Oregon Health Plan

Section 1115 Quarterly Report

1/1/2021 – 3/31/2021
Demonstration Year (DY): 19 (7/1/2020 – 6/30/2021)
Demonstration Quarter (DQ): 3
Federal Fiscal Quarter (FQ): 2/2020

Oregon Health Authority

Oregon HEALTH PLAN

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I. Introduction

A. Letter from the State Medicaid Director

During this reporting period, Oregon's Medicaid enrollment continued to grow steadily, and the Oregon Health Authority (OHA) continued to collaborate with Coordinated Care Organizations (CCOs) to identify and meet the changing needs of our Medicaid population.

Once CCO is expanding its coverage to a new region and OHA continues to monitor that expansion to ensure network adequacy standards are met. One CCO demonstrated significant progress on key areas of their corrective action plan (CAP) and those areas of their CAP have been resolved.

Also, during this reporting period, OHA continued to work with partner state agencies and community organizations 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.

Lori Coyner, State Medicaid Director

B. Demonstration description

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

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

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

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

- Improving the individual experience of care;
- Improving the health of populations; and
- Reducing per capita costs of care for populations through such improvements.

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

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

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

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

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II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 1/1/2021 – 3/31/2021
Demonstration Year (DY): 19 – Quarter 3
Demonstration Quarter (DQ): 3/2021
Federal Fiscal Quarter (FQ): 2/2021

III. Overview of the current quarter

During this reporting period the ongoing public health emergency continued to create challenges for individual members of Coordinated Care Organizations (CCOs), and the providers and delivery systems that serve them. Enrollment in CCOs continued to grow and the Oregon Health Authority (OHA)

The OHA continued to develop metrics related to Equity and Social Determinants of Health through various workgroups incorporating input from tribes, stakeholders, and advocates.

CCOs continued to engage in technical assistance on, and provide reporting on Health-Related Services, Community Advisory Councils, Traditional Health Workers and other key features of the 2021 CCO contracts.

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. Individuals are generally transitioned between programs as their income changes or as they age-out of their current programs. Additionally, the 2020 annual open enrollment period for the Federally-Facilitated Marketplace was extended, which has also resulted in higher numbers of continued Medicaid and CHIP referrals into early 2021. Oregon has now completed the major activities associated with a 9-month-long waved transition to an integrated eligibility system. Eligibility staff are getting more accustomed to the new system and new business processes after a steep learning curve period which is slowly increasing daily work efficiencies.

2. Coordinated care organization enrollment

Total CCO enrollment during the reporting period grew by 3.5%, across all plan levels (CCOA, CCOB, CCOE, CCOG), reflecting a moderate slowdown from than the previous quarter's growth rate (4.6%). Each specific Coordinated Care Organization experienced membership growth between 1.5% – 4.6%, with the exception of Trillium Community Health Plan in the Portland metro tri-county area which experienced nearly 50% growth as it continues to establish itself in this new market.

As a reminder, 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 through June 30, 2021. Across the 16 Coordinated Care Organizations, there are 48 unique CCO-county combinations. In this reporting period, only one CCO experienced membership above the 2021 contract limits within one of its counties. At the CCO level, the following capacity levels were experienced at the end of March:

- 5 CCOs have membership within 90-99% of contract limits
- 3 CCOs have membership within 75-89% of contract limits
- 5 CCOs have membership within 50-74% of contract limits
- 3 CCOs have membership at <50% of contract limits

In addition to demand for Oregon Health Plan coverage, capacity levels are influenced by the membership capacity contract limits requested by each CCO. Approval of these requests are based on various factors, including community population, historical and expected future enrollment patterns, and network adequacy.

In conjunction with wave two (February, 2021) of the Integrated Eligibility implementation, a few issues that created downstream effect on CCO enrollment, due to incorrect or failed transactions of eligibility information, continued to be proactively identified and resolved to reconcile eligibility and enrollment information in MMIS. The scale and scope of these issues was limited to a very small percentage of CCO members given insights and data fixes applied during pilot and wave one implementation.

B. Benefits

The Health Evidence Review Commission oversaw the following benefit changes during the reporting period:

The Jan 1, 2021 prioritized list went into effect on 1/1/2021. The Feb 1, 2021 prioritized list went into effect 2/1/2021. Both of these lists were reported in a Notification of Interim Changes. Errata to the February 1, 2021 list were published on 2/23/21.

C. Access to care (ANNUAL)

D. Quality of care (ANNUAL)

E. Complaints, grievances, and hearings

1. CCO and FFS complaints and grievances

The information provided in the charts below is a compilation of data from the current 15 coordinated care organizations (CCO) and fee-for-service (FFS) data. The quarterly reporting period covers Jan 1, 2021 through March 31, 2021.

Trends

	Apr – Jun 2020	Jul – Sep 2020	Oct – Dec 2020	Jan – Mar 2021
Total complaints received	2,503	3,181	3529	3437
Total average enrollment	1,046,476	1,093,854	1,138,377	1,344,628
Rate per 1,000 members	2.39	2.91	3.10	2.56

Barriers

The first quarter of 2021 shows a slight decrease in the number of complaints. The CCOs indicate the level of complaints are starting to level out as the pandemic and restrictions on office visits start to be modified. The Interaction with Provider/Plan category continues to receive the highest number of complaints with a slight decrease of 4.9% from the previous quarter. The Access to Care category remained relatively level this quarter as is the same for Quality of Care issues. FFS data shows the highest number of complaints are again the Billing category, with Access to Care the next highest category.

Interventions

CCOs –CCOs are reporting complaints are starting to level out to pre-pandemic levels, however the continued restrictions have caused complaints to change slightly to include wanting to have in-office visits, and complaints about using or not using face masks. 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 that continues to improve services to 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 they are continuing to work closely with their NEMT and Dental providers to reduce complaints.

