Oregon Health Plan

Section 1115 Quarterly Report

10/1/2020 – 12/31/2020

Demonstration Year (DY): 19 (7/1/2020 – 6/30/2021)

Demonstration Quarter (DQ): 2/2020

Federal Fiscal Quarter (FQ): 1/2020

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I. Introduction

A. Letter from the State Medicaid Director

During this reporting period, the Oregon Health Authority (OHA) continued to monitor the changing needs of Medicaid members and health care providers as a result of the Covid-19 pandemic. In partnership with Coordinated Care Organizations (CCOs) Oregon continued to maintain members' access to quality services, and ensure the integrity of our health care system.

Through collaborative cross-sector meetings, and additional and refocused communications, OHA continues to maximize the ways in which CCOs are engaged as partners in responding to emerging social needs. OHA also continues to work with CCOs and their partner organizations who have received funding related to public health emergencies to ensure that CCOs leverage all available funding sources to benefit their Medicaid members.

In addition to working directly with stakeholders in the Medicaid system, OHA continues to work with the Oregon Incident Management Team for Covid-19 and the Covid-19 Response and Recovery Unit (CRUU), cross-agency workgroups to create alignment in goals and best practices for serving Oregon's most vulnerable populations.

Public workgroups and many cross-sector workstreams that were interrupted during last quarter's wildfire-related public health emergency were able to refocus their work on the emerging needs of the populations they serve.

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.

C. State contacts

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II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 10/1/2020 – 12/31/2020
Demonstration Year (DY): DY 19 – Quarter 2
Demonstration Quarter (DQ): 2/2020
Federal Fiscal Quarter (FQ): 1/2020

III. Overview of the current quarter

During the second quarter of Demonstration Year 19, Oregon's Medicaid enrollment continued to climb, and providers continued adapt to changing demands of the Covid-19 pandemic. OHA continued the implementation of the Integrated Eligibility system and continued to make adjustments during the rollout to ensure Medicaid applications and renewals are processed in a timely manner.

Complaints and grievances continue to rise along with enrollment, but still do not exceed pre-COVID levels.

One CCO began receiving members in the Portland metro area, and the OHA continues to monitor network adequacy in that CCO region through a corrective action plan.

A. Enrollment progress

1. Oregon Health Plan eligibility

Title XIX and XXI enrollment has continued to show small but steady increases which are attributable to continued coverage protections and simplified eligibility requirements provided under H.R.6201 Families First Coronavirus Response Act. During the public health emergency period, coverage for individuals is not terminated or reduced with only a few exceptions; otherwise, individuals are transitioned between programs as their income changes. This accounts for some of the increase in Title XXI enrollment. Oregon is also in the middle of a 9-month waved roll-out of an integrated eligibility system across the state. Eligibility workers continue to have steep learning curves working in the new system and with new programs, however applications and renewals continue to be processed within required timeframes.

2. Coordinated care organization enrollment

Total CCO enrollment for 4Q 2020 grew by 4.6%, across all plan levels (CCOA, CCOB, CCOE, CCOG). Each specific Coordinated Care Organization experienced an increase in enrollment in the 3-6% range, with the exception of Trillium Community Health Plan in the Portland metro tri-county area which began operations on September 1, 2020. During the 4Q, Trillium tri-county nearly quadrupled in size, from approximately 2,200 to 8,400 members. At the county level for each CCO, one-third experienced an enrollment increase of over 5% and only one county showed a decrease.

Since May 1, 2020, Oregon Health Authority has waived the requirement to limit each Coordinated Care Organization's enrollment to the county limit(s) and grand total limit listed in its contract. CCO Account Representatives monitor both current and future enrollment each week and initiate incremental capacity increases to be reflected in the MMIS system, as necessary, to ensure that enrollment limits do not create access to care issues during the pandemic. Initially, the waiver applied to contract year 2020; however, in December, the decision was made to extend the waiver through 6/30/21.

As anticipated with any implementation, there were a few ONE system defects that arose during both the pilot (July, 2020) and wave one (November, 2020) of the Integrated Eligibility implementation. Defects that created downstream effect on CCO enrollment, due to incorrect or failed transactions of eligibility information, were proactively identified and resolved to reconcile eligibility and enrollment information in MMIS. The defect impacted a small percentage of CCO members and CCOs were informed on a monthly basis for awareness and tracking of issues and data fixes.

B. Benefits

The Pharmacy and Therapeutics Committee:

The P&T Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: Atopic Dermatitis; Dupilumab; Roflumilast; Monoclonal Antibodies; Fenfluramine; Cannabidiol; Non-injectable Antiepileptics; Proton Pump Inhibitors; Anti-Parkinson's Agents; Targeted Immune Modulators; Oncology Agents; Orphan Drugs; Modafinil/Armodafinil; Sedative Class; Teprotumumab; Gout Class; Risdiplam; Cenegermin; ICS/LABA/LAMA; Biologic Therapies; Topical Antipsoriatics;

The committee also recommended changes to the preferred drug list (PDL): make Tudorza® Pressair® (aclidinium bromide) non-preferred; make AirDuo RespiClick® (fluticasone/salmeterol), Anoro Ellipta (umeclidinium/vilanterol) and Stiolto® Respimat® (tiotropium/olodaterol) preferred; designate Fintepla®

(fenfluramine) non-preferred; maintain Nayzilam® (midazolam nasal spray) and Valtoco® (diazepam nasal spray) as non-preferred; make famotidine/Ca carb/mag hydrox chewable tablets, nizatidine solution, Aciphex® (rabeprazole), Dexilant (dexlansoprazole), Prevacid® DR (lansoprazole) capsules and the generic formulations, and Pylera™ (bismuth/metronidazole/tetracycline) capsules and lansoprazole/amoxicillin/clarithromycin combo pack preferred; designate Nourianz™ (istradefylline), Ogentys® (opicapone) and Kynmobi™ (apomorphine sublingual) as a non-preferred; make amantadine capsules and tablets preferred; make Cosentyx® (secukinumab) non-preferred; make Melatonin preferred (upon CMS approval); designate Tepezza® (teprotumumab) as non-preferred; make Colcrys® (colchicine) tablets preferred; designate Evrysdi™ (risdiplam) as non-preferred; designate Oxervate™ (cenegermin) as non-preferred; make Ajovy® (fremanezumab-vfrm) preferred.

Health Evidence Review Committee

The October 1, 2020 prioritized list went into effect on October 1, 2020 and was reported in a Notification of Interim Changes. Errata were posted 9/25/2020, 11/5/2020, 11/9/2020 and 12/21/2020.

C. Access to care (ANNUAL)

D. Quality of care (ANNUAL)

E. Complaints, grievances, and hearings

1. CCO and FFS complaints and grievances

CCO and FFS Complaints

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 Oct 1, 2020 through December 31, 2020.

