Oregon Health Plan

Section 1115 Quarterly Report

7/1/2021 – 9/30/2021
Demonstration Year (20): (7/1/2021 – 6/30/2022)
Demonstration Quarter (DQ): 1

Table of contents

I. Introduction

A. Letter from the State Medicaid Director

In July, August, and September of 2021, Oregon continued to work with our Coordinated Care Organizations (CCOs), providers, and community partners to respond to the COVID-19 Public Health Emergency, and to meet the changing needs of Oregon Health Plan (OHP) members.

The Oregon Health Authority (OHA) has explored flexibilities available under the current waiver and has begun dialogues with partners about the implementation of in-lieu-of services (ILOS). ILOS are medically appropriate and cost-effective substitutes for covered services or settings under the State Medicaid Plan. Oregon values the participation in our Medicaid program by providers who are able to meet members where they are, and ILOS allows CCOs greater flexibility to include those partners and their services in the networks available to OHP members.

In July, OHA welcomed its new dental director, Kaz Rafia, DDS MBA. Dr. Rafia brings broad experience and leadership to the OHA team and has already begun to lead conversations between Coordinated Care Organizations and Dental Care Organizations to better integrate oral health with physical and behavioral health.

Dana Hittle, Interim State Medicaid Director

B. Demonstration description

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

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

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

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

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

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

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

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

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

C. State contacts

Medicaid Director

Dana Hittle, Interim Medicaid Director
503-991-3011 phone
503-945-5872 fax

Medicaid Deputy Director

Dana Hittle, Medicaid Deputy Director
503-991-3011 phone
503-945-5872 fax

Eligibility Policy Business Director

Vivian Levy, Eligibility Policy Business Director
503-519-3512 phone

503-945-5872 fax

Demonstration and Quarterly and Annual Reports

Tom Wunderbro, Medicaid Demonstration Waiver Manager
503-510-5437 phone
503-945-5872 fax

State Plan

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

Coordinated Care Organizations

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

Quality Assurance and Improvement

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

For mail delivery, use the following address

Oregon Health Authority
Health Policy and Analytics
500 Summer Street NE, E54
Salem, OR 97301-1077

II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 7/1/2021 – 9/30/2021
Demonstration Year (DY): 20 – Quarter 1

III. Overview of the current quarter

Enrollment in the Oregon Health Plan continued to increase during this quarter as more Oregonians seek coverage and existing members remain enrolled during the COVID-19 Public Health Emergency.

The Oregon Health Authority (OHA) worked with the Health Information Technology Oversight Council (HITOC) to discuss the need for a community information Exchange (CIE) workgroup to explore statewide strategies. At HITOC's direction, OHA developed a draft CIE workgroup charter and OHA is seeking broad CCO participation to better support our care coordination goals in each region of the state.

A. Enrollment progress

1. Oregon Health Plan eligibility

Title XIX and Title XXI enrollment has continued to incrementally increase each month as more Oregonians seek coverage and as existing members remain enrolled due to Oregon's election to apply continued eligibility protections during the COVID-19 public health emergency period as permitted under the Families First Coronavirus Response Act.

The state's transition to a new integrated eligibility system, which was complete as of March 2021, has resulted in some ongoing backlogs of work as eligibility staff learn the new system and settle into a new statewide work allocation model. Priority in processing is regularly given to those who are currently without coverage, and the majority of applications and renewals continue to be processed within required timeframes. Focused system updates and processing measures are being taken to help reduce existing backlogs and stabilize processing times.

2. Coordinated care organization enrollment

Total CCO enrollment for July 2021 – September 2021 grew by 2.2%, across all plan levels (CCOA, CCOB, CCOE, CCOG). Specific Coordinated Care Organization membership growth ranged between 0% – 2.9%, with the exception of Trillium Community Health Plan in the Portland metro tri-county area which continued to experience greater than 20% growth as it established itself in this new market.

Across the 16 Coordinated Care Organizations, there are 48 unique CCO-county combinations. To provide context for geographic variability in membership growth trends, please see the table below.

DY 20: Q1 **Member Growth Zone**	**Number of** **CCO-County areas**
>10% growth	3
5-10% growth	2
2-5% growth	22
0-2% growth	17
Negative growth	4

All CCOs saw July 2021 – September 2021 enrollment growth slow-down from the pace seen in the previous four quarters.

DY 19: Q1	**DY 19: Q2**	**DY 19: Q3**	**DY 19: Q4**	**DY 20: Q1**

(Jul-Sep)	(Oct – Dec)	(Jan – Mar)	(Apr – Jun)	(Ju1 – Sep)
3.3%	3.9%	3.5%	2.4%	2.2%

As noted in previous reports, on May 1, 2020, Oregon Health Authority waived the requirement to limit each Coordinated Care Organization's enrollment to the county limit(s) and grand total limit listed in its contract to mitigate enrollment challenges during the pandemic. This requirement was initially established for CCO contract year 2020 and has since been extended through contract year 2021 (December 31, 2021).

Across the January-September 2021 time period, 10 CCO-County areas – representing three distinct CCOs – have required adjustments above their 2021 contract limits in order to sustain auto-enrollment algorithms. These temporary increases increased enrollment capacity by approximately 5% for 8 of the 10 CCO-County areas. The other 2 CCO-County areas were granted a 10-15% enrollment capacity increase.

B. Benefits

There have been no changes for the time period specified (7/1/21-9/30/21).

C. Access to care (ANNUAL)

D. Quality of care (ANNUAL)

E. Complaints, grievances, and hearings

CCO and FFS Complaints

The information provided in the charts below is a compilation of data from the current 15 coordinated care organizations (CCO) and fee-for-service (FFS) data. The annual reporting period covers July 1, 2021 through Sep 30, 2021.

Trends

	Oct – Dec 2020	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
Total complaints received	3,529	3,437	3,895	4415
Total average enrollment	1,138,377	1,344,628	1,389,453	1,394,117
Rate per 1,000 members	3.10	2.56	2.80	3.17

Barriers

The third quarter of 2021 shows an increase in the number of grievances from the second quarter. The Access to Care category increased 18.3% from the second quarter of 2021. The Interaction with Provider/Plan category shows a 13.3% increase from the second quarter of 2021. Quality of Care was the third highest category of complaints with an increase of 8.2% from the second quarter. CCOs report the overall increases may be due to providers, clinics, etc. return to normal in-person practice. FFS data shows the highest number of complaints are again the Billing category, with Access to Care the next highest category.

Interventions

CCOs –CCOs continue to report grievances due to COVID precaution protocols. Some CCOs are reporting grievances related to providers using telehealth and limited available appointment times are decreasing as more in-person visits are allowed. One CCO reported that grievances around dental visits have increased due to the influx of delayed dental work during the pandemic. Some CCOs are also continuing to report increases in membership and decreasing available providers causes an increase in provider grievances. CCOs are reporting continued work on NEMT issues including Covid19 safety precautions. CCOs continue to report they have established committees and taskforces specifically to address provider capacity within their networks. CCOs are assigning liaisons to work with providers to improve education and awareness of Medicaid members' needs. CCOs report they have increased care coordination and are providing more health navigators to assist members in making appointments, attending appointments, etc. 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.