Fee-For-Service – The number of complaints from members who were on Fee for Service coverage during the Jan - Mar quarter was 84. An additional 345 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 88 complaints from members enrolled in Dental Care Organizations. 6,988 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	Apr – Jun 2020	Jul – Sep 2020	Oct – Dec 2020	Jan – Mar 2021
Access to care	667	847	1,044	1086
Client billing issues	446	343	266	236
Consumer rights	168	256	281	247
Interaction with provider or plan	690	1,079	1,244	1186
Quality of care	344	455	494	487
Quality of service	188	201	200	195
Other	0	0	0	0
Grand Total	2,503	3,181	3,529	3437

Related data

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

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 an appeal was filed. During this quarter CCOs report that the highest number of NOABDs issued were Pharmacy related. Specialty Care was the next highest and issues related to Behavioral Health issues 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)	**Apr – Jun 2020**	**Jul – Sep 2020**	**Oct – Dec 2020**	**Jan – Mar 2021**
a) Denial or limited authorization of a requested service.	21,311	27,215	29,315	28,984

b) Single PHP service area, denial to obtain services outside the PHP panel	215	286	459	771
c) Termination, suspension, or reduction of previously authorized covered services	62	81	109	118
d) Failure to act within the timeframes provided in § 438.408(b)	11	10	10	12
e) Failure to provide services in a timely manner, as defined by the State	21	40	55	43
f) Denial of payment, at the time of any action affecting the claim.	40,779	58,588	56,932	56,909
g) Denial of a member's request to dispute a financial liability.	0	0	0	1
Total	62,399	86,220	86,880	86,838
Number per 1000 members	60	86	84	81

2. CCO and FFS appeals and hearings

The table below shows the number of appeals the CCOs received over the first quarter of 2021. There has been a 5.9% 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	Apr – Jun 2020	Jul – Sep 2020	Oct – Dec 2020	Jan – Mar 2021
a) Denial or limited authorization of a requested service.	766	1,055	1,078	1,031
b) Single PHP service area, denial to obtain services outside the PHP panel.	7	6	15	36
c) Termination, suspension, or reduction of previously authorized covered services.	1	3	2	1
d) Failure to act within the timeframes provided in § 438.408(b).	0	0	2	0
e) Failure to provide services in a timely manner, as defined by the State.	0	2	0	0
f) Denial of payment, at the time of any action affecting the claim.	409	438	346	293
g) Denial of a member's request to dispute a financial liability.	0	0	0	0

Total	1,183	1,504	1,443	1,361
Number per 1000 members	1.13	1.5	1.4	1.27
Number overturned at plan level	308	475	432	379
Appeal decisions pending	12	5	10	0
Overturn rate at plan level	26%	31.58%	29.94%	27.85%

CCO and FFS Contested Case Hearings

The following information is a compilation of data from 16 Coordinated Care Organizations (CCOs), 5 Dental Care Organizations (DCOs) and Fee-for-Service (FFS). FFS members may be enrolled with a DCO for dental coverage.

During the third quarter (January 1, 2021 – March 31, 2021), the Oregon Health Authority (OHA) received 275 hearing requests related to the denial of medical, dental and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 233 were from CCO-enrolled members and 42 were from FFS members.

277 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 January of 2021 may be cases OHA received as far back as October and November of 2020.

OHA dismissed 126 cases that were determined not hearable cases. Of the not-hearable cases, 110 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 151 cases that were determined to be hearable, 36 were approved prior to hearing. Members withdrew from 48 cases after an informal conference with an OHA hearing representative. 41 cases went to hearing, where an administrative law judge upheld the OHA or CCO decision and 23 cases were dismissed for the members failure to appear. During the third quarter there were no cases where the administrative law judge reversed the decision stated in the denial notice.

3 cases were 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	36	13%
Client withdrew request after pre-hearing conference	48	17%
Dismissed by OHA as not hearable	126	45%
Decision affirmed*	41	15%
Client failed to appear*	23	8%
Dismissed as non-timely	3	1%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	0	0%
Set Aside	0	0%
Total	277	

* Resolution after an administrative hearing.

F. CCO activities

1. New plans

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

One of the previously existing plans – Trillium Community Health Plan – had applied to continue in its historical Lane County service area and to expand into Clackamas, Multnomah, and Washington Counties (the Tri-County). OHA denied Trillium a notice to proceed in the Tri-County and gave until June 30, 2020, for Trillium to demonstrate a sufficient provider network in the Tri-County or that service area would be removed from its contract. On August 14, 2020, OHA approved Trillium's expansion into the Tri-County, effective September 1, 2020. This expansion is subject to a Corrective Action Plan.

2. Provider networks

There were no significant changes in provider networks during the reporting period.

3. Rate certifications

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

In 2019, OHA underwent a procurement process to determine participating CCOs. 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 First Coronavirus Relief Act (FFCRA).

OHA held monthly dental workgroup meetings with the dental partners to discuss the current rate methodology and to propose alternative methodologies that would better address the amount of APM contracting arrangements between CCOs and dental providers.

In addition, OHA provided CCOs their CY2020 dashboards and data for the time period January 2018 through December 2020 to assist the CCOs in their data validation for the CY2022 rate development process.

In preparation for the CY22 Rate Development year OHA provided the annual rates package to the CCOs which outlined deadlines and the data grouping process utilized by OHA and Optumas for categories of services to aid CCOs.

4. Enrollment/disenrollment

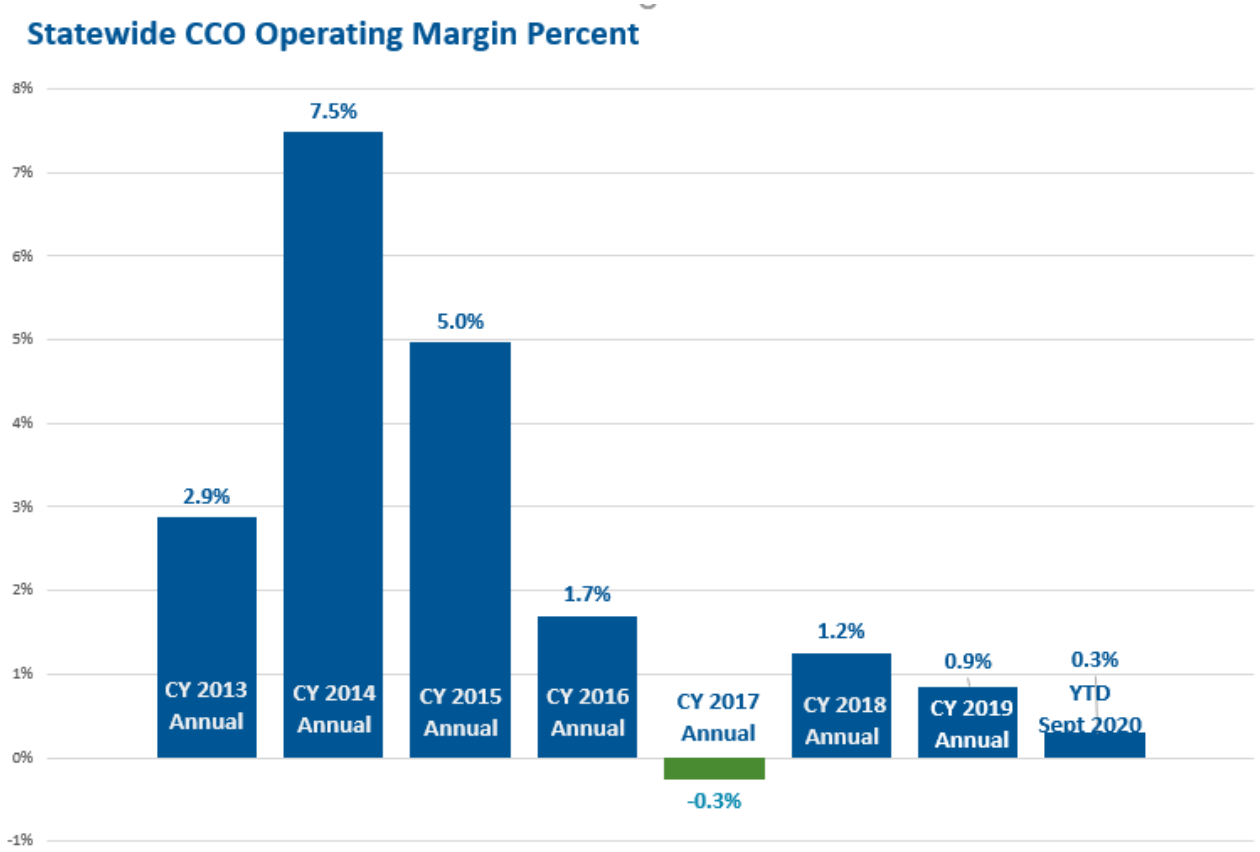
No significant changes during this reporting period.