Trends

	Jan – Mar 2020	Apr – Jun 2020	Jul – Sep 2020	Oct – Dec 2020
Total complaints received	4,233	2,503	3,181	3,529
Total average enrollment	1,050,851	1,046,476	1,093,854	1,138,377
Rate per 1,000 members	4.03	2.39	2.91	3.10

Barriers

The 2020 fourth 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 office visits continue to be 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 15.3% from the previous quarter. The Access to Care category shows a 23.3% increase this quarter. Over the previous quarter Quality of Care issues had a slight increase of 8.6%. 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 restrictions being lifted for in-office visits as well as 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 Oct – Dec quarter was 146. An additional 357 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 118 complaints from members enrolled in Dental Care Organizations. 7984 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	Jan – Mar 2020	Apr – Jun 2020	Jul – Sep 2020	Oct – Dec 2020
Access to care	1,566	667	847	1,044
Client billing issues	293	446	343	266
Consumer rights	277	168	256	281
Interaction with provider or plan	1,464	690	1,079	1,244
Quality of care	397	344	455	494
Quality of service	223	188	201	200
Other	13	0	0	0
Grand Total	4,233	2,503	3,181	3,529

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 Pharmacy related. Behavioral Health 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)	**Jan – Mar 2020**	**Apr – Jun 2020**	**Jul – Sep 2020**	**Oct – Dec 2020**

a) Denial or limited authorization of a requested service.	25,964	21,311	27,215	29,315
b) Single PHP service area, denial to obtain services outside the PHP panel	326	215	286	459
c) Termination, suspension, or reduction of previously authorized covered services	267	62	81	109
d) Failure to act within the timeframes provided in § 438.408(b)	47	11	10	10
e) Failure to provide services in a timely manner, as defined by the State	111	21	40	55
f) Denial of payment, at the time of any action affecting the claim.	41,912	40,779	58,588	56,932
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	68,627	62,399	86,220	86,880
Number per 1000 members	65	60	86	84

2. CCO and FFS appeals and hearings

The table below shows the number of appeals the CCOs received over the past year. There has been a 4% decrease in the number of appeals this quarter over last quarter. CCOs reported the highest number of appeals for Outpatient services. Appeals related to Specialty Care were the next highest and Pharmacy 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	Jan – Mar 2020	Apr – Jun 2020	Jul – Sep 2020	Oct – Dec 2020
a) Denial or limited authorization of a requested service.	811	766	1,055	1,078
b) Single PHP service area, denial to obtain services outside the PHP panel.	4	7	6	15
c) Termination, suspension, or reduction of previously authorized covered services.	6	1	3	2
d) Failure to act within the timeframes provided in § 438.408(b).	4	0	0	2
e) Failure to provide services in a timely manner, as defined by the State.	0	0	2	0
f) Denial of payment, at the time of any action affecting the claim.	353	409	438	346
g) Denial of a member's request to dispute a financial liability.	0	0	0	0

Total	1,178	1,183	1,504	1,443
Number per 1000 members	1.1	1.13	1.5	1.4
Number overturned at plan level	379	308	475	432
Appeal decisions pending	9	12	5	10
Overturn rate at plan level	32.17%	26%	31.58%	29.94

CCO and FFS Contested Case 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 280 hearing requests related to the denial of medical, dental and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 243 were from CCO-enrolled members and 37 were from FFS members.

During the second quarter (October 1, 2020 – December 31, 2020), 285 cases were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. In every quarter there is an overlap of processed cases with those received. For instance, cases processed and resolved in October of 2020 may be cases OHA received as far back as July and August of 2020.

OHA dismissed 153 cases that were determined not hearable cases. Of the not-hearable cases, 122 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 132 cases that were determined to be hearable, 17 were approved prior to hearing. Members withdrew from 50 cases after an informal conference with an OHA hearing representative. 39 cases went to hearing, where an administrative law judge upheld the OHA or CCO decision and 21 cases were dismissed for the members failure to appear. In 5 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.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	17	6%
Client withdrew request after pre-hearing conference	50	18%
Dismissed by OHA as not hearable	153	53%

Decision affirmed*	39	13%
Client failed to appear*	15	5%
Dismissed as non-timely	1	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	5	1%
Set Aside	0	0%
Total	285	

Resolution after an administrative hearing.

Related data

Reports are attached separately as appendices.

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

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. Oregon Health Plan members in the Tri-County area (Multnomah, Clackamas, and Washington) will have an additional option for CCO enrollment. Through the CAP imposed on Trillium Community Health Plan, OHA will monitor key areas in the network development to ensure the network of contracted providers is sufficient to serve assigned members and meet time and distance standards for access outlined in OAR 410-141-3515 and per federal authority under 42 CFR 438.68(b). Trillium must ensure that its members have the same access to certain services as other patients in the service area.

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. The procurement resulted in changes in service areas and member choice in the Oregon program. These changes were effective January 2020 and resulted in a member choice period that inserted some uncertainty into the original 2020 capitation rate development. In Quarter 4, OHA submitted a retroactive amendment for CY20 rates (effective January-December 2020) to adjust the capitation rates for member risk changes that occurred due to procurement process, and also react to the disenrollment freeze required by the Families Frist Coronavirus Relief Act (FFCRA).

OHA also delivered the final CY21 CCO and DCO rates package to the Centers for Medicare & Medicaid Services (CMS), which included the Oregon CY21 rate certifications and contract rate Sheets. OHA continues to monitor the COVID-19 pandemic closely and working with CCOs in a partnership in maintaining our healthcare system.

Separately, due to feedback from stakeholders, OHA also convened a workgroup to discuss the dental category of service development in the CCO rate development that started in December 2020. OHA plans to continue these Dental Rates workgroup meeting through May 2021.

4. Enrollment/disenrollment

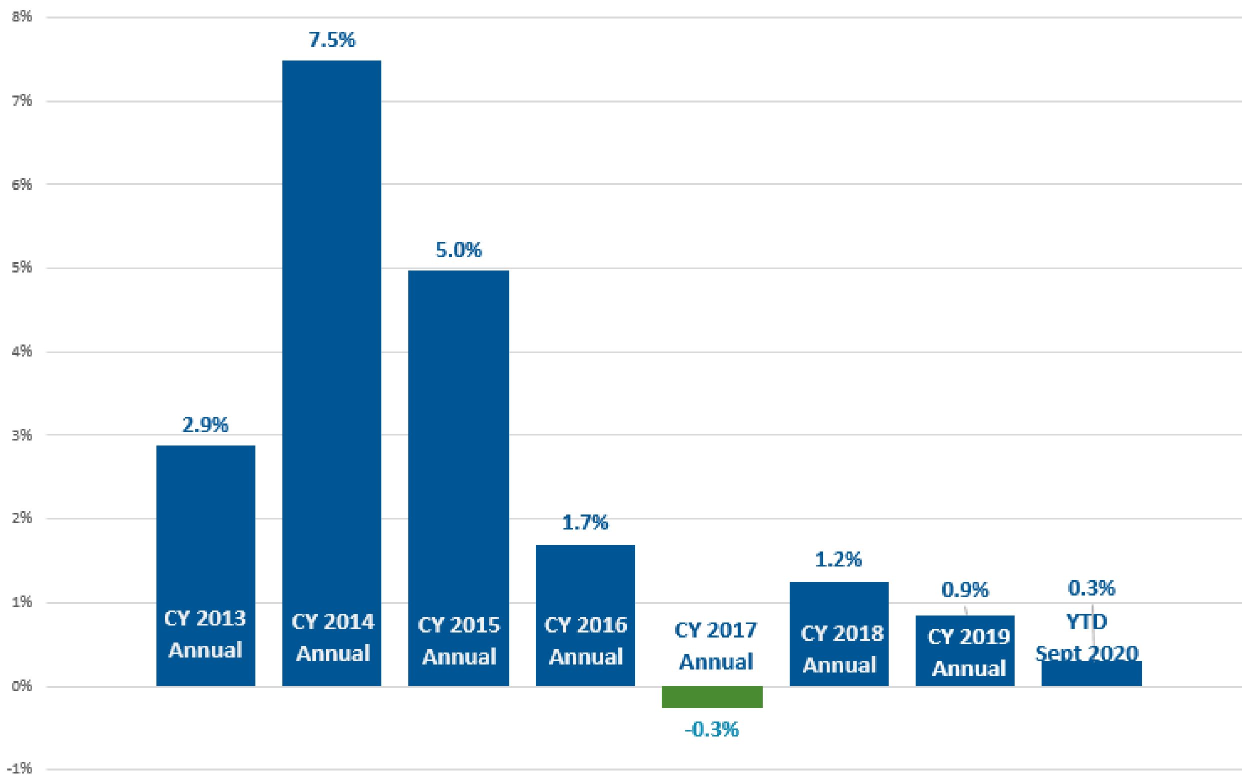
There are no significant changes in enrollment other than those noted in Section III. A of this report.