Fee-For-Service – The number of complaints from members who were on Fee for Service coverage during the Jul – Sep third quarter was 193. An additional 349 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 53 complaints from members enrolled in Dental Care Organizations. 8812 informational calls were received asking for a variety of information, such as information about their coverage, CCO enrollment, request ID cards, etc.

Statewide rolling 12-month Complaints totals

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

Complaint category	Oct – Dec 2020	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
Access to care	1,044	1,086	1,324	1566
Client billing issues	266	236	278	394
Consumer rights	281	247	301	288
Interaction with provider or plan	1,244	1,186	1,281	1451
Quality of care	494	487	498	539
Quality of service	200	195	213	177
Other	0	0	0	0
Grand Total	3,529	3,437	3,895	4,415

Related data

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

CCO Notices of Adverse Benefit Determinations and Appeals

Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs during each quarter. The NOABDs are listed by reason, as per 42 CFR 438.400(b)(1-7) and are the total number of NOABDs issued, regardless of whether or not an appeal was filed. During this quarter CCOs report that the highest number of NOABDs issued were Pharmacy related. Specialty Care was the next highest and Outpatient 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)	Oct – Dec 2020	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
a) Denial or limited authorization of a requested service.	29,315	28,984	29,931	27,636
b) Single PHP service area, denial to obtain services outside the PHP panel	459	771	490	897
c) Termination, suspension, or reduction of previously authorized covered services	109	118	129	224
d) Failure to act within the timeframes provided in § 438.408(b)	10	12	15	7
e) Failure to provide services in a timely manner, as defined by the State	55	43	28	59
f) Denial of payment, at the time of any action affecting the claim.	56,932	56,909	64,915	46,204
g) Denial of a member's request to dispute a financial liability.	0	1	0	0
Total	86,880	86,838	95,508	75,027
Number per 1000 members	84	81	86.8	66.6

CCO Appeals

The table below shows the number of appeals the CCOs received over the third quarter of 2021. In the third quarter CCOs reported the highest number of appeals were issues with Outpatient services. Pharmacy was the next highest category and appeals related to Specialty Care were the next highest. CCOs report they review the overturn rates which leads to more in-depth discussions and reviews, monitoring and process changes. Some CCOs are reporting that Peer Reviews with Providers is resulting in improvements to services. CCOs report they are continuing to do activities such as staff education and monitoring for providers to improve understanding of the appeal process. CCOs also work with members to assist them in finding services they need or assist them with finding alternative covered options.

CCO Appeals	Oct – Dec 2020	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
a) Denial or limited authorization of a requested service.	1,078	1,031	1,145	1,116
b) Single PHP service area, denial to obtain services outside the PHP panel.	15	36	7	29
c) Termination, suspension, or reduction of previously authorized covered services.	2	1	10	5

d) Failure to act within the timeframes provided in § 438.408(b).	2	0	0	0
e) Failure to provide services in a timely manner, as defined by the State.	0	0	1	0
f) Denial of payment, at the time of any action affecting the claim.	346	293	357	245
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	1,443	1,361	1,520	1,395
Number per 1000 members	1.4	1.27	1.38	1.24
Number overturned at plan level	432	379	436	388
Appeal decisions pending	10	0	9	0
Overturn rate at plan level	29.94%	27.85%	28.68%	27.8%

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 first quarter (July1, 2021 – September 30, 2021), the Oregon Health Authority (OHA) received 247 hearing requests related to the denial of medical, dental, and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 225 were from CCO-enrolled members and 22 were from FFS members. 276 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 July of 2021 may be cases OHA received as far back as May and June of 2021.

OHA dismissed 128 cases that were determined not hearable cases. Of the not-hearable cases, 105 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 148 cases that were determined to be hearable, 26 were approved prior to hearing. Members withdrew from 66 cases after an informal conference with an OHA hearing representative. 37 cases went to hearing,

where an administrative law judge upheld the OHA or CCO decision and 17 cases were dismissed for the members failure to appear. During the third quarter there was one case set aside by the Administrative Law Judge. The Administrative Law judge revered the decision in one case.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	26	9%
Client withdrew request after pre-hearing conference	66	24%
Dismissed by OHA as not hearable	128	46%
Decision affirmed*	37	13%
Client failed to appear*	17	6%
Dismissed as non-timely	0	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	1	0%
Set Aside*	1	0%
Total	276	

* Resolution after an administrative hearing.

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

F. CCO activities

1. New plans

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

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

2. Provider networks

No significant changes during this reporting period.

3. Rate certifications

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

OHA met with CCOs from May to August 2021 to discuss the CY2022 rate development process. At the end of the process, OHA delivered the final CY22 rate packages to CCOs in early August 2020 and met with each CCO, individually, to discuss their rates and request feedback. In addition, OHA also hosted a Dental Rates Workgroup meeting to further discuss the CY2022 Dental rates with the Dental Care Organizations (DCO). The CY2022 CCO and DCO capitation rates were submitted to CMS October 1, 2021 and are posted on our website: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/OHP-Rates.aspx