5. Contract compliance

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

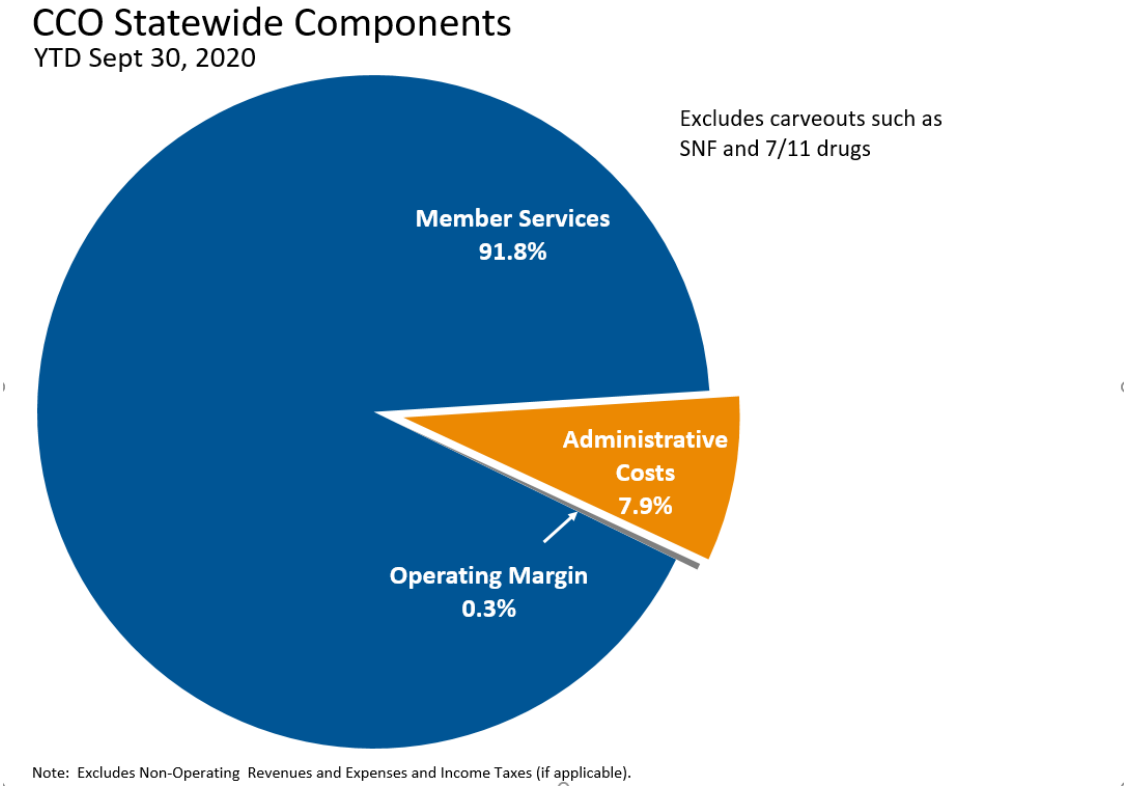
6. Relevant financial performance

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 please follow the link below -

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 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. In a letter dated January 29, 2021, OHA formally notified HSO that it is satisfied with the improvements made in four of the five areas; the CAP is considered "closed" for those areas. HSO is required to continue to submit monthly progress reports for the area of member grievances.

For January-March 2021, HSO continued to exceed the performance target for the member grievances metric. The major factor affecting HSO's performance in this quarter continued to be the COVID-19 Emergency.

NEW CAP

- *Entity name:* Trillium Community Health Plan
- *Purpose and type of CAP:* Original CAP: Insufficient compliance with CCO contract, Oregon Administrative Rule, and federal regulations regarding network adequacy, language access, health equity, and community engagement for the Tri-County service area.
- *Amendment to CAP*: Insufficient compliance with CCO contract and Oregon Administrative Rule regarding timely access to Intensive Care Coordination services for the Tri-County service area.
- *Start date of CAP:* March 5, 2021
- *End date of CAP:* No earlier than September 5, 2021, which is six months from the 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 months.
- *Progress during current quarter:* OHA is in the process of reviewing Trillium's monthly progress report submitted during the reporting period.

8. One-percent withhold

This quarterly report is for data from January 1, 2021 through March 31, 2021. OHA analyzed encounter data received for completeness and accuracy for the subject months finalized for June 2020 through August 2020.

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

9. Other significant activities

During this reporting period, the Health Systems Division of the Oregon Health Authority continued to work with partner state agencies and community organizations 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 March 2021, more than $210 million in federal incentive payments have been dispersed to 60 Oregon hospitals and 3,851 Oregon providers. Between January and March 2021, 74 providers received $624,981 in incentive payments. The program sunsets December 31, 2021.