5. Contract compliance

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

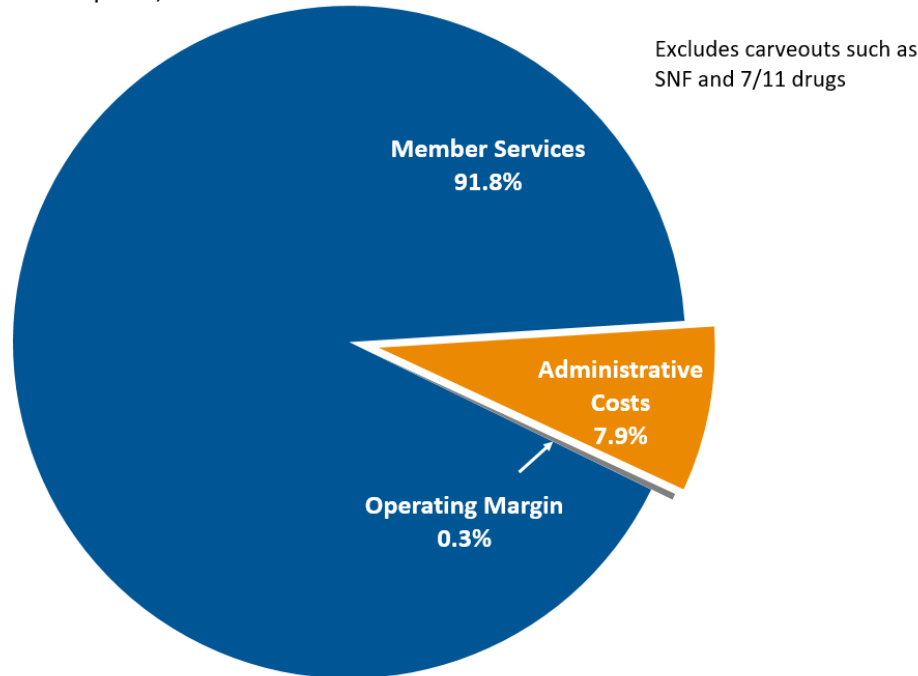
6. Relevant financial performance

For the nine-months ended September 30, 2020, the statewide CCO operating margin was at 0.3% compared to 0.9% for the year ended December 31, 2019. For reference, the capitation rates include a 1% profit margin. CCO operating margins on tracking as the lowest margin after the loss sustained in the year ended December 31, 2017.



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (this includes medical, behavioral, dental and health-related services, reinsurance premiums and recoveries, and other adjustments) as a percentage of total revenue. For the 9-months ended September 30, 2020, the MSR for all CCOs in aggregate was 91.8%. Administrative Services accounted for 7.9% of total CCO revenue, leaving 0.3% as Operating Margin.

For the 9-months ended September 30, 2020, all of the 15 CCOs met or exceeded the 85% target for MSR, a key indicator for MLR (8 of the CCOs had MSRs above 90%).



At end of September 30, 2020, Net Assets of the CCOs ranged from a low of $176 per member (Health Share of Oregon) to a high of $1,848 per member (Trillium Comm. Health Plan), averaging $431 per member for the state.

For additional CCO financial information and audited financials are available on the public-facing webpage (http://www.oregon.gov/oha/FOD/Pages/CCO-Financial.aspx).

7. Corrective action plans

For the current quarter, one CCO continues to be on a Corrective Action Plan (CAP) and 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 October-December 2020 is as follows:

- Provider (driver) no-shows: The first two months of this quarter were generally in line with the performance shown throughout most of the CAP period but are still outside the performance target. Data was not required to be reported for the third month due to an agreement between OHA and HSO to change which provider no-show data is relevant to this metric. For the duration of the CAP, the data used to assess performance on this metric included instances where providers picked up members earlier than scheduled. When such instances are removed from the data, HSO has been exceeding the performance target for this metric since August 2020.
- On-time (pick-up) performance: The first two months of this quarter were generally in line with the performance shown since early 2020 but are still considerably outside the performance target. Data was not required to be reported for the third month due to an agreement between OHA and HSO to change which on-time performance data is relevant to this metric. For the duration of the CAP, the data used to assess performance on this metric included instances where providers picked up members earlier than scheduled. When such instances are removed from the data, HSO has been exceeding the performance target for this metric since November 2020.
- 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. 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 public health emergency.

New CAP

• *Entity name:* Trillium Community Health Plan

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

• *Start date of CAP:* 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. On October 28, 2020, OHA issued an amendment to the original CAP notice and received the supplement to the proposed CAP on November 18, 2020. The proposed CAP, with the supplement, was under review by OHA at the end of the reporting quarter.

• *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 October 1, 2020 through December 31, 2020. OHA analyzed encounter data received for completeness and accuracy for the subject months finalized for March 2020 through May 2020.

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of March 2020 through May 2020. All CCOs except for one met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

One CCO did not meet the Administrative Performance (AP) standard for the months of March and April 2020 subject months no 1% withhold was taken as the CCO put remediation in place to ensure ongoing compliance and a decision was made by OHA leadership that due to the current pandemic affecting recent submissions, no withhold would be applied.

9. Other significant activities

During this reporting period, the Health Systems Division of the Oregon Health Authority continued to work with the Oregon Incident Management Team for Covid-19 and the Covid-19 Response and Recovery Unit (CRUU) to maximize the ways in which CCOs are engaged as partners in responding to the public health emergency. OHA also worked with CCOs and their partner organizations who have received funding related to public health emergencies to ensure that CCOs leverage all available funding sources to benefit their Medicaid members.

G. Health Information Technology

Medicaid Electronic Health Record (EHR) Incentive Program

The Medicaid EHR Incentive Program (also known as the Promoting Interoperability Program) offers qualifying Oregon Medicaid providers federally-funded financial incentives for the adoption or meaningful use of certified electronic health records technology. Eligible professional types include physicians, naturopathic physicians, pediatric optometrists, nurse practitioners, certified nurse-midwives, dentists, and physician assistants in certain settings. As of December 2020, more than $210 million in federal incentive payments have been dispersed to 60 Oregon hospitals and 3,849 Oregon providers. Between July and September 2020, 191 providers received $1,623,500 in incentive payments. The program sunsets December 31, 2021.

HIT Commons

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

EDie and the Collective Platform (formerly known as PreManage)

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

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

EDie and the Collective Platform are in use statewide and adoption for Collective continues to grow. All of Oregon's CCOs receive hospital notifications through the Collective Platform (and all CCOs are extending their Collective subscriptions down to their contracted providers), as are most major Oregon health plans, and all of Oregon's Dental Care Organizations. About 2/3rds of Oregon's Patient-Centered Primary Care Homes, many

behavioral health and community mental health program clinics, tribal clinics and others are participating, as well as state programs for Aging & People with Disabilities and Developmental Disabilities.

Recent highlights:

- As of January 18, 2021, statewide COVID-19 positive case data are flowing from OHA's Oregon Pandemic Emergency Response Application (Opera), the state's COVID-19 case investigation system, into EDIE notifications across 63 Oregon hospitals and are visible in real-time through integrated EHR and other clinical workflows. For more information see this link.
- OHA, HIT Commons and Collective worked together in 2020 to deploy three statewide flags indicating a patient had an ED visit with a presumptive COVID-19 indicator. Educational materials were also developed and sent to all EDie/Collective Platform users. Confirmed COVID-19 status from some hospital facility ADT and Reliance lab feeds are now live in EDIE/Collective Platform. For more information see this link.

Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative

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

- 20,965 prescribers[1] across 200 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), 9 retail pharmacy chains (across 890 sites) and 1 rural pharmacy are also live.
- Recent efforts to encourage small and rural clinics to integrate their EHR access to PDMP have proven fruitful, and HIT Commons expects to bring on a number of new organizations in 2021.

Direct Secure Messaging Flat File Directory

The Flat File Directory assists organizations with identifying Direct secure messaging addresses across Oregon to support use of Direct, including to meet federal Meaningful Use requirements for sharing Transitions of Care summaries. As of January 2021, the Flat File Directory includes more than 17,000 Direct addresses from 25 interoperable, participating entities who represent 890 unique health care organizations (primary care, hospital, behavioral health, dentistry, FQHC, etc.).