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

4. Enrollment/disenrollment

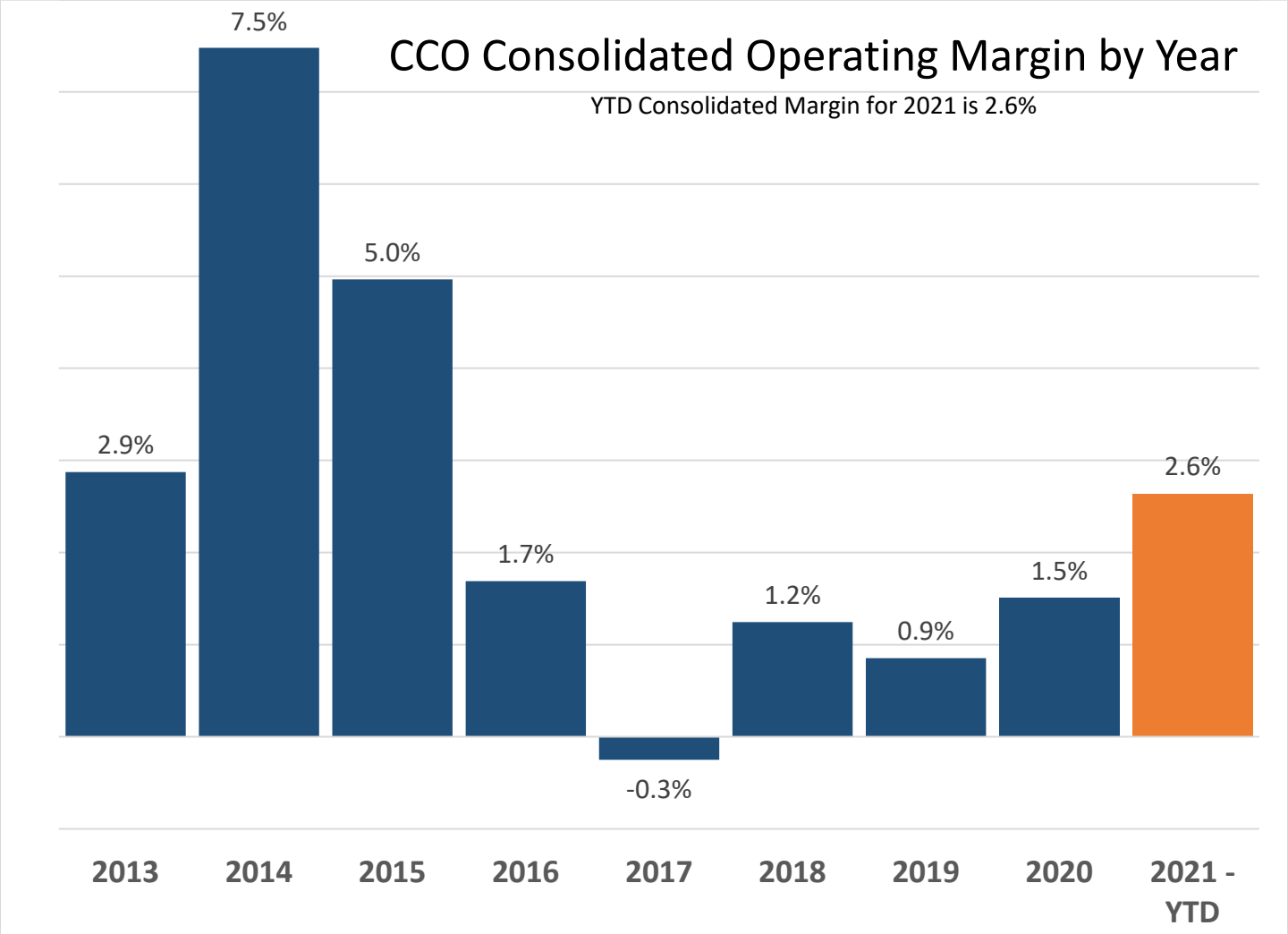
No significant changes during this reporting period.

5. Contract compliance

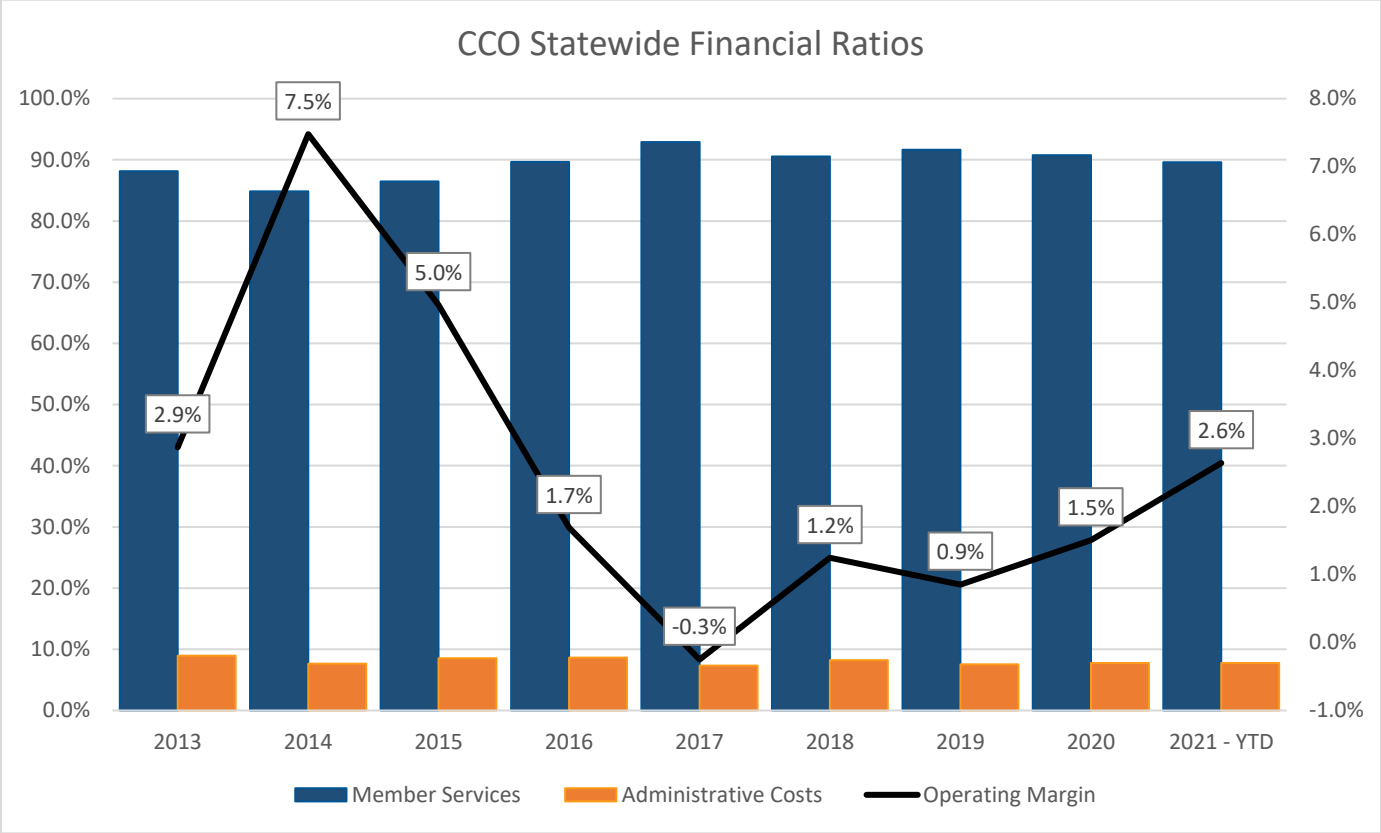
There are no issues with CCO contract compliance other than as described in the Corrective Action Plans section.

6. Relevant financial performance

CCOs achieved a statewide operating margin of 2.6% through the 6-months ending June 30, 2021. This is a slight decrease from the margin reported for the first three months of 2021 of 3.2%. However, this may be trending downward towards the prior margin reported in 2020 of 1.5%.



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. A breakdown of key statewide financial ratios by year indicates that the Member Services component as a percent of the payments which CCOs received has remained relatively consistent over the last two years. Through the first six months of 2021, spending on Member Services was at 89.0%, which is 0.4% lower than the average Member Services expense from the previous 8 years. Administrative costs of 7.7% through the first half of 2021 is in line with the prior year average, which was also 7.7%.



For the 6-months ended June 30, 2021, the majority of the 16 CCOs met or exceeded the 85% target for Member Service Ratio (MSR), a key indicator for MLR (3 CCOs were below the 85% MSRs, and 2 of the CCOs had MSRs above 90%).