CCO Health IT Roadmap & Data Reporting

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

In 2021, in order to establish a baseline for setting HIT adoption and access targets, CCOs are expected to collect HIT adoption and access data on their contracted providers and report their findings to OHA. The expectations and initial plan for 2021 CCO HIT Data Reporting were discussed at the February 2021 CCO Health IT Advisory Group meeting. The discussion included a review of HIT data collection expectations and timeline for CCO contracted physical, oral, and behavioral health entities. This information will be used to inform CCO efforts to support their providers with health IT adoption and use to increase care coordination and engagement in value-based payment models.

HIT Commons

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

EDie and the Collective Platform (formerly known as PreManage)

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

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

EDie and the Collective Platform are in use statewide and adoption for Collective continues to grow. All of Oregon's CCOs receive hospital notifications through the Collective Platform (and all CCOs are extending their Collective subscriptions down to their contracted providers), as are most major Oregon health plans, and all of Oregon's Dental Care Organizations. About 2/3^{rds} of Oregon's Patient-Centered Primary Care Homes, many behavioral health and community mental health program clinics, tribal clinics and others are participating, as well as state programs for 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 Medical partnered to bring statewide COVID-19 vaccination information from the state's ALERT Immunization registry into EDIE/the Collective platform. As of April 2021, population reports are available via the platform for all CCO and health plan users, which allow for quickly assessing members who have received no vaccine, as well as identifying the manufacturer and dose of vaccines that have been administered.

Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative

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

- 222 organizations have integrated access to Oregon's PDMP data – either through their EDie alerts, or through one-click access at the point of care (EHR or HIE), with a total of 15,702[1] prescribers active in the 18 months leading up to March 31, 2021. 11 retail pharmacy chains (across 895 sites) and 1 rural pharmacy are also live.

- 21 new organizations went live with PDMP integration in Q1 2021.

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

- 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.

Health IT Stakeholder Groups

Health IT Oversight Council (HITOC)

HITOC is tasked with setting goals and developing a strategic health information technology plan for the state, as well as monitoring progress in achieving those goals and providing oversight for the implementation of the plan. The HITOC HIT 2017-2020 Strategic Plan was approved by the Oregon Health Policy Board in October 2017 and provides a roadmap for Oregon's HIT work ahead. Highlights of the February 2021 meeting include:

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

ONC and CMS Interoperability Final Rules

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

- OHA has hosted three webinars related to these rules to inform the public and CCOs. The most recent public webinar was a CCO/DCO Final Rules Follow-up Webinar in January focusing on the newly released Interoperability and Prior Authorization final rule and CCO/DCO information sharing and coordination. Recordings and materials for these webinars and additional resources (e.g., webinar Q&As, links to federal websites and documents) can be found on the Office of Health IT final rules webpage.
- OHA hosted work sessions with CCOs and DCOs to allow focused time on each area of the rules and giving them the opportunity to ask questions of OHA's health IT consultant.
- OHA is planning additional workgroups hosted by HIT Commons that include the CCOs, DCOs, and Medicare Advantage plans to discuss where there may be shared alignment and pain points.

Health Information Exchange (HIE) Onboarding Program

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

Reliance eHealth Collaborative was the selected community-based HIE to onboard priority physical, oral, and behavioral health Medicaid providers according to a work plan developed in consultation with CCOs. OHA launched the onboarding program in January 2019 has approved Reliance workplans to onboard providers contracted with 9 current CCOs, covering 14 Oregon counties. As of March 31, 2021, there are 11 behavioral health practices, three oral health clinics, 44 critical physical health entities, and four major trading partners (hospital/health system) participating in the Program. Between January and March 2021, 15 new entities were onboarded. The Program ends June 30, 2021.

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 November 2020 the Metrics & Scoring Committee reviewed measure progress and supported moving into piloting to broaden testing base and collect data to assess feasibility, reliability, and validity.

In this last quarter, the partnership team provided a high-level background and measure overview presentation to the Health Plan Quality Metrics Committee, with an opportunity for one-on-one follow-up for additional context. Eleven CCOs volunteered to engage in piloting of the measure beginning in February 2021 and continuing into the next quarter. The final measure will be presented to both the Health Plan Quality and Metrics & Scoring Committees in the next quarter.

2. SDOH/Health-related Social Needs Measure

OHA is working with stakeholders and contractors to develop a measure intended to ensure that CCO members' social needs are acknowledged and addressed. In 2020, OHA convened a public Social Determinants of Health

Measurement Workgroup to recommend a measure concept for development. The Workgroup's final meeting was February 9, 2021. They reviewed recommendations from a subcommittee on screening tools and questions, discussed next steps in measure development, and shared closing thoughts. The Workgroup's final report, including the recommended measure concept and glide path for implementation, was posted to their webpage and shared with stakeholders.

Following the completion of the Workgroup's work, information on the recommended measure concept was presented to the Metrics and Scoring Committee at their February 19, 2021, meeting. The committee unanimously voted to endorse the measure concept to move forward to pilot testing. OHA staff then presented to the CCO Metrics Technical Advisory Group (TAG) at their March 25 meeting about the pilot testing process and began recruiting participants for the pilot.

During this time, OHA staff also worked with a consulting firm to draft detailed measure specifications, based on the recommended measure concept, for pilot testing. Pilot testing will take place during the spring and summer of 2021 so that the draft specifications can be refined and presented to committees and other stakeholders in the late summer and fall.

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

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

The evidence-based obesity measure has two-parts. Part One addresses obesity prevention and reducing the prevalence of obesity through evidence-based multisector community interventions. Part One was developed and recommended to the Metrics and Scoring Committee for inclusion in the 2021 CCO quality incentive program but was not selected. Part Two, an outcome measure, has been envisioned to use BMI measurement and interventions completed to assess the decrease in obesity prevalence. Development work on Part Two is currently on hold.

Public Health Division staff have engaged with community groups about revisions to the measure. The workgroup plans to reconvene in 2021 to begin reworking the measure based on community and stakeholder feedback.

4. Health Equity Measurement Workgroup (Development measure workgroup)

This workgroup led the development of the Meaningful Access to Health Care Services for persons with limited English proficiency measure, which has been adopted into the CCO quality incentive program starting in measurement year 2021. Having concluded its measure development work, this workgroup is no longer meeting.

I. Budget neutrality

See Appendix E Budget Neutrality Reports.

J. Legislative activities

No significant activity during this reporting period.

K. Litigation status

No significant activity during this reporting period.

Member appeals and hearings are not reported in this section, but they are included in this quarterly report under section III. D. and in Appendices C & D.