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.

ONC and CMS Interoperability Final Rules

[1] This number cannot be deduplicated and may reflect duplicate prescriber counts.

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

- OHA has hosted three webinars related to these rules to inform the public and CCOs: (1) a HITOC-sponsored Federal Interoperability Final Rules Webinar on 10/1/2020 which provided an overview of both interoperability final rules; (2) a CCO/Payer Interoperability Final Rules Webinar on 11/5/2020 which focused on the CMS payer requirements; and (3) a CCO/DCO Final Rules Follow-up Webinar focusing on the newly released Interoperability and Prior Authorization final rule and CCO/DCO information sharing and coordination. Recordings and materials for these webinars and additional resources (e.g., webinar Q&As, links to federal websites and documents) can be found on the Office of Health IT final rules webpage.

H. Metrics development

1. Kindergarten Readiness
As a reminder, 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 partnership team presented on the progress it has made at the November 2020 Metrics & Scoring Committee meeting[2]. Dr. Dana Hargunani from OHA, Elena Rivera from Children's Institute, and Colleen Reuland from the Oregon Pediatric Improvement Partnership updated the Committee on background and progress on the measure being developed to improve the social-emotional health of young children, reminding them that this measure is part of a multi-measure, multi-year strategy on how the health sector can improve kindergarten readiness that was previously endorsed by both the Metrics and Scoring and Health Plan Quality Metrics Committees.

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[2] https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/1B-MS-Committee_nov%202020_agenda_updated.pdf

- The vision for the metric is that children from birth to age 5, and their families, have equitable access to services that support their social-emotional health and are the best match for their needs.
- The purpose is to drive CCOs to address complex system-level factors that impact the services kids and families receive and how they receive them, and for which there may be payment or policy barriers that need to be addressed.
- The metric includes a glide path that builds over multiple years. In year 1, the focus is on building a data foundation by assessing current reach of services. Years 2 to 5 are for building on that foundation to enhance capacity and services.
- Note that the goal is to propose the metric in 2021 for inclusion in the 2022 incentive measure set. Young children and families have faced barriers to accessing social-emotional health services that they critically need, and the need is growing during the pandemic.

Discussion included:

- How the measure addresses racial equity. In addition to looking at asset mapping and looking at capacity by language, race ethnicity, and region, the development team is thinking about how to incorporate those pieces as the CCO, with community partners, makes a plan to address key gaps for target populations in the region.
- How gaps will be addressed, including schools, and the need to pull in community sectors and brainstorm innovative ways providers can provide services.
- Ensuring that the measure pushes for trauma informed care.
- Metrics & Scoring Committee members expressed support for the measure, and the chair and vice-chair said they would champion the measure.

2. SDOH/Health-related Social Needs Measure

The public workgroup initially planned to begin meeting in April 2020 but due to the pandemic the meetings were delayed until October. The workgroup roster, meeting materials, and meeting recordings all are available on the workgroup page here: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx

To support the workgroup's condensed schedule, a smaller Expanded Planning Team met over the spring and summer to gather information and create a set of options for the Workgroup to consider. This team included representatives from OHA; consultants from Nancy Goff & Associates and the Oregon Rural Practice-based Research Network (ORPRN); ODHS; Community Information Exchange partners; and the National Committee for Quality Assurance. The team developed 4 measure concepts for the full workgroup to consider.

The full workgroup started meeting in October 2020 and met a total of 4 times from October through December 2020, culminating in the workgroup's vote on a recommended measure concept at the December meeting. In February 2021, there will be an optional meeting about screening tools and to address any outstanding questions. All of the workgroup meetings were open to the public, and public comment was invited at each meeting.

In the October 7th meeting, the workgroup went over Oregon's CCO Incentive Program, an overview of social needs screening on a national level and a review of the measure concepts from the Expanded Planning Team.

At the November 2nd meeting, the workgroup saw a presentation on an environmental scan done by ORPRN and had both small and large group breakout discussion about the measure concepts.

At the November 19th meeting, the workgroup continued its discussion of the measure concepts incorporating additional information that the workgroup members requested from OHA including scope of measure, implementation of measure and possible data sources for measure.

At the December 8th meeting, the workgroup reviewed the results of a survey completed by workgroup members. The survey evaluated each of the 4 measure concepts based on the guiding principles of the workgroup (Equity, Alignment, Feasibility). Measure Concept 1 (any data source) received the highest rating. The survey also asked members to prioritize several screening domains by high, medium and low priority. The screening domains that received the highest priority rating were food insecurity, housing insecurity and transportation. Finally, members voted on a measure concept to send to consideration to the Metrics and Scoring Committee. The measure concept decided on was the rate of social needs screening in the total member population from any data source. The numerator would be CCO members screened while the denominator would be total CCO membership. The measure concept includes a multi-year glide path, beginning with a structural measure to ensure that screening is done in an equitable and trauma-informed way and that systems are in place for sharing data and making referrals to meet identified social needs.

Next steps for the workgroup include helping to draft and review the final workgroup and attend an optional meeting in February 2021. The final report will be delivered to Metrics and Scoring Committee in February and posted on the workgroup's webpage. With approval from the Metrics and Scoring Committee, the next step in measure development would be drafting detailed measure specifications and pilot testing the measure.

3. Evidence-based Obesity Measure Workgroup (Development 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 measure for 2021. The workgroup will reconvene in 2021 to begin reworking the measure based on community and stakeholder feedback from the July 2020 Metrics and Scoring Meeting.

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.

Oregon Health Authority

Effective January 2021, Oregon will be the first state to use a Medicaid pay for performance measure focused on health equity. This workgroup is no longer meeting.

I. Budget neutrality

There are no significant issues with financial accounting, budget neutrality, or CMS 64 reporting for the current quarter.

J. Legislative activities

There were no significant legislative activities during this reporting period.

K. Litigation status

There are no changes in litigation status during the reporting period.

L. Public forums

Health Evidence Review Commission

October 1, 2020

This testimony concerned coverage of Cologuard for colon cancer screening.

Melissa Wood, from Exact Sciences, the developer and marketer of Cologuard, provided testimony. She did not describe any other conflicts of interest. She said their patient adherence program, where they follow up with the patients, is included in the price of the test. She said they have a complete database of who has been screened and can appropriately rescreen in three years, taking that work necessity away from the providers. She said there is a 20% delta between screening rates for Medicaid and Medicare patients, for many socioeconomic reasons.

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

Koa Kai is a patient-ambassador for the Chronic Disease Coalition and stated she has no conflicts of interest. She said the most concerning part of Guideline Note 60, for patients, is the policy overreach from what the committee's given task was: from solely deciding coverage to making requirements that demand doctor's performance of treatments, often against the doctor's best clinical judgement. Kai said this policy interferes in the patient-doctor relationship to provide appropriate medical treatment and can cause patient harm and disability. She said the guideline is not scientifically supported. Although the clause "when clinically indicated" was added in the middle of aggressive taper language, the rest of the guideline note renders that statement moot.

OHA, to date, has not acquired any patient outcome data for this unprecedented policy so we are forced to rely on anecdotal evidence such as the 33% rise in deaths of Medicare/Medicaid patients in the last year alone in the Death with Dignity program due to lack of pain control. The OHA's Ombud office was forced last year to seek emergency funding to add additional workers to deal with the increased number of concerns and complaints about the continuity of pain medication. She said doctors need to be able to use their best clinical judgement without fear of regulatory attention or retribution. Kai said patients are continuing to be harmed by this radical policy that needs to be revoked immediately.

November 12, 2020

This testimony concerned Expanded Carrier Screening (ECS) for genetic anomalies.

Devki Nagar testified about Expanded Carrier Screening (ECS). Ms. Nagar is a Myriad Genetic's genetic counselor and was otherwise silent on conflicts of interest. She applauded the Commission for continuing to review this topic. She feels that ECS provides equity across ethnicities. Ms. Nagar said there are a wide range of panels, including panels with 15 genes or more. Some labs are publishing data stating that their tests align with American College of Obstetricians and Gynecologists (ACOG) recommendations. ACOG supports this approach so that patients have a choice which would align with their values and preferences. Based on the information, patients are making appropriate changes for their current or future pregnancies.