Additional CCO financial information and audited financials are posted here:

http://www.oregon.gov/oha/FOD/Pages/CCO-Financial.aspx

7. Corrective action plans

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

CONTINUING CAP

- *Entity name:* Health Share of Oregon (HSO)
- *Purpose and type of CAP:* Non-compliance with CCO contract and Oregon Administrative Rule. CCO was not providing reliable non-emergency medical transportation (NEMT) services to covered appointments, resulting in disruption to members' access to care.
- *Start date of CAP:* October 14, 2019
- *End date of CAP:* Original end date: April 14, 2020. First extended end date: October 31, 2020. Second extended end date: April 30, 2021. Current end date: When OHA determines the remaining area for improvement can be "closed".

- *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. 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. Per that letter, all CAP areas for improvement were "closed", except for member grievances. HSO is required to continue to submit monthly progress reports for the area of member grievances as well documentation relating to specific NEMT concerns identified through member grievances. Also, weekly reporting changed to monthly reporting effective for the report due in February 2021.
- *Progress during current quarter:* For July-September 2021, HSO continued to exceed the performance target for the member grievances metric. HSO determined in July that the metrics data reported to OHA did not include all grievances received by its NEMT subcontractor. This deficiency has been resolved, and HSO's report for September included corrected data. Even with correcting for this error, HSO continued to exceed the performance target.

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:* Original end date: September 5, 2021. Current end date: March 5, 2022, or when OHA determines that the CAP can be "closed".
- *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:* The areas for improvement identified in the CAP are network development, health equity and language access, community engagement, and intensive care coordination. OHA's review of Trillium's progress reports for July-September 2021 indicate varying degrees of progress in CAP areas. The most substantive progress was in the areas of community engagement and intensive care coordination. However, the progress was insufficient to close out these areas of the CAP.

8. One-percent withhold

This quarterly report is for data from July 1, 2021 through September 30, 2021. OHA analyzed encounter data received for completeness and accuracy for the subject months finalized for December 2020 through February 2020.

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of December 2020 through February 2021. All CCOs except for one met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

One CCO did not meet the Administrative Performance (AP) standard for the month of February 2021 subject month no 1% withhold was taken as the CCO put remediation in place to ensure ongoing compliance and a decision was made by OHA leadership that due to the current pandemic affecting recent submissions, no withhold would be applied.

9. Other significant activities

No other significant activities during this reporting period.

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 (EHR) technology. Eligible professional types include physicians, naturopathic physicians, pediatric optometrists, nurse practitioners, certified nurse-midwives, dentists, and physician assistants in certain settings. As of September 30, 2021, more than $212 million in federal incentive payments have been dispersed to 60 Oregon hospitals and 3,863 Oregon providers. Between July 2021 and September 2021, 141 providers received $1,275,000 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 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). CCOs submit their Updated HIT Roadmaps to OHA annually on March 15th for review and approval starting in 2021.

Between July and December of 2020, OHA developed an Updated HIT Roadmap template to help streamline CCO responses and reduce burden. CCOs used this template to complete their Updated HIT Roadmaps and submit to OHA March 2021. In June 2021, OHA completed an initial review of the Updated HIT Roadmaps and has approved some, while requesting additional information from CCOs on others. OHA anticipates that all CCOs will have an approved Roadmap by October 2021.

Starting in 2022, CCOs will be 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, and report on their annual progress toward reaching targets within their HIT Roadmaps. To support this requirement OHA worked with CCOs and DCOs around the HIT Data Collection and Reporting survey and distribution. The survey (in partnership with CCOs) will be distributed in October of 2021 to the CCO contracted provider organizations to collect EHR and HIE information. 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 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 DCOs. 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 Oregon's Department of Human Services' Aging & People with Disabilities and Developmental Disabilities.

Recent highlights:

- As of July 9, 2021, COVID-19 positive case data from OHA's Oregon Pandemic Emergency Response Application (Opera), the state's COVID-19 case investigation system, is being shared with all users of the Collective Platform. A flag is visible on a patient's record if they had a confirmed positive COVID-19 test result in the last 42 days. This information is also included in EDie notifications across 63 Oregon hospitals. More information about this initiative it is available here. See the COVID-19 Data Sharing Initiative section below for more information on COVID-19 data sharing.

- 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, dose, and type (e.g., adult vs. children age 11 and under) of vaccines that have been administered.

- On September 20, 2021, HIT Commons hosted a learning webinar, "Back to Basics on the Collective Platform." Materials and the webinar recording can be found here.

- The HIT Commons EDIE Steering Committee met on August 27, 2021. Topics of discussion included product and support updates from Collective Medical, EDIE/Collective Platform use cases under development, potential changes to the report that ED users see in EDIE notifications, and the possibility of HIT Commons convening an ED physician advisory committee in 2022. Materials from that meeting are available here. The Committee's next meeting is October 22, 2021.

Public Health Data Sharing Workgroup

HIT Commons, in partnership with OHA, has convened a Public Health Data Sharing Workgroup to discuss and assess efforts to integrate public health data into HIT or HIE systems, and make policy and operational recommendations to HIT Commons and OHA. Workgroup membership includes representation from OHA's Public Health Division, payers/CCOs, health systems, and providers. The Workgroup had its second meeting on August 12th where draft data dashboards showing utilization of COVID-19 data in the Collective Platform were reviewed. The dashboards will be finalized at upcoming meetings and in October the Workgroup will shift to supporting a qualitative analysis of COVID-19 data integration with the Collective Platform. The group will continue to meet monthly at least through the end of 2021.

Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative

Oregon's PDMP Integration initiative connects EDie, Reliance eHealth Collaborative 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:

- 30 new organizations went live with PDMP Integration in Q2 2021.

- 304 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). 14 retail pharmacy chains are also live. In the 18 months leading up to July 31, 2021, 18,499 prescribers and 1,243 facilities have actively used PDMP Integration.

- The PDMP Integration Steering Committee met on July 8, 2021. Topics of discussion included updates to the group's charter, PDMP Integration metrics, Q1 2021 progress on integrations, updates from Public Health PDMP staff, and new reporting functionality

Direct Secure Messaging Flat File Directory

OHA ended the Flat File Directory (FFD) service in August 2021. The FFD served as Oregon's address book for Direct secure messaging addresses since 2014. The purpose of the FFD was to enable participants to find or "discover" Direct addresses for providers outside their own organizations. In 2020, the Interoperability and Patient Access final rule from CMS established a requirement for providers to list and update their digital

contact information in the National Plan and Provider Enumeration System (NPPES) thus eliminating the need for OHA to provide the FFD.

Health IT Stakeholder Groups

Health IT Oversight Council (HITOC)

HITOC is tasked with setting goals and developing a strategic HIT 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.

Annual priorities: HITOC reported on 2020 progress and 2021 annual priorities at the February Oregon Health Policy Board (OHPB) retreat. Priorities include HIT needed to support COVID response and recovery, Strategic Plan Update work, and further work related to HIT and social determinants of health and health equity.

Strategic Plan Update: HITOC resumed Strategic Plan Update work in the summer of 2021 starting with a kick-off meeting at the August 5th HITOC meeting. In that meeting, HITOC discussed the proposed process for updating the Strategic Plan as well as primary topic areas.