L. Public forums

Health Evidence Review Commission (HERC)

January 21, 2021

This testimony concerned coverage of expanded carrier screening (ECS).

Devki Nagar: Ms. Nagar is an employee of Myriad Genetics, a genetic counselor, and representative of the Coalition for Access to Prenatal Screening (CAPS). Ms. Nagar appreciated the robust discussion earlier in the day at VBBS and had a few additional comments. The first comment was a clarification in that conditions screened are for autosomal recessive conditions. For these conditions, many carriers lack family history of the condition, so including family history as a requirement for screening would miss many potential carriers. These conditions occur in patients with diverse genetic backgrounds given the "blended" genetic diversity of Americans. Ms. Nagar asked if staff can remove the fragile X family history requirement, as that could exclude many fragile-X carriers. Similarly, Ms. Nagar requested the "high-risk ethnicity" requirement also be removed from the prenatal testing guideline for other conditions. Ms. Nagar concluded by thanking the Commission for their work.

This testimony concerned coverage substance use treatment. This topic was not on the Commission's agenda.

Erika Crable: Ms. Crable identified herself as a post-doctoral researcher from UC San Diego and wanted to ask which services HERC had covered for substance use treatment. HERC staff said they will email Ms. Crable a more detailed response to coverage for SUD.

March 11, 2021

This testimony concerned genetic screening tests.

Devki Nagar stated she was available for questions regarding genetic screening tests today and thanked the Commission for this opportunity.

HERC's Value-based Benefits Subcommittee

January 21, 2021

This testimony concerned coverage of expanded carrier screening (ECS).

Taylor Kane: Kane introduced herself as a carrier of a rare X-linked genetic disorder. She was diagnosed as a carrier at the age of 3 when her father was diagnosed with the disease as an adult. Any children she has will have a 50/50 chance of inheriting her affected X chromosome. Ms. Kane affirmed that knowing her status has helped her make decisions about family planning. Carriers of genetic conditions have long faced obstacles in getting genetic testing to make decisions. Women face barriers to informed and knowledge about getting testing for genetic disease. Ms. Kane founded an organization in 2017 for women to get access to genetic screening. Knowing your genetic status prior to having children allows knowledgeable decisions about reproduction and Ms. Kane stated that she believes all women should have access to ECS regardless of their income level or source of health insurance. The emotional toll and financial toll of having a child with a genetic condition are high. Ms. Kane spoke about the disparities of women of color getting tested for genetic conditions.

Adria Decker: Ms. Decker identified herself as a geneticist and lawyer who is employed by the state but stated she is testifying as a family member of a person with an X-linked genetic disease that was identified through ECS. Her sister is a genetic carrier. Ms. Decker's nephew has a severe genetic illness, diagnosed at 18 months with a post-natal genetic screen. Ms. Decker waited eight months to see a geneticist; her private insurance covered her genetic testing and determined she is not a carrier. Had her sister been able to obtain ECS as a routine part of family planning, Ms. Decker stated her family would not have spent the first 18 months of her nephew's life trying to figure out what was wrong. Ms. Decker stated that information is power and that we must trust women to make decisions for their reproductive health. Making expanded carrier screening would not mandate it but would give women another tool in their toolbox.

Peggy Flanigan: Ms. Flanigan described how 34 years ago, during her first pregnancy, she and her husband were worried--Ms. Flanigan's two nephews had developmental delays and they wondered if that was a coincidence. Ms. Flanigan had a daughter without any developmental delays. After Ms. Flanigan's sister had a third son with developmental delays, the family learned that the three boys had fragile X. Upon greater testing, it was determined that Ms. Flanigan and all her sisters were carriers. The couple received genetic counseling and they now keep up with the literature to continue to monitor their family's health. Ms. Flanigan said their awareness of this family condition led to their decision to not have any more children. All patients need timely and accurate information to be able to care for themselves and their families.

Mike Flanigan: Mr. Flanigan continued Ms. Flanigan's testimony. Mr. Flanigan said they appreciate that Fragile X is now a covered prenatal screening test and said that the earlier a family can be aware of a condition, the better people are able to manage symptoms. He compared ECS to cholesterol testing or other bloodwork, saying ECS is similarly a preventive test that people should be able to use to make health decisions. As genetics is changing rapidly, expanded carrier screening can keep up with changing tests. Providers would only offer tests they feel comfortable with. They strongly recommend expanded carrier screening.

Devki Nagar: Ms. Nagar is an employee of Myriad Genetics, a genetic counselor, and representative of the Coalition for Access to Prenatal Screening (CAPS). She said that the core goal of prenatal care is identification of higher risk pregnancies, and current ethnicity-based screening creates bias. Providers have ability to screen for multiple conditions in one test. ACOG has two committee opinions (#690 and #691) that address carrier screening. Expanded carrier screening is an acceptable approach per ACOG, if conditions included in the screen meet certain criteria. A Blue Cross and Blue Shield Technology Evaluation Center (BCBS TEC) assessment found that expanded carrier screening improved health outcomes [*Editor's note: This is a*

proprietary document]. Coverage of ECS would not require providers to order them. Moving to pan-ethnic screening would make more equitable coverage for OHP patients. Nagar requested that the Commission cover the conditions in listed in ACOG committee opinions #690 and #691.

Michelle Erskine: Ms. Erskine is the mother of three, including a son with a rare X-linked condition. She discovered that several of her brothers also had this condition, but it was not diagnosed due to the fact that there was no knowledge of the condition when they were born. Ms. Erskine said that sometimes carriers express only mild symptoms of conditions. She said it is important that of women of all backgrounds have access to expanded carrier screening. Improvements in genetic testing have made this type of testing more affordable and more education of patients is available than in the past. Ms. Erskine was in favor of expanded carrier screening.

March 11, 2021

This testimony concerned prenatal genetic testing guideline equity.

Devki Nagar, a Myriad employee and genetic counselor, testified in favor of the proposed changes. These tests are standard prenatal screenings. Many patients with hemoglobinopathies (>50%) are not from a high-risk ethnic group.

This testimony concerned biomarkers for prostate cancer.

Melissa Stoppler, MD, Exact Sciences senior advisor: Dr. Stoppler testified that the score informs the patient of their risk of high-risk disease if radical prostatectomy is done. NCCN has newly released its 2021 guideline. The recommendation to use biomarkers is now a 2A category recommendation (uniform consensus among panelists). ASCO 2020 guideline states "biomarkers are reasonable in low risk men in whom management decisions will be affected by the results." Medicare, 8 Medicaid programs (including CA and WA), and most private payers cover these tests.