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

Koa Kai from the Chronic Disease Coalition stated no conflicts of interest. Ms. Kai lauded the changes to Guideline Note 60 (GN 60). She said it is imperative to provide options for pain relief and patient safeguards from harm. She said one of the misperceptions HERC seems to have is that GN 60 is merely a guideline but in the past, this policy has been aggressively implemented without regard to patient safety. It is imperative to recognize the patient harms caused by the unintended consequences from the history of GN 60 and to recognize the organization's responsibility to remedy the resulting harms from forced tapers and denials of pain medication. It is also important to recognize the damage this policy has done to the doctor-patient relationship. She urged HERC to make small changes and evaluate the outcomes and adjusting policies based on those assessments in a timely manner. There are other issues from the creation of GN 60 which must be acknowledged including one multi-committee member's excessive participation in the policy's conception authorship, voting, promotion and subsequent review participation. The additional destruction of the taskforces public records and the various taskforce member's undisclosed conflicts of interest has allowed for a lack of public transparency and consideration of public input in the creation of public health policy.

Wendy Sinclair, founder of the Oregon Pain Action Group, declared no conflicts of interest. Ms. Sinclair said she appreciated the proposed changes to Guideline Note 60. She has been involved with this issue for some time. She said people have reached out to her to share that they have been taken off their medication and are contemplating suicide as they try to cope with pain as they are unable to manage. Guideline Note 60 has caused a lot of harm to people. She said she was able to read letters given to doctors stating that opioids are not safe or effective for back pain, so you need to taper your patient. This has caused entire clinics to eliminate opioids for back pain for all Medicaid patients, sending patients into turmoil. She said she appreciates the language has changed but she is concerned that this new language will not get the same level of promotion as the taper-language notice did. She would like to see providers notified of these changes.

Steven Hix testified; he declared no conflicts of interest. Mr. Hix said he is a pain patient and an advocate for pain patients. He thanked the Commission for hearing the concerns brought forward about GN 60. He asked if he would now get his medication paid for a whole month rather than seven days. He said he agreed with the first two speakers about the damage that has been done with the implementation of the original GN 60 and there is a lot of repair work that needs to be done.

Amara M, a mother, advocate for human rights and co-founder of the Oregon Pain Action Group testified. Ms. M. declared no conflicts of interest. She commended HERC for making significant positive changes to GN 60. She said she hopes the gravity of the effect the policy has had on patients is looked into further. She said she was a patient at a clinic when GN 60 was first enforced. All Medicaid patients with back conditions, regardless of severity, were handed a letter to inform them that patients would be force-tapered off their opioid medication in six weeks. Amara said her regular doctor at the clinic decided to retire rather than be instructed to go against her Hippocratic Oath. She said she had many meetings with the new clinic director and that led her to the underlying guideline note that caused the forced tapers. She then started attending meetings. She said she would like to see promotion and clarity of the new language given to the CCOs. EOCCO has force-taper language live on their website right now. She said an analysis of the Health Authority's Ombud's program said that the

volume and acuity of client calls from pain conditions significantly increased in the last two years, more than doubled. The number one concern is continuity of care for pain management.

This testimony concerned facial feminization surgery for gender dysphoria

Mareinna (Shawn) Kangiser offered comments about facial feminization surgery (FFS). Ms. Kangiser said she wanted to talk about changing facial feminization surgery from a cosmetic procedure to a medical necessity. Ms. Kangiser said that gender reassignment surgery (GRS) changes a person's relationship to their body and affects interactions with one's partner but argued that one's face is how a person is identified in society. She said that make up is cosmetic, meant to improve one's appearance, but FFS is meant to feminize one's appearance, not to make one more attractive. Part of the diagnostic criteria for gender dysphoria is the desire to live and be accepted as a member of the gender they identify as; the inability to achieve this can cause significant distress. That distress is why it's being treated, because of this need to be accepted as one's true gender. Part of treating gender dysphoria means helping one be accepted as their true gender. FFS is protective against violence and discrimination. Violence is often the result of being "visibly gender non-conforming," which has been found to elicit anti-transgender bias. She said when a trans woman has an appearance that conforms to the typical conceptions of gender, it serves as protection from violence and discrimination, and by extension reduces their risk of depression and suicide. The high rates of suicide in transgender people are largely due to their treatment by society. She said this treatment is even cost effective. California did an economic-impact analysis and found that removing transgender exclusions had an immaterial effect on premium costs, which were far exceeded by the benefits. Those benefits include improved health outcomes among transgender people such as reduced suicide risk, lower rates of substance use and increased adherence to HIV treatment. She said a recent study estimated that without the transition surgeries (a one-time cost) healthcare for a transgender person is, on average, $10,712 a year. Therefore, FFS is a cost-effective intervention, and it needs to be covered by insurance policies. She said the fact that GRS is covered and FFS is not shows that gender dysphoria and its implications are not being well understood by insurance companies. Until one is accepted in society as their true gender, something necessary to function in our current American society, gender dysphoria will persist, and procedures such as FFS will still be medically necessary as a potential treatment of gender dysphoria.

HERC Value-based Benefits Subcommittee

October 1, 2020

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

Koa Kai offered similar testimony as she did at the Health Evidence Review Commission meeting held the same day.

November 12, 2020

This testimony concerned Non-invasive prenatal screening for aneuploidies (NIPS).

Hannah Baer: Coalition for Access to Prenatal Screening (CAPS) representative. CAPS is a group sponsored by seven genetic testing companies. Ms. Baer testified that NIPS is a sensitive and specific screening tool that should be offered to all pregnant women. In 2020, Washington and Idaho Medicaid programs added NIPS for average-risk pregnancies. Other states' Medicaid program, such as Alaska and Delaware, changed their policy to cover NIPS for all pregnant women (CPTs 81420 and 81507). Additionally, Connecticut and Wisconsin made changes in their Medicaid policy based on Practice Bulletin 226 by the American College of Obstetricians and Gynecologists (ACOG, August 2020). Many private insurers cover NIPS testing for average-risk pregnancies. Six other state Medicaid programs (Iowa, Massachusetts, Louisiana, Maryland, Nevada and Texas)

are considering coverage for NIPS. Ms. Baer said these tests should be covered for all women regardless of age or risk.

Vanessa Nitibhon: Ms. Nitibhon is a certified genetic counselor employed by and speaking on behalf of Integrated Genetics. She was formerly a genetic counselor at OHSU. She testified that NIPS coverage ensured the most equitable care for all pregnant women. ACOG and SMFM support NIPS testing for all women per ACOG's Practice Bulletin 226. NIPS screening has the lowest chance for error and has the best detection rate for the common aneuploidies. Fewer false positive results mean fewer invasive procedures. Ms. Nitibhon cited a paper by Norton (2015) which stated that the false positive rate is 100 times lower than standard serum screening. A reduction in false positive rates also reduces anxiety as well as complications from invasive testing. Ms. Nitibhon shared scenarios she encountered when counseling average-risk women in her practice, stating that those commercially-insured patients who had access to NIPS had more timely results than her Medicaid patients, leading to a division of care based on insurance coverage. Covering NIPS can also allow patients and families prepare for the arrival of a special needs baby. This test is more equitable, and, in rural areas, easier to access than fetal nuchal lucency ultrasound.