The Strategic Plan Update will center equity in its recommendations and process, and focus on the HIT strategies needed to support health system transformation and achieve health equity, including prioritizing efforts that support Medicaid priorities (as identified in CCO 2.0, 1115 waiver renewal), legislative priorities (including demographic data collection of race, ethnicity, language, disability (REALD) and sexual orientation and gender identity (SOGI), behavioral health investments), and broader priorities identified in the State Health Improvement Plan. Areas HITOC will explore under the Strategic Plan Update include community information exchange (CIE), statewide HIE, patient access to data, EHRs, public health, and more. At the October HITOC meeting, HITOC began developing vision statement components for the Strategic Plan and approved the charter for a CIE workgroup*. Once drafted, the plan will be submitted to the Oregon Health Policy Board. Target date for completion is January 2023.

*Oregon state House Bill 3039 was considered this legislative session but was not passed. It would have directed HITOC to explore technology, funding, incentives, and policy options for statewide CIE, statewide HIE, patient access to data, and incentivizing EHR adoption. HITOC will consider exploring these areas under the Strategic Plan Update.

Health IT Advisory Group (HITAG)

The HIT Advisory Group (HITAG) provides input to OHA about CCOs' HIT needs and efforts and informs OHA's work on the Oregon HIT Program. Each CCO designates a representative to attend HITAG meetings.

OHA works with HITAG to:

- Gather input on ongoing HIT efforts so that OHA's work supports and aligns with CCOs' efforts and provides some accountability back to CCOs
- Raise awareness of OHA's HIT efforts and progress to inform CCOs as they plan their own technology efforts

- Identify challenges and opportunities from CCO perspectives to inform OHA's planning for HIT efforts
- Provide a forum for CCOs to learn from each other and from presenters sharing information of value to CCOs

In August 2021, the HITAG convened to discuss opportunities in 2021/2022, CCO Updated HIT Roadmap requirements, the 2021 legislative session and the HITOC Strategic Plan Update. CCOs provided OHA with input on how OHA could further support and prioritize health IT efforts moving forward.

CMS Interoperability Final Rule

On May 1, 2020, CMS published the Interoperability and Patient Access Final Rule. To support the implementation of the rule, partnering with the HIT Commons OHA has hosted meetings for a Payer Interoperability Collaborative for CCOs, DCOs, and Medicare Advantage plans to focus on alignment and implementation of the CMS Interoperability and Patient Access Rules. The most recent September meeting focused on the payer-to-payer data exchange requirements and possible implementation paths.

HIE Onboarding Program

Oregon's HIE Onboarding Program launched in January 2019 and concluded September 30, 2021 with the sunsetting of federal funding. The Program leveraged significant federal funding to increase Medicaid providers' capability to exchange health information by supporting the initial costs of connecting (onboarding) priority Medicaid providers to community-based HIEs. Priority Medicaid providers included behavioral health, oral health, and critical physical health. Reliance eHealth Collaborative was selected as the HIE vendor.

By the end of the Program, over $2.4 million had been spent onboarding 73 entities, including 12 behavioral health practices, 4 oral health clinics, 50 critical physical health entities, and 7 major trading partners (hospital/health system/major referral center) across seven CCOs and 13 counties. Between July 2021 and September 2021, a total of 14 entities completed onboarding.

Community Information Exchange (CIE)

CIE is a network of healthcare and human/social service partners using a technology platform with functions such as a shared resource directory, "closed loop" referrals, reporting, social needs screening, and other features to electronically connect people to social services and supports. CIEs are developing rapidly across the state with two main CIE vendors: Aunt Bertha and Connect Oregon (powered by Unite Us). To learn more, see the OHA CIE webpage.

OHA presented to HITOC in August of 2021 to discuss the need for a CIE workgroup to explore statewide strategies. At HITOC's direction, OHA developed a draft CIE workgroup charter after interviewing stakeholders and working with a HITOC liaison. The draft CIE workgroup charter is to be presented to HITOC at their October 2021 meeting.

H. Metrics development

1. Kindergarten Readiness

This developmental work comprises a 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.

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 July 2021 the Metrics & Scoring Committee voted to add the third component of the four-part measurement strategy (a CCO-level measure to improve the social-emotional health of young children) to the 2022 CCO Quality Incentive Program. In September, the Committee further voted to include the three kindergarten readiness measures that have been developed thus far in the Challenge Pool, potentially worth additional quality incentive payments if CCOs achieve these measures.

During the last quarter the partnership team of Children's Institute, OPIP, and OHA worked on making final updates to the specifications for the social-emotional health measure. This will continue into the next quarter. In addition, OHA's Transformation Center began work on a technical assistance plan related to the social-emotional health measure. This included conducting two needs assessments calls with CCOs.

2. SDOH/Health-related Social Needs Measure

The draft measure was pilot tested over the summer. Between July and September, the OHA team and consultants reviewed the measure and results of the pilot with interested parties and Tribes. Discussions of the measure took place at these meetings: July 22 CCO Metrics TAG, September 10 Tribal Advisory Council, and September 22 Medicaid Advisory Council. In addition, OHA sought further input from the Integrated Care for Kids (InCK) team and the Oregon Primary Care Association. The pilot test and additional input will be incorporated into the measure specifications over the fall. This will be followed by presentation and consideration of the finalized metric by the Health Plan Quality and Metrics & Scoring Committees.

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. In response, extensive measure development occurred in a workgroup with members including Oregon Health Authority staff from the Public Health Division and the Health Policy and Analytics Division, and CCO and Local Public Health representatives.

The Metrics and Scoring Committee, after much discussion, ultimately did not select the measure the workgroup developed. Since then, Public Health Division staff have engaged with community groups about equity-centered revisions to the measure. However, further work on this measure continues to be delayed by other priorities, particularly COVID response.

I. Budget neutrality

There are currently no system/issues with financial accounting, budget neutrality, or CMS-64 reporting during this reporting period.

J. Legislative activities

No significant activities during this reporting period.

K. Litigation status

Family Care v. OHA

A former coordinated care organization (CCO), FamilyCare, has filed a lawsuit making the following claims against OHA and its former Director: a federal civil rights claim against the former Director; breach of a settlement agreement between OHA and the CCO; and breach of OHA and the CCO's contract governing the CCO's participation in the Oregon Health Plan. The case is set for trial beginning on April 25, 2022.

Bay Area Hospital v. Oregon Health Authority

In December of 2019, Bay Area Hospital, formed by a health district, filed an administrative appeal to challenge a supplemental assessment on hospitals to support the Oregon Health Plan. According to the request for hearing, the supplemental assessment constitutes a tax that may not be imposed on hospitals created by health districts absent an affirmative legislative declaration. Hospital sought refund with interest. A final order denying the hospital's appeal was issued July 30, 2020. Hospital has petitioned for review in the Oregon Court of Appeals, and oral argument is expected November 18, 2021.

Connecticut v. Generic Drug Manufacturers and Wisconsin v. Indivior

These are multi-state antitrust suits that include the State of Oregon in its enforcement capacity (not the agency specifically). Among other claims, the suits allege pharmaceutical manufacturers illegally colluded to raise prices on certain drugs. There is potential for recovery for the agency for purchases/reimbursements of the drugs at issue; the State is working with the agencies to collect the applicable data.