Jeffrey Lawrence, MD, retired medical oncologist, former employee of Genomic Health and current consultant for Exact Sciences, declared no compensation for this testimony: Dr. Lawrence testified about his personal experience with prostate cancer. When he was diagnosed, he requested Oncotype Dx; the score helped him make a decision about treatment. He went on to have a radical prostatectomy and was found to have high risk disease at surgery. He had adjuvant radiation therapy, hormonal therapy. He is doing well now. He feels that active surveillance would have been a big mistake in his case. He noted that two studies show Oncotype Dx is equal or superior to MRI for determining a patient's risk status.

Ashley Svenson, genetic counselor and policy specialist at Myriad, the company that markets Prolaris: Ms. Svenson testified that the ASCO guideline is based on a 2019 systematic review of the literature and recommends consideration of use of these tests in specific clinical scenarios. Ms. Svenson strongly encouraged the Commission to take the ASCO recommendation into account. MediCal, California's state Medicaid program, is evidence-based and covers these tests. An AHRQ review did not find studies on biomarkers that met inclusion criteria; the review did not find evidence of ineffectiveness. The Oregon Health Plan covers breast cancer prognostics but not prostate prognostics.

Medicaid Advisory Committee

January 27, 2021 Meeting:

- DHS Updates /OHA Updates

- Legislative Update
- Advancing Consumer Experience – Subcommittee Update
- Health-related services Spending Trend for CCOs
- Oregon Health Policy Board Retreat and MAC

Public Comment:
Heather Gately is an OHP member who is enrolled in a CCO. Heather shared the following public testimony:

- The grievance process is not helpful; lots of misinformation and conflicting information
- Customer service process lacks continuity (no notes for each interaction)
- OHA appeals process requires an attorney; she has two college degrees and cannot discern the meaning of the letters she receives

Patti Maloney is the billing manager for a medical supply company. Patti was interested in information about any COVID-related waivers for medical supply order renewals. With fewer patients receiving in-person care, getting documents and signatures is more challenging for patients.

February 24, 2021 Meeting

- Agency Updates for OHA and DHS
- Healthcare Interpreter Report Findings
- Quality Strategy
- Telehealth Workgroup
- Oregon Health Policy Board Retreat – Debrief

There was no public comment

March 2021 – No MAC Meeting

Metrics and Scoring Committee

The Metrics and Scoring Committee met once during this quarter. There was no meeting scheduled in January 2021 and the March 2021 was cancelled.

February 19, 2021
The Committee reviewed 3 pieces of written public testimony and heard oral testimony from 5 people.
Oral testimony:

1. Maggie Klein, Director of Care Integration and Coordination for OHSU Health Services
    - Re: Social determinants of health (health related social needs) measure
2. Courtney Rivera, Supervisor of Quality Improvement for the Eastern Oregon CCO
    - Re: Social determinants of health (health related social needs) measure
3. Elise Darnell, Senior Manager of Operations for Providence Medical Group in Yamhill County
    - Re: Social determinants of health (health related social needs) measure
4. Ginger Scott – Jackson Care Connect in Jackson County
    - Re: Social determinants of health (health related social needs) measure
5. Rachel Smith – Program Manager, Providence Health and Services Patient Health
    - Re: Social determinants of health (health related social needs) measure

Written testimony is available on the Committee webpage:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metric-Scoring-Committee-Archives.aspx
Written testimony was received from:

1. Matthew Mitchell, Data Analytics Manager, Member of the SDOH measure concert workgroup, Central City Concern
    - Re: Social determinants of health (health related social needs) measure

2. Gary Plant MD FAAFP, Madras Medical Group
    - Re: Social determinants of health (health related social needs) measure
3. Carly Hood-Ronick MPA, MPH, Project Access NOW (PANOW)
    - Re: Social determinants of health (health related social needs) measure

Health Plan Quality Metrics Committee

January 26, 2021
The Committee reviewed 1 piece of written public testimony and heard oral testimony from 1 person.
Oral testimony:
Laura McKeane, Director of Oral Health Services, Co-Chair of the CCO Oregon Oral Health Workgroup, from AllCare CCO

- Re: In support of recommendation brought to Metrics and Scoring Committee to expand the providers included in the preventive dental measure.

Written testimony is available on the Committee webpage:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Quality-Metrics-Committee-Archive.aspx
Written testimony was received from:
CCO Oregon on behalf of CCOs, DCOs, and provider partners

- Re: In support of proposed preventive dental specification change brought to the Metrics and Scoring Committee to expand the providers that count towards the measure.

February 23, 2021
There was no public comment at this meeting.

March 30, 2021
There was no public comment at this meeting.

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 has been conducting all site visits virtually since August 2020 and completed 16 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 March 31, 643 clinics were recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Ninety PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model.

In January 2021 the Oregon Health Authority implemented 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 provided 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 was 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.

Oregon Health Authority

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. Initially it is expected that I/T/Us will establish five Indian Managed Care Entities (IMCE), although additional tribes may establish IMCEs at a later time. A state plan amendment has been submitted to CMS to establish the IMCE program with an anticipated start date of 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. Track 2 alternative comprehensive primary care payment launched in January 2021. The quarterly hybrid payment includes a prospectively paid PMPM payment and a corresponding FFS claims reduction on payments for specific claims submitted during the program year. Track 2 practices selected their hybrid payment ratio for CMS in the fall of 2020, and OHA is using the same payment ratio.

The Oregon CPC+ payers met to discuss revisions to four Data Bytes documents, which compare trends in quality measure results for patients of practices participating in both CPC Classic and CPC+, with trends for practices not participating in either program. The payers also met to finalize the Data Bytes and discuss sustainability of the CPC+ payment model.

Value-Based Payment Innovations and Technical Assistance

During this period, primary care, behavioral health, and maternity care providers were invited to the first of a five-part webinar series focused on increasing readiness for VBP and taking advantage of the flexibility VBPs offer for innovatively redesigning care models. The series provides an overview of VBP models as they apply to the Oregon landscape and how providers can improve patient outcomes through more comprehensive and flexible approaches to delivering health care. Participants learn methods to maximize the full care team and services uniquely feasible under VBP modes and how to evaluate contract offers. Speakers include experts with firsthand local experience and extensive national experience practicing and advising others working under similar payment models.

The first session ("Value-based payment: Is it disrupting health care for the better?") had 89 attendees, and the recording is available online. No-cost CME was available.

