		Coordinated Care				Dental Care
		CCOA**	CCOB**	CCOE**	CCOG**	DCO
July	1,072,829	977,385	603	154	11,234	48,476
August	1,086,542	985,729	418	125	11,333	50,077
September	1,099,809	999,814	658	126	11,711	51,658
Quarter average	1,086,393	987,643	560	135	11,426	50,070

B. Complaints and grievances

Attached separately as Attachment B.

C. CCO appeals and hearings

Attached separately as Attachments C & D.

D. Neutrality reports

Budget monitoring spreadsheets

Attached separately.