Sarepta Therapeutics Inc. v. OHA

This is a petition for judicial review of the agency's prior authorization criteria that are the rule for determination for Oregon Health Plan coverage of the prescription medication Exondys 51.

The parties submitted briefs regarding the validity of the prior authorization criteria, and the case was argued before the Oregon Court of Appeals on March 12, 2021. A decision by the court is presently pending.

Cal. et. al v. Azar.

Oregon is a co-plaintiff in litigation challenging CMS's Rule revision which removed the ability of the state Medicaid agency to deduct union dues and other voluntary deductions such as health insurance premiums from the providers' payment for services and direct those moneys to third parties. A recent NPRM effectively reverses CMS's Rule revision, which has been enjoined in *California et al. v. Azar*, 501 F.Supp.3d 830 (N.D. Cal. 2020).

L. Public forums

Health Evidence Review Commission

August 12, 2021

This testimony concerned coverage of PET scans for breast cancer.

Ms. Holli Thomas offered testimony about PET scans. She said she has metastatic breast cancer that is now in remission. Ms. Thomas reports that she recently was able to have a PET scan paid for and will need another scan at some point. She pointed out that she had no tumors so her lymph nodes were not enlarged; there was nothing a CT or MRI would show. However, the PET scan showed cancer in one of the lymph nodes under her left arm. She said that the PET scan saved her life.

This testimony concerned electrolysis for transgender services.

Ms. Petra Wilson stated she is a transgender woman with OHP health insurance. She urged the Commission to consider the World Professional Association for Transgender Health (WPATH) letter about electrolysis published on July 15, 2016. That letter was written by Dr. Jamison Green who, at the time, was the immediate past-president and chair of the WPATH Ethics Committee.

HERC Value-based Benefits Subcommittee

August 12, 2021

This testimony concerned breast cancer index.

Max Salganik, Associate Director of Medical Affairs for Biotheranostics, testified that the breast cancer index's (BCI's) role is to inform extended endocrine therapy. He agreed with including both node negative and node positive patients based on NCCN recommendations. All of their studies have had a mix of node negative and positive patients. BCI could be used for identifying very low risk patients who could avoid chemotherapy, but he was not requesting coverage for such an indication.

This testimony concerned PET scans in breast cancer.

Ms. Holli Thomas said she is a breast cancer patient and expressed her support for the newly revised proposed guideline. She questioned the use of the word "tumor" in the staff recommended guideline but agreed with the general staff recommended changes.

This testimony concerned Cologuard.

Leslie Dennis, Quality Director for Adventist Health: Ms. Dennis testified about Cologuard as an option for colorectal cancer screening. Hawaii and California Medicaid cover this test, but not Oregon

Medicaid. Adventist is requesting inclusion of all options to increase CRC screening. During the pandemic, she said Adventist has had a high return rate of mailed Cologuard tests and are increasing their colorectal cancer screening rates. She also said they were using Cologuard to reduce the number of colonoscopies that can be done due to COVID-19. Dennis noted that Adventist is seeing a higher return rate for Cologuard as compared to FIT. Cologuard also has a 3-year testing interval rather than a 1-year interval of FIT. Cologuard has an outreach program which is why she feels there is an increased return rate.

Melissa Wood, Exact Sciences, testified that patient follow up and adherence is more challenging in the Medicaid population compared to other populations. However, Cologuard has seen a greater than 50% return rate nationwide in Medicaid populations. She said that flex sigmoidoscopy is not being used anymore. FIT has low return rate, which gets lower over each year in the 10-year screening cycle. Cologuard is 92% sensitive for early stage cancer. Cologuard has no longitudinal data on reducing CDC incidence or mortality. In Oregon, the only patients not covered for Cologuard are underserved patients.

This testimony concerned smoking cessation and elective surgery.

Tamara Fountain, ophthalmologist in Chicago and President of the American Academy of Ophthalmology (AAO), requested coverage of cataract surgery regardless of smoking status. Cataracts can lead to blindness and surgery is the only definitive treatment for cataracts. The AAO supports the HERC staff recommendation. There is no evidence that smoking status impacts cataract surgery outcomes. Current guidelines do not address smoking cessation prior to this surgery. The Centers for Medicare and Medicaid Services (CMS) local coverage determination does not include any smoking cessation prior to cataract surgery.

Nisha Nagarkatti-Gude, ophthalmologist in Portland, board member of the Oregon Academy of Ophthalmology, agreed with the staff recommendation to exclude cataract and other bloodless surgeries. Cataract surgery is not always elective. Cataracts affect ability to drive, work, take medication, or perform other activities of life. Unlike other surgeries, cataract surgery does not have the risks of many complications. It involves a very small incision and no sutures. No adverse events have been seen in healing with smoking. Active smoking status and use of anesthesia is a concern, but most patients have little to no anesthesia for cataract surgery.

This testimony concerned rhinoplasty and septoplasty.

Dr. Richard Kohl testified regarding lack of coverage for deviated septum repair for his daughter, who is an OHP patient. He discussed the impact of deviated septum on her physical and mental health. Staff offered to conduct research to see whether a change to the List may be appropriate and offered to connect him with appropriate resources to deal with individual circumstances.

This testimony concerned electrolysis for transgender services.

Ms. Petra Wilson testified she was a transgender woman on the Oregon Health Plan who is requesting coverage for electrolysis for facial hair. The current exceptions process requires severe psychosocial comorbidities for coverage of facial feminization, which acts as an inducement to present that kind of behavior in order to receive care. Ms. Wilson requested clarification of when electrolysis is covered around surgical sites and stated that it should be covered for the top of breasts and between the breasts as well as for facial hair. Does this include around the surgical site or just at the incision? She cited a 2016 statement from the World Professional

Association of Transgender Health (WPATH) which says that the WPATH 7.0 guideline intended to recommend electrolysis for facial hair as medically necessary.

HERC Evidence-based Guidelines Subcommittee

September 9, 2021

This testimony concerned high-frequency chest wall oscillation devices.

Joey Razzano introduced herself as the Oregon representative for the International Rett Sydrome Foundation and said she is speaking on behalf of the Northwest Rett Syndrome Association. She disclosed that she is employed by the Oregon Health Authority but is speaking on behalf of her developmentally disabled daughter. She said that studies for conditions such as Rett Syndrome will always be too small to be considered for these kinds of policy decisions. She described her personal experience of intensive hospital care every winter and how "vest therapy" can be a cost-effective alternative to emergency room use. Manual chest physiotherapy is not effective or safe for someone who is as medically complex as her daughter. She asked the subcommittee to expand the coverage recommendation to include conditions such as her daughter's.

Gary Hansen, Director of Scientific Affairs for RespirTech (manufacturer of devices), thanked the subcommittee for their thorough review of the evidence that was submitted by RespirTech. He is disappointed with the narrowness of the criteria and said he is hopeful that the subcommittee will be open to accepting future evidence that RespirTech is working to produce.