Ashley Svenson: Ms. Svenson is a policy specialist employed by Myriad Genetics. She was formerly a genetic counselor practicing at a large academic perinatology clinic. Ms. Svenson cited cost-effectiveness modeling studies that demonstrated NIPS as net cost effective when additional costs are taken into account such as increased number of ultrasounds, consults, amniocenteses, etc. Svenson stated that NIPS is also easier for women with low medical literacy or resource constraints, underscoring the anxiety and emotional burden of a positive screening test. Svenson read a patient quote from "Stand Up for Accurate Prenatal Answers," a patient group. The patient quote recounted a women's second trimester of pregnancy while waiting for a diagnostic test result from a positive 20-week ultrasound. Ms. Svenson cited her own clinical experience stating that false positive results after traditional serum screening were common. Svenson concluded by citing an article from the "Healthy African American Families" patient group, who stated that disparities in coverage lead to racial disparities in aneuploidy screening, with women of color disproportionately not being screened. Svenson stated that non-white women are significantly less likely to pursue NIPS when coverage is unclear.

Kim Martin: Dr. Martin is an obstetrician-gynecologist and board-certified clinical geneticist. She is also a consultant to a genetics testing company but states she is not being reimbursed for her testimony today. Dr. Martin stated that the introduction of cell-free DNA in 2012 should have revolutionized aneuploidy screening for all women regardless of age or risk given the dramatically improved performance of the screen as well as the ability to perform it early in pregnancy. This test can be performed in the office during a routine OB visit. This is in contrast to the second most sensitive test, which is the nuchal translucency ultrasound, which requires a certified nuchal translucency provider. Oregon has 22 of these certified providers in Oregon, but the vast majority are not in rural areas. Martin states this disadvantages woman living in rural areas. Martin also states that over 80% of Asian and Caucasian women enter prenatal care in first trimester of pregnancy compared to <70% of women of color, leaving women of color with less access to tests like fetal nuchal lucency screening that need to be performed early in pregnancy. Another test, the quad screen, has poor accuracy if the dating is poor for the pregnancy. Martin stated that about 10% of women get poorly dated. NIPS is better for uncertain dates, as its results are independent of gestational age.

Nathan Slotnick: He is a medical geneticist and high-risk obstetrician, practicing in Nevada. Dr. Slotnick spoke about his clinical experience. He cited Norton's 2015 study that NIPS has a higher positive predictive value and a high negative predictive value. If the test is negative, the chance that the result is wrong is near zero, which makes this a powerful screening tool. Slotnick says that the question of screening then becomes a question of justice and equity. He noted the equity issue with limited access in rural areas.

This testimony concerned Expanded Carrier Screening (ECS).

Devki Nagar offered similar testimony as she did at the Health Evidence Review Commission meeting held the same day.

Kim Martin: Dr. Martin is an OB-Gyn who consults for a genetic testing company. Martin said that professional societies have recommendations regarding ECS coverage. She noted that the increasing diversity of the US population makes ethnicity-based testing more problematic given two societal changes: 1) individuals partnering with those of different ethnicities, and 2) individuals cannot or do not accurately report their ancestry, as defined by the ethnicity of the individual's four biological grandparents. Pan-ethnic expanded carrier screening results in identifying more at-risk couples, who are commonly missed. Martin concludes that professional societies have not acknowledged X-linked disorders (such as Fragile X), which should be included in pan-ethnic panels, as carriers of these disorders are at increased risk of premature ovarian failure, cardiomyopathies, and arrythmias, among other conditions.

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

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

This testimony concerned facial feminization surgery for gender dysphoria

Mareinna Kansiger offered similar testimony as she did at the Health Evidence Review Commission meeting held the same day.

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

October, 2020
Agenda Items:

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

There was no public comment.

November 2020 (No Meeting)

December 2020
Agenda Items:

- COVID-19 – Impact on Social Needs
- Medicaid Quality Strategy
- Community Advisory Council – Panel Discussion
- Innovator Agent Update

There was no public comment.

Metrics and Scoring Committee

October 16, 2020

The Committee reviewed 7 pieces of written public testimony and heard oral testimony from 2 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:

- Outside In
  - Re: 2021 CCO Incentive Metrics and 2021 Benchmarks and using 2019 as a benchmark year for targets.
- One Community Health
  - Re: 2021 CCO Incentive Metrics and 2021 Benchmarks and using 2019 as a benchmark year for targets.
- Mid-Valley Medical Center
  - Re: CCO Diabetes Incentive Measure Benchmarking and using 2020 benchmarks for diabetes measure
- Children's Health Alliance
  - Re: 2021 CCO Incentive Metrics and 2021 Benchmarks and setting benchmarks for immunization measures
- CCO Oregon
  - Re: Provider disparity in the Preventive Dental Services measure for children
- CCO Oregon
  - Re: Definitions for Oral Health Services and Providers related to the Preventive Dental Services measure
- Rinehart Clinic
  - Re: 2021 CCO Incentive Metrics and 2021 Benchmarks and using 2019 as a benchmark year for targets

Verbal public testimony provided during meeting:

- Julie Harris Children's Health Alliance
  - Raised concerns that 2021 targets for childhood and adolescent immunizations apply to care that was provided in 2020 and provided input on preventive dental measure, including that while dental home should be led, services from primary care providers should be counted in the metric.
- Samantha Shepherd CCO Oregon
  - Spoke to written testimony supporting expansion of preventive dental measure such that services from any primary care provider should count towards the metric.

November 20, 2020

The Committee reviewed 3 pieces of written public testimony and heard oral testimony from 5 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: 2021 CCO Incentive Metrics and 2021 Benchmarks and setting benchmarks for immunization measures
- CCO Oregon
  - Re: Preventive Dental Services measure for children
- All Care CCO
  - Re: Kindergarten Readiness Metric

Oregon Health Authority

Verbal public testimony provided during meeting:

- Dr. Logan Thomas Clausen – Central Oregon Pediatric Associates
  - Re: Children's Social Emotional Health Metric
- Robin Hill-Dunbar – Ford Family Foundation
  - Re: Children's Social Emotional Health Metric
- Jeanne McCarty – EOCCO
  - Re: Children's Emotional Health Metric
- Susan Fischer-Macki - All Care Health
  - Re: Children's Social Emotional Health Metric
- Samantha Shepard - CCO Oregon
  - Re: Preventive Dental Services measure

No December Meeting was scheduled.

Health Plan Quality Metrics Committee

No public comment in October, November or December 2020. The Health Plan Quality Metrics Committee did not meet in October or November as a result of OHA suspending non-critical committee meetings while our health care partners focused on the COVID-19 response. The committee did meet on December 21, 2020 and there was no public comment at this meeting. The committee will resume a monthly meeting schedule in January, 2021.

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 eight 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 December 2020, 651 clinics were recognized as PCPCHs (six more than the prior quarter). This is approximately three-quarters of all primary care practices in Oregon. Seventy-one 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. The PCPCH program is providing technical assistance for primary care practices applying for PCPCH recognition under the revised standards in the form of pre-recorded webinars followed by a scheduled live question and answer virtual meeting with program staff. This technical assistance is offered twice a month from October 2020 through March 2021.

Tribal Care Coordination

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

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

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

To further assist in efforts to expand coordination of care for tribal members, the Oregon Health Authority has contracted with CareOregon to provide care coordination services for the roughly 17,000 AI/AN people enrolled in the Oregon Health Plan who are Fee For Service patients. CareOregon's model of care coordination was led and developed by the tribes during discussions taking place in 2016. The tribes requested establishment of a program that focused on culturally-responsive health care and took into account the unique nature of the AI/AN health care delivery system. During the first 11 months of the program 766 members enrolled in the program, and 1,336 calls were received by CareOregon's call center. 140 of these tribal members were enrolled in one of Oregon's nine federally recognized tribes; 346 individuals were enrolled in an out of state tribe. CareOregon reports high rates of member satisfaction with the program, which has been renewed for a second year.

OHA has been working with tribal health representatives from Oregon's nine Federally-recognized Tribes to support efforts to establish one or more Indian Managed Care Entities. OHA has been hosting weekly meetings since April 2019 to move this project forward. It is expected that I/T/Us will establish five Indian Managed Care Entities. A state plan amendment will be submitted to CMS to establish the IMCE program, and it is expected to begin 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 were completed 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 November to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers reviewed quality data trends for 2015–2018. Overall, the analysis indicates that primary care quality measure performance in Oregon is improving for CPC+ practices and non-CPC+ practices. The payers discussed the Oregon Health Leadership Council's work on low-value care and the opportunity to connect this work to CPC+.