In addition, the Transformation Center brought national expert Marshall Chin, MD, to help CCOs and health system partners apply lessons from care transformation and VBP models from systems throughout the U.S. to reduce health disparities. The "Evidence-based strategies for advancing health equity" webinar had 120 participants, and the recording is available online**.**

Value-based Payment Compact

The Oregon Value-based Payment Compact represents a collaborative partnership to advance the adoption of VBPs across the state. As part of Oregon's legislatively mandated initiative to contain growth in health care costs, payers and providers are working together to advance payment reform and move to VBP. The Oregon VBP

Compact is a voluntary commitment by payers and providers to participate in and spread VBPs, meeting specified targets and timelines over the next four years. This effort will increase the impact of the CCO VBP work by spreading VBPs across other payers. The compact, jointly sponsored by the Oregon Health Authority and the Oregon Health Leadership Council, already has 44 signatories, covering 71 percent of the people in Oregon. Signatories include commercial, Medicaid and Medicare Advantage payers.

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 January to prioritize opportunities to incorporate health equity into primary care payment reform and the Collaborative's work and to discuss 2021 session legislative concepts related to VBP and primary care. The collaborative's Implementation and Technical Assistance Workgroup met in February to identify recommendations for consideration by the full collaborative to incorporate health equity into primary care payment reform.

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

Statewide Performance Improvement Project

No significant changes during this reporting period.

Roadmap to Oral Health

Oregon kicked off its work as part of the Medicaid/CHIP Oral Health Affinity Group to build a learning collaborative with coordinated care organizations (CCO) to increase integration of dental care into primary care and strengthen ties between the two systems of care. Staff from the Health Systems Division (which houses Medicaid/CHIP), Transformation Center, and Public Health met with CMS three times, with separate prep meetings, during the quarter to lay the groundwork for the larger learning collaborative, slated to start in July 2021.

The Transformation Center completed 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. Seventy-four participants from 45 clinics or health systems received four hours of instruction and up to five hours of follow up one-on-one technical assistance. To date, 33 clinics have been involved in follow up technical assistance.

Using resources from the HRSA Oral Health Workforce Grant, the Primary Care Office (PCO) facilitated the partnership of Advantage Dental and Coast Community Health Center in the rural coastal town of Port Orford. Advantage Dental is now sending an expanded practice dental hygienist (EPDH) to render preventative oral health services at facility and to refer patients with more complex cases to dentists within their network. This is the first time the town has had dental services in over 20 years.

The PCO has also worked with the Oregon Office of Rural Health to tailor the Health Care Provider Incentive Program to enable community-based providers, including traveling EPDHs, to receive incentive awards like loan repayment. The goal is to increase the retention time of these types of providers and expand the number of community-based providers providing services via teledentistry.

The PCO is also reviewing federally-designated Dental Health Professional Shortage Areas (HPSAs) to determine trends and changes to the dental FTE relative to the population in different areas of the state.

The Public Health Division's (PHD) Oral Health Program updated COVID-19 guidance documents to provide school oral health services (e.g. dental screenings, fluoride varnish, silver diamine fluoride, dental sealants, etc.), as some schools in Oregon began providing in-person instruction in January 2021. The state required all public schools to offer universal access to in-person learning by March 29, 2021, for K-5 students and April 19, 2021, for students in grades 6-12.

- OHA Guidance on Resumption of Dental Services in School Settings
- OHA Guidance for Certified School Dental Sealant Programs

The PHD Oral Health Program is also hosting regular, brief "Spotlight Segments" on training topics pertaining to certified school dental sealant programs, such as infection control, sealant placement, retention, etc. Dental hygienists and program coordinators have attended six virtual spotlight segments so far from January 22 - April 9, 2021.

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

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

In December, OHA 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. 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.

During Q3, the eight (8) SRCH teams began work on their proposed projects which include, 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; increasing closed loop referrals to tobacco cessation services centering the Latinx community; expanding systems, infrastructure and programming across a tri-county area for diabetes prevention (National DPP). OHA and contractors provide technical assistance and support to teams as requested.

Progress and Findings:

The flexible SRCH funding opportunity allowed teams to utilize SRCH funding, training, and technical assistance to use innovative methods to prevent and address chronic disease disparities.
For example, the Confederated Tribes of Siletz Indians SRCH team is piloting a virtual Diabetes Self-Management Education and Support (DSMES) Native cohort with the OHSU-Harold Schnitzer Diabetes Health Center. This work includes tribal adaptations to the DSMES curriculum, launch of a "Three-Touch" communications campaign to encourage people to visit their PCP for their annual screening, and establishing a closed loop referral between Siletz Tribal Health and OHSU.

The Central Oregon (Crook, Deschutes and Jefferson Counties) SRCH team is working on scaling and sustaining chronic disease and self-management programming and infrastructure across the region with a focus on ensuring access for the Latinx community. Deschutes County, on behalf of the Central Oregon team, applied and the CDC approved Deschutes to be a National Diabetes Prevention Program Umbrella hub organization. The Umbrella hub model has multiple benefits including aggregate Diabetes Prevention Recognition Program (DPRP) data submission, share CDC recognition status, operate as one Medicare DPP supplier, streamline business and administrative support, and pursue sustainability and achieve scale. The Central Oregon regional umbrella hub work also provides a foundation for continued growth and expansion of prevention and self-management services across the region with a focus on communities disproportionately affected by chronic disease.

The additional SRCH teams continue to make progress with their work, and all teams provided verbal and written interim reports to OHA by March 31, 2021 detailing successes and barriers.

Trends, Successes, or Issues:

The interim reporting period illustrated that the SRCH teams were implementing projects over the three month period since OHA awarded funds, and the flexible funding opportunity allowed teams to address disparate health and social impacts experienced by communities in Oregon who are affected by higher incidences of chronic disease and COVID-19. Given the shorter funding cycle of this SRCH opportunity (January 1- June 30, 2021), OHA is discussing potential additional and/or carry over funding in FY22 for SRCH teams to continue their work.

OHA is engaged with an external evaluation firm, Rede Group and is conducting developmental evaluation to inform an adapted SRCH model. To date, Rede Group has supported convening of an internal OHA group to review a "modernized" SRCH model that defines desired outcomes at the systems and local level. Rede Group will help OHA incorporate learnings from the current SRCH funding initiative into the new model. Next steps are to identify the needed functional model to continue to deliver and support the SRCH initiative in the current context of health systems transformation and public health modernization in Oregon.