Shani Noel, Director of Market Access for Hillrom (manufacturer of devices, began her testimony by discussing her employer's recent publication of the budget impact of the vest for managing airway clearance in patients with complex neurological disorders. She presented the Hillrom study findings, disclosing that she is a co-author, and said that there were significant cost reductions associated with high-frequency chest wall oscillation. The cost analysis also demonstrates that use of this device is cost effective for patients with complex neurological disease.

This testimony concerned PANDAS/PANS/pediatric autoimmune encephalitis.

Kym McCornack, outreach coordinator for Northwest PANDAS PANS Network, ceded her time to Dr. Dritan Agalliu.

Dritan Agalliu, Columbia University Associate Professor in the Department of Neurology, began his testimony by questioning the expertise and literature that was used to inform the report and presentation. He said he has worked in PANDAS and PANS for 10 years and many of his studies are not cited or discussed and described two of his group's basic science papers. He has mice models that study the mechanisms of these diseases and that strep infections elicit an immune response that targets the brain, which can lead to neuropsychiatric symptoms. He described other studies that are under review that show that PANS patients have a cytokine profile in their blood indicative of inflammation. He said these children have abnormal immunity and that azithromycin reduces obsessive compulsiveness in these children, as does cognitive therapy.

Sarah Lemley, Director of the Northwest PANDAS PANS Network began her testimony by describing her 12-year old daughter who has PANDAS and whose condition was reversed by azithromycin and steroids. Lemley stated that in 2019, a house bill was passed to promote awareness for PANDAS/PANS and the declaration

stated that treatments may include antibiotics, steroids, IVIG, therapy, and other modalities as needed. Lemley said this report dismisses work done by NIMH and the legislative work in other states. She said adopting this guidance would be irresponsible for Oregon children and that expertise from national experts and bodies are needed.

Deborah Miller described her 12-year old son who has not been able to get treatment for his PANDAS condition. She said he is a victim of the broken health care system because he does not have access to the treatments he requires. The IVIG treatment that has been recommended for him is every 4 to 6 weeks at a cost of $50,000. She urged the subcommittee to make treatments accessible for children like her son.

Meggan Bennett described her 11-year old son with PANDAS, saying he is receiving social security benefits because of his symptoms. He has not improved on antibiotics, steroids, or tonsillectomy and is unable to take psychiatric medication. His pediatrician has recommended IVIG but her family is unable to afford the treatment. She described her son before he got sick and how their family has been experiencing this since he was 6 years old. She pays out of pocket for many treatments that insurance doesn't cover, including hyperbaric infusions and supplements.

Jennifer Matson described how her 14-year old son was diagnosed with PANDAS when was 12, developing psychiatric and compulsive symptoms. Physicians in the hospital would not consider a PANDAS diagnosis so she sought a Chicago pediatrician who treated many PANDAS and PANS children. Her son had his tonsils and adenoids removed and her employer paid for IVIG treatments. Today, her son is free of PANDAS symptoms. She said that her insurance company paid over $30,000 to acutely hospitalize her son but the IVIG only cost $12,000. His medical care has been about $1,200 per year since he received IVIG.

Paul Ryan, President of PACE Foundation discussed the national standard of care for PANDAS and PANS, presenting a slide of a map that showed national locations of centers of excellence across the country, some of which were created with assistance from the NIMH. The standard of care includes the treatments that are under consideration in the draft coverage guidance report. Eight states have authorized insurance coverage for such medical treatments. The subcommittee should join the recent legislative expansions by recommending these treatments, as any other decision would deny Oregon families the same treatment protocols that are available elsewhere.

Rachel Prusak, Oregon House Representative introduced herself and stated she is the Chair of the House Healthcare Committee as well as a family nurse practitioner. She supports evidence-based decisions regarding PANDAS and PANS treatment. After working with advocates on this issue and hopes that the subcommittee can consider this discussion more broadly than just the evidence. During legislative session, she was looking forward to HERC's deliberation of this topic. She said that while side effects exist for any of these treatments, that practitioners must weigh the risk and benefit of such interventions. She concluded by stating it is vital to increase access to care for Oregon families who experience these conditions.

Diana Pohlman, Director of PANDAS Network, founded the network in 2009 because of her two children who had PANDAS at the age of 7. Repeated strep infections led her to discover PANDAS and the IVIG protocol and within one year of treatment, her son was fine and is now a young adult and successful. Her daughter also recovered in a relatively short amount of time. She didn't understand a lot of the research presented today but hopes that the conversation can be broader than just the evidence. She has spoken to thousands of families over 14 years, and IVIG is important to families.

Medicaid Advisory Committee

The Medicaid Advisory Committee is a federally mandated body that advises the State Medicaid Director and the Oregon Health Policy Board on the policies, procedures, and operation of Oregon's Medicaid program through a consumer and community lens. The MAC met one time between 7/1/21 and 9/30/21; details of public comment along with agenda topics are summarized below.

September 22, 2021 Meeting:

The committee received the following public comments:

1. Beth Englander from the Oregon Law Center shared concerns about how health-related services (HRS) are run in general. Beth stated that there is a lack of fairness across the state in how people can access flexible services (Beth clarified that her comments are related to flexible services, which are HRS for individual needs). It is difficult for individuals to find out what flexible services exist. Some members also do not know how to request them and if they get denied, there is no recourse for OHP members to challenge the decision. An example of this is a person with congestive heart failure being denied an air conditioner even though they live in an area that gets very hot. There is also no data on how many requests come in for flexible services to each CCO, how many are rejected and the reasons why requests are rejected.

2. Heather Jefferis, Executive Director of the Oregon Council for Behavioral Health expressed her thanks for the analysis of the behavioral health sector. Heather also asked what the roadmap is to integrate the recommendations into the waiver.

Committee members discussed the following topics:

- 1115 Waiver Interim Evaluation Findings
- CCO 2.0 Updates & OHA Agency Updates
- DHS Agency Updates
- 1115 Waiver Renewal
- SDOH Screening Measure
- Ombuds Program Quarterly Report
- Consumer Voice Subcommittee Report and Recommendations

Metrics and Scoring Committee

July 16, 2021

Written public comment is available on the MSC webpage and includes the following:

- Representative Andrea Salinas, Representative Rachel Prusak, Representative Rob Nosse, Representative Tawna Sanchez, Senator Kate Lieber, and Senator Deb Patterson of the Oregon Legislature provided joint public comment in support of continuing to include the (1) emergency department utilization for members with mental illness and (2) cigarette smoking prevalence measures in the CCO Quality Incentive Program.
- Jennifer Little, Director - Klamath County Public Health, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