Value-Based Payment Innovations and Technical Assistance

Staff from the OHSU Center for Health Systems Effectiveness interviewed providers across the state to better understand the impact of COVID-19 on their ability and interest in adopting new VBP contracts. The Transformation Center will use information collected, as well as information from interviews with Oregon provider associations, as part of a larger effort to support Oregon providers with interactive virtual VBP learning collaboratives to promote adoption.

Primary Care Payment Reform Collaborative

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

The collaborative met in October to learn how practices are incorporating equity and identify opportunities to support this work; hear about the *Primary Care Spending in Oregon* report; and discuss overlapping state initiatives focused on primary care and payment reform to determine coordination. Practices are incorporating a variety of strategies to improve health equity, including screening for health-related social needs, offering health navigators and providing equity-focused staff trainings on topics such as anti-racism and culturally responsive care. Members heard presentations on the Sustainable Health Care Cost Growth Target Implementation Committee and the Universal Access to Primary Care Workgroup of the Legislature, and discussed how the collaborative can coordinate and build on this work.

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

Statewide Performance Improvement Project

OHA and CCOs are updating the statewide Performance Improvement Project topic for 2021 to reflect a behavioral health integration focus. CCOs will be submitting EQR PIP validation for 2021 in September 2021 to be reported in April 2022 technical report.

Roadmap to Oral Health

Oregon was accepted into the Medicaid/CHIP Oral Health Affinity Group and will receive technical assistance from CMS to improve the rates of delivery of topical fluoride varnish in primary care settings. OHA, through the Transformation Center, will work with coordinated care organizations (CCO) to use this opportunity to increase integration of dental care into primary care and strengthen ties between the two systems of care. The Metrics and Scoring Committee recommended a change to the existing CCO incentive metric to allow topic fluoride varnish applied by physical health care providers to count in the numerator of the metric.

The Transformation Center also kicked off a series of trainings in quality improvement that uses the CCO incentive metric regarding oral health exams for adults with diabetes as a tool for learning. Training participants receive four hours of instruction and up to five hours of follow up one-on-one technical assistance.

The Public Health Division conducted a Certification Training for School Dental Sealant Programs on November 17, 2020 that provided dental hygienists and program staff with technical assistance around the CCO incentive metrics for the 2020-21 school year and COVID-19 guidelines for operating in schools. Most of the children they serve are covered by Medicaid.

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

Sustainable Relationships for Community Health program

Activities: Sustainable Relationships for Community Health (SRCH) is a grant funded opportunity for 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-10 pandemic, two SRCH teams continued their work during this reporting period and participated in three (3) virtual SRCH sessions during October, November and December 2020. In December, OHA also released a new flexible SRCH funding opportunity to support Tribes and Local Public Health Authorities (LHPAs) from January 1- June 30, 2021. This new SRCH funding is an opportunity to apply lessons learned from the pandemic to chronic disease prevention and management efforts and focus these efforts on addressing disparate health and social impacts experienced by communities in Oregon who are affected by higher incidences of chronic disease and COVID-19. Funds provided via this funding opportunity are to be used to address chronic disease disparities informed by lessons learned from collaborative partnerships established during the COVID-19 pandemic.

Tribes and LPHAs could apply for one (or more) of the following project areas:

1) Take intentional steps and focused time to **improve relationships and co-plan strategies** with key health system and community-based partners to support future prevention and management of chronic diseases for communities most disparately affected by both COVID-19 and chronic conditions;

2) **Augment or accelerate existing** chronic disease prevention and management work with key health system and community-based partners **or**;

3) Support an already planned and **"shovel-ready" project** with key health system and community-based partners focused on chronic disease prevention or management that needs supplemental funding to get started or take the next key step toward success.

Progress and Findings:

During this period, OHA and contractors provided technical assistance to the Tillamook and Regional Health Education Hub (RHEHub) SRCH teams. The Tillamook SRCH team established a closed loop referral process between two health systems and a local community-based organization and developed a sustainability plan for 2021. The team also worked with the community information exchange, Unite Us (aka Connect Oregon), and

will launch Connect Oregon in Q3 FY21 across Tillamook County, building off their closed loop referral work from SRCH. The RHEHub SRCH team continued work on virtual chronic disease self-management programming with focus on increased reach to rural communities and communities facing structural inequities leading to disparate chronic disease outcomes. They also discussed health education billing efforts to ensure sustainability.

One (1) Tribe and seven (7) LPHAs applied for the SRCH funding opportunity for (funding period 1/1/21-6/30/21) and all teams were awarded funds. OHA and contractors will be providing technical assistance to the eight (8) SRCH teams throughout the grant cycle. The proposed work includes, but is not limited to: convening health systems and community partners to explore and create a plan for implementation of Traditional Health Workers to support chronic disease prevention and self-management; cross-sector work to create an equity-focused chronic disease prevention community plan; and increasing closed loop referrals to tobacco cessation services centering the Latinx community.

Trends, Successes, or Issues:
OHA continues to be flexible and make adaptions to the SRCH model and funding structure to support Tribes, local public health, and community and clinical partners. With reduced capacity and partners operating in a constantly changing environment due to COVID-19, OHA pivoted to virtual SRCH session sessions tailored to each SRCH team to meet teams' needs and capacity in 2020.
OHA adapted the SRCH model to support community chronic disease prevention programs to navigate the current challenges and opportunities in the COVID-19 pandemic through a shorter-term flexible funding opportunity. This SRCH funding addresses how structural inequities lead to higher rates of chronic disease in Tribal communities, communities of color, in people living with disabilities and in people experiencing addiction and mental health issue and these disparities are compounded by the acute impact of COVID-19 in many of the same communities. By offering multiple funding pathways, communities can utilize SRCH funding, training, and technical assistance to use innovative methods to prevent chronic disease disparities and to reach people who are struggling to manage chronic diseases amid the current COVID-19 crisis.

OHA is engaged with an external evaluation firm, Rede Group to conduct an evaluation of the SRCH initiative including sustainability of funded projects to date as well as supporting some developmental evaluation which will inform future planning and evolution of the SRCH model and funding initiative. To date, Rede Group has produced a preliminary evaluation report which includes: a theory of change, a functional model, an evaluation framework/approach to examine sustainability. The Rede Group and OHA are also taking initial steps to convene a set of stakeholders/experts through a structured process to inform a future SRCH initiative and funding model.

State Health Improvement Plan
OHA recently released the 2020-2024 State Health Improvement Plan (SHIP), Healthier Together Oregon (HTO). The SHIP identifies our state's health priorities with strategies to advance improvement and measures to monitor our progress. The goal of the SHIP is to advance health equity for five priority populations: people of color and tribal communities, people who identify as LGBTQ+, people with low-income, people who live in rural areas, and people with disabilities. Five priorities were identified by a community-based steering committee; institutional bias, adversity, trauma and toxic stress, behavioral health, access to equitable preventive health care, and economic drivers of health (to including housing, transportation, and living wage jobs). The plan is intended to inform policies, priorities and investments of state agencies, and Community Health Improvement Plans (CHIPS) developed and implemented by CCOs, local public health authorities and non-profit hospitals.

Since launch of the plan in fall of 2020, OHA has been communicating about the plan with other state agencies, CCOs and community-based organizations. To support alignment of CHIPs with the SHIP, OHA hosted webinars for CCOs and local public health authorities to share information about HTO, and to solicit ideas from CHIP implementers on formation of learning collaboratives around the SHIP priorities and strategies.

OHA also took steps to reform the PartnerSHIP, the community-based steering committee that holds all decision-making authority for the SHIP. The PartnerSHIP was originally convened in 2018 to develop the plan and will now be reformed to direct implementation. The PartnerSHIP will include representatives of priority populations and potential implementers of the plan, including CCOs, public health and hospital partners.