Public Health Modernization

The PartnerSHIP, the community-based steering committee for the State Health Improvement Plan (SHIP), was reformed for implementation. The PartnerSHIP holds decision making authority for the SHIP and includes trusted representatives of priority populations and implementers of the plan, including representatives from CCOs, hospitals and local public health.

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 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. SB698 required every pharmacy to provide written translation and oral interpretation for anyone with limited English proficiency (LEP) to receive their prescription instructions in both their language of choice (14 languages are legally required to be translated) and in English. The IAs have ensured this information has been shared amongst providers, OHP members, and with pharmacies across the state. 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-19 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

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

Staff evaluated the 2020 CCO HRS policy and procedures using recently developed evaluation criteria (www.oregon.gov/oha/HPA/dsi-tc/Documents/2020-CCO-HRS-Policy-Eval-Criteria.pdf). All CCOs will be required to meet all requirements before the policies are considered final.

To improve future use of and support potential increases to HRS spending, staff continue to develop and update guidance for HRS, including HRS guidance specific to traditional health workers, health information technology, and care coordination and case management. All HRS guidance documents for CCOs and external partners are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx

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

Transformation Center activities

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

Behavioral health integration

The center coordinated with the Health Systems Division Adult Mental Health Program to contract with a subject matter expert to provide technical assistance on the development of the Adult Suicide Intervention and Prevention Plan. Contents of the plan will include guiding principles, a framework for suicide intervention and prevention, models for suicide intervention and prevention, cultural implications, groups with increased risk for suicide, limitations of data used for suicide surveillance, strategic directions, goals, objectives and action steps.

Population health

Community advisory council activities

The center continued to host peer-to-peer meetings with community advisory council (CAC) members and CAC coordinators. Meeting topics this quarter included: planning a virtual CAC conference, collecting feedback on the Medicaid 1115 waiver, improving virtual CAC member onboarding practices, accommodating non-English speaking CAC members, responding to a Medicaid Advisory Committee request for common consumer concerns, and structuring CACs to meet CCO 2.0 requirements. The center also continued to host its learning collaborative for CAC members serving on CCO governing boards and hosted a CAC office hour session.

In addition, staff developed a Spanish version of the CAC 101 presentation for new and current CAC members, and continued with planning for the June 8–9 virtual CAC conference.

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

The Transformation Center launched a series of virtual CHA/CHP trainings available for CCOs and their CHA/CHP partners. The trainings are being offered from the end of April through the end of June. The center also brought on a consultant to identify and share best practices from CCOs attempting to develop shared CHAs and CHPs with their collaborative CHA/CHP partners. This project will include a June webinar highlighting best practices in June and follow-up direct TA.

Traditional health worker (THW) technical assistance

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

In February, in partnership with OHA's Equity and Inclusion Division, the Transformation Center began convening a statewide THW learning collaborative to engage CCOs, health system providers, CCOs' THW liaisons, THW workforce, private payers, community-based organizations, culturally specific organizations and key stakeholders in peer-to-peer learning and networking opportunities to work on strategies to better integrate and utilize THWs, with the goal of addressing social determinants of health. This virtual learning collaborative is being convened monthly February–June 2021. Sessions will highlight peer learning and best practices among CCOs and will include subject matter experts to discuss key issues and relevant topics.

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 completed four 4-hour online trainings and continues follow-up one-on-one technical assistance calls between practice coaches and participating clinics. In addition, they have begun creating a tool kit to support the two metrics and are planning a webinar to introduce the tool kit.

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

The Transformation Center is leading a two-year learning collaborative in the state to increase rates of topical fluoride varnish applied in primary care and improve overall performance on the preventive dental care metric. This quarter's progress includes identifying stakeholders and goals for the learning collaborative.

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.

In February, the Transformation Center, in partnership with the OHA Equity and Inclusion Division, began hosting a short-term learning collaborative for CCO staff focused on meaningful language access to culturally responsive health care services. This virtual learning collaborative will be convened monthly from February through June 2021.

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. The project team is continuing to work on new clinic recruitment strategies.

Cross-cutting supports
Children's health complexity
The Office of Health Analytics, in collaboration with the Oregon Pediatric Improvement Partnership (OPIP), released updated statewide-, CCO- and county-level data on children's health complexity. The Transformation Center is supporting TA to CCOs to use this data, provided through OPIP. This work was completed in March 2021.

REALD (race, ethnicity, language, and disability) learning series
The center partnered with the OHA Division of Equity and Inclusion to host several REALD sessions for phase 1 organizations. This meeting series replaced the REALD technical work group and focused on hearing from partners on lessons learned while operationalizing REALD.

Transformation and quality strategy (TQS) technical assistance
OHA held one access webinar and three office hours for CCOs developing their 2021 TQS. All CCOs met the March submission deadline, and OHA subject matter experts began reviewing submissions.

Social Determinants of Health Measurement Workgroup
During their February 2021 meeting, the Metrics and Scoring Committee endorsed the proposed measure concept ("Rate of social needs screening in the total member population using any qualifying data source") and approved the request to move forward into pilot testing. Pilot testing will begin in May 2021. For more details, see the SDOH measurement work group's final report.

Supporting Health for All through REinvestment: the SHARE Initiative
The SHARE Initiative comes from a legislative requirement for CCOs to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity. In January, OHA hosted a webinar covering the SHARE Initiative.

B. Lower cost (ANNUAL)

C. Better care and Better health (ANNUAL)

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports
Attached separately as Appendix A.

2. State reported enrollment table

Enrollment	January/2021	February/2021	March/2021
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,276,679	1,137,972	1,145,380
Title XXI funded State Plan	97,225	98,065	99,945
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	1/31/2021	2/28/2021	3/31/2021

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%	44,703	158,530	2.26%	2.92%
Optional	**Title XIX**	PLM women FPL 133-170%	0	0		
	Title XXI	SCHIP FPL < 170%	114,099	387,407	10.72%	8.75%
Mandatory	**Title XIX**	Other OHP Plus	174,353	712,903	4.80%	8.45%
		MAGI adults/children	886,248	3,144,784	7.89%	14.85%
		MAGI pregnant women	10,640	41,405	-5.30%	-5.08%
		QUARTER TOTALS	1,230,043			

** 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
January	1,237,081	1,049,019	540	149	13,152	59,166	N/A
February	1,247,253	1,065,348	733	141	13,683	59,941	N/A
March	1,258,307	1,073,916	680	128	13,980	59,962	N/A
Quarter average	1,247,547	1,062,761	651	139	13,605	59,690	

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

B. Complaints and grievances

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

C. CCO appeals and hearings

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

D. Neutrality reports

Attached separately.