Innovator Agents

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

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

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

IAs ensured safety and health equity across the state of Oregon. SB 698 required every pharmacy to provide written translation and oral interpretation for anyone with limited English proficiency (LEP) to receive their prescription instructions in both their language of choice (14 languages are legally required to be translated) and in English. The IAs have ensured this information has been shared amongst providers, OHP members, and with pharmacies across the state. This is a more effective model of care that ensures OHP members receive the correct instructions about their medication. IAs have worked with community partners, representatives from Refugee Assistance programs and CCOs to ensure these new standards are made available through every pharmacy in Oregon.

IAs continued to provide coordination and communication between OHA, CCOs, and LPHAs around COVID and related health activities. IAs continued to support COVID vaccine distribution efforts by providing CCOs community-based organizations, and public health with routine OHA updates. Innovator Agents leveraged their relationships in local communities to inform COVID-19 testing strategies and events, to support COVID-19 contact tracing and quarantine/isolation efforts and to plan for COVID-19 vaccination. By connecting local

partners with CCOs and OHA and carrying current COVID-19 related information to the community level, IAs helped to assure universal communication and coordinated planning.

Innovator Agents provided information to Community Based Organizations to apply for funding to support testing, contact tracing and social supports for quarantine and isolation. One IA served as an evaluator of grant proposals to OHA by CBOs.

Innovator Agents continued to "bridge" the work of the Oregon Incident Management Team for COVID and the development of the COVID Response and Recovery Unit (CRUU) with the work of the Health Systems Division and Medicaid.

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

OHA updates are continually shared which has increased efficiency among the CCOs and partners. In addition, IAs have supported community organizations, public health, and OHP members with resources developed by OHA. IAs assisted and supported the CCOs in providing resources available through OPRIN and the Transformation Center which were stipulated in the CCO/OHA contract. They assisted in the implementation of innovative projects and pilots. They helped the CCOs in the development of strategies to support quality improvement and the adoption of innovations in care through facilitating collaboration and knowledge sharing across the state.

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

Health-Related Services

OHA staff held an HRS community benefit initiative webinar for CCOs and their contracted providers and organizations. One hundred and two people attended.

Staff developed evaluation criteria for the required CCO HRS policies and procedures which are available to CCOs on OHA's public facing website (https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2020-CCO-HRS-Policy-Eval-Criteria.pdf). The criteria will be used to review the annual CCO HRS policy and procedure submissions.

To improve future use of and support potential increases to HRS spending, staff are updating guidance for HRS and developing HRS traditional health worker guidance. All HRS guidance documents for CCOs and external partners posted publicly 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

Behavioral health integration

The center coordinated with the Health Systems Division Licensing and Certification Unit to finalize a document clarifying the purpose of and requirements for a Certificate for Behavioral Health Outpatient Services, which will help CCOs and clinics facilitate behavioral health integration.

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, CACs' 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 held its first meeting in December.

Staff also updated a CAC 101 presentation for new and current CAC members, and are moving forward with hosting a virtual CAC conference in spring 2021.

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.

Traditional health worker (THW) technical assistance

Staff, in partnership with the Division of Equity and Health Systems Division, developed a Q&A document addressing CCO questions related to new traditional health worker contractual requirements.

In partnership with the Office of Equity and Inclusion and the THW Commission, the Transformation Center will be convening a statewide THW learning collaborative.

CCO incentive metrics technical assistance: Diabetes (HbA1C and a new oral health visit metric)

The Transformation Center continued its work with the Oregon Rural Practice-based Research Network (ORPRN) to increase quality improvement capacity in clinics by concentrating on two CCO incentive metrics: HbA1C poor control and dental exams for adults with diabetes. ORPRN has delivered two of four 4-hour online trainings and started follow-up one-on-one technical assistance calls between practice coaches and participating clinics.

Kindergarten readiness (well-child visits and preventive dental)

The Transformation Center contracted with Brink Communications 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). These tools were shared with CCOs through a webinar; the recorded webinar and the assets developed can be found here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/kindergarten-readiness.aspx

Oregon was accepted into the Medicaid/CHIP Oral Health Affinity Group to address early childhood caries. Oregon's project will focus on increasing the rates of applying topical fluoride varnish in primary care. This is one of the services CCOs can count toward meeting targets on the preventive dental care metric. The Transformation Center is leading this two-year learning collaborative in the state.

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 three needs assessment calls with clinic and CCO staff. These conversations will help OHA prioritize future technical assistance.

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. The project team developed manuscripts and continued recruitment this quarter.

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 requested data from the OHA Office of Health Analytics in support of this work and as part of their technical assistance. This work will be completed spring 2021.

Patient-centered counseling trainings

The Transformation Center held six patient-centered counseling virtual trainings for Medicaid providers, and 144 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 95.5% of respondents indicating the training was valuable to their work, and 97% planned to take some action as a result. Five more trainings are scheduled for late spring 2021.

REALD learning series

The center partnered with the OHA Division of Equity and Inclusion to host a six-part learning series focusing on the use of REALD (race, ethnicity, language and disability) for CCOs, clinics and other health care entities. REALD is an effort to increase and standardize race, ethnicity, language and disability data collection across OHA and the Oregon Department of Human Services. Sessions included an introduction to REALD; implementing new REALD data collection for providers; strategies for asking REALD questions; using REALD data to advance health equity; and COVID-19, disabilities and REALD data.

Statewide CCO learning collaborative for the Quality and Health Outcomes Committee

In October, staff hosted a learning session exploring the state of immunizations during the COVID-19 pandemic. Participants learned from various stakeholders and convened in breakouts to share best practices with the intent to improve immunization rates in Oregon.

Transformation and quality strategy (TQS) technical assistance

OHA held five webinars/office hours for CCOs developing their 2021 TQS: updates and global feedback, social determinants of health and equity, special health care needs, health equity and CLAS standards, and serious and persistent mental illness.

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 committee to include population health, social determinants of health, and health equity measures in the CCO quality incentive pool.

The SDOH Measurement Work Group: Screening for Social Needs, a public work group, convened four times. The purpose of this work group was to recommend a measure related to the social determinants of health for consideration by Oregon's Metrics and Scoring Committee and the Health Plan Quality Metrics Committee. Specifically, the work group was charged with recommending a measure that would incentivize screening for individual health-related social needs. After thorough consideration of the benefits and drawbacks of several measure concepts, the work group selected Measure Concept 1: Rate of social needs screening in the total member population using any qualifying data source. The Metrics and Scoring Committee will vote on whether to advance this measure concept to pilot testing during their February 2021 meeting.

Supporting Health for All through REinvestment: the SHARE Initiative

The SHARE Initiative comes from a state legislative requirement for CCOs to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity. The Transformation Center published a guidance document for CCOs on how to meet the SHARE Initiative requirements and accurately report their SHARE Initiative spending to OHA.

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.

2. State reported enrollment table

Enrollment	October/2020	November/2020	December/2020
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,073,804	1,093,401	1,112,940
Title XXI funded State Plan	92,633	93,979	96,141
Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A
Enrollment current as of	October 31, 2020	November 30, 2020	December 31, 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		
		Pregnant women FPL > 170%	0	0		
	Title XXI	SCHIP FPL > 170%	41,297	114,452	2.80%	15.26%
Optional	Title XIX	PLM women FPL 133-170%	0	0		
	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%	5.30%
		QUARTER TOTALS	1,131,936	3,22,1,178		

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

OHP eligible and managed care enrollment

OHP eligible*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
October	1,217,596	1,009,682	600	126	11,741	52,994	
November	1,234,680	1,017,991	691	143	11,970	55,008	
December	1,248,657	1,036,950	678	128	12,581	56,691	
Quarter average	1,233,644	1,021,541	656	132	12,097	54,898	
		Average percentage					

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

B. Complaints and grievances

Attached separately.

C. CCO appeals and hearings

Attached separately.

D. Neutrality reports

Budget monitoring spreadsheets

Attached separately.