- Glenn Gailis, MD, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Ralph Eccles, DO, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Jessica Guernsey, Public Health Director - Multnomah County Health Department, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Margo Lalich, Interim Public Health Director - Clatsop County Department of Public Health, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Julia Hesse, Health Promotion Specialist – Clatsop County Department of Public Health, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Merritt Driscoll, Executive Director – Blue Zones Project-Healthy Klamath, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Karen Ard, Tobacco Prevention and Education Program Coordinator – Deschutes County Health Services, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Donna Mills, Executive Director, Central Oregon Health Council, provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Armando Jimenez, Program Manager Tobacco Prevention & Education Program - Clackamas County Public Health Division provided written comment in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.
- Elena Rivera, Senior Health Policy and Program Advisor - Children's Institute, and Colleen Reuland, Director - Oregon Pediatric Improvement Partnership, provided a joint letter in support of the social-emotional health measure that is part of the multi-3 year multi-measure health aspects of kindergarten readiness measurement strategy previously endorsed by MSC.
- Melinda Davis, Associate Director - Oregon Rural Practice-based Research Network and Associate Professor, OHSU Department of Family Medicine & School of Public Health; John Muench, Professor – OHSU Department of Family Medicine & School of Public Health; Nancy Elder, Director - Oregon Rural Practice-based Research Network and Professor – OHSU Family Medicine; Brigit Adamus Hatch, Assistant Professor – OHSU Department of Family Medicine; Susan Lowe, Patient Advisor/Advocate - ANTECEDENT Advisory Board Member; Kyle Higgins, Behavioral Health Consultant, - South Waterfront Family Medicine Clinic OHSU; and, Josh Haynes, Vice President - Cresa Patient Advisor/Advocate ANTECEDENT Advisory Board provided joint letters in support of continuing to

include the screening, brief intervention, & referral to treatment measure in the CCO Quality Incentive Program.

- Jay Rosenbloom, MD, Resa Bradeen, MD, Deborah Rumsey, Executive Director and Julie Harris, Director of Population Health (Children's Health Alliance and Children's Health Foundation) provided testimony on the pandemic and impact on benchmarks set for the program.

In addition to the written public comment above, MSC also heard oral comment as below:

• Melinda Davis, Associate Director - Oregon Rural Practice-based Research Network spoke to written testimony in support of continuing to include the screening, brief intervention, & referral to treatment measure in the CCO Quality Incentive Program.

• Jennifer Little, Director, Public Health, Klamath Public Health, spoke to written testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

• Glenn Gailis, MD, family physician in Klamath Falls, spoke to written testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

• Julie Harris, Director of Population Health - Children's Health Alliance, spoke to submitted written testimony and encouraged MSC to extend benchmark reconsideration factors into the decisions regarding targets for childhood immunization status and immunizations for adolescents measures in the future.

• James McCormack – OHSU, provided testimony in support of continuing to include the screening, brief intervention, & referral to treatment measure in the CCO Quality Incentive Program.

• Jessica Guernsey, Public Health Director - Multnomah County Health Department, spoke to written testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

• Michelle Glass, Policy & Advocacy Coordinator - SO Health-E (Southern Oregon Regional Health Equity Coalition), provided testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

• Miriam Herrmann, Manager, Strategic Provider Partnerships – Trillium CCO, provided testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

• Jacqueline Moreno – Lane County Public Health, provided testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

• Nadia LeMay, Tobacco Prevention & Education Coordinator – Crook County Health Department, provided testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

• Rebecca Pearson, Vice-chair - Jackson County Community Advisory Council for AllCare CCO and Rogue Action Center, provided testimony in support of continuing to include the cigarette smoking prevalence measure in the CCO Quality Incentive Program.

August 20, 2021

Written public comment is available on the MSC webpage and includes the following:

• Tara Jegtvig, Director of Finance & Human Resources, Northwest Medical Homes, LLC, regarding 2021 benchmarks and requesting pay-for-reporting

• April Hansey, Clinic Administrator, South Hilyard Clinic regarding 2021 benchmarks and requesting pay-for-reporting

• Megan Fields, Administrator, River Road Medical Group, regarding 2021 benchmarks and requesting pay-for-reporting

• David Huntley, Epidemiologist, supporting continuation of the Cigarette Smoking Prevalence measure in the program (pertinent to last meeting)

In addition to the written public comment above, MSC also heard oral comment from the following:

• Julie Harris, Children's Health Alliance, regarding preventative care in primary care setting

September 17, 2021

Written public comment is available on the MSC webpage and includes the following:

- Cat Livingston, MD, MPH Medical Director Health Share of Oregon, in support of majority of changes proposed to the 2021 benchmarks and also to postpone 2022/2023 benchmarks.
- Marshall Greene, M.S. Director of Value Improvement, Mosaic Medical, supporting a "pay-for reporting" approach for 2021 reporting.
- Andrew Luther, MD Jennifer Lind Medical Director, Jackson Care Connect CEO, Jackson Care Connect regarding 2021 benchmarks
- Children's Health Alliance and Children's Health Foundation regarding 2021 benchmarks and challenge pool measure pool selection
- Central Oregon Health Council's Operations Quality Incentive Measure (QIM) Workgroup regarding 2021 benchmarks.
- Avery T. Horton, Jr. Citizen, Voter, Taxpayer, regarding correct dosages at pharmacy and quality checks.
- Erin Fair Taylor, Vice President of Medicaid Programs, PacificSource Community Solutions regarding the 2021 benchmarks.
- Advantage Dental, Capitol Dental, CareOregon Dental, ODS, Willamette Dental Group regarding the 2021 benchmarks.

In addition to the written public comment above, MSC also heard oral comment from the following:

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

HPQMC

July 27, 2021

There was no public comment for this meeting.

August 24, 2021

This meeting was cancelled.

September 24, 2021

There was no public comment for 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

As of September 30, 629 primary care practices were recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Eighty-six PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model.

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 12 virtual site visits this quarter. Site visits include verification that the practices is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address barriers.

The PCPCH program recently launched a health equity initiative to ensure the program supports a primary care system that addresses community-identified needs, especially the needs of those who experience systemic racism, barriers in accessing care, and health inequities. From March 2021 through July 2021, the PCPCH program conducted listening sessions with over 40 community-based organizations, primary care practices and those experiencing health inequities. These learnings will inform the next iteration of the PCPCH standards.

Certified Community Behavioral Health Clinics

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 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 SHO #16-002 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. As of November 2021, seven tribes participate in the 100% FMAP Savings and Reinvestment Program.

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 28,000 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 fourth year.

In July 2021, OHA received approval of a State Plan Amendment to allow tribes and the urban Indian health program to form Indian Managed Care Entities (IMCEs). OHA is currently in contract discussions with the IMCEs and is conducting and documenting IMCE readiness reviews before operations will begin. Once operations start, these IMCEs will provide tribal care coordination services to approximately 15,000 of the 20,000 fee for service AI/AN Oregon Health Plan members.

OHA is working to update our claims processing system to automate State Plan Amendment OR 21-0001, which supports tribal care coordination by recognizing up to five billable encounters per day for services received at an Indian Health Service or Tribal 638 health clinic.

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 continue discussion from last quarter to finalize data documents summarizing quality, cost and utilization across commercial and Medicaid payers for 2019. The payers also debriefed the July practice learning session.

Value-Based Payment Innovations and Technical Assistance

The Transformation Center produced two additional webinars for CCOs, one focused on VBPs to address substance use disorder and another addressing performance benchmarks for VBP models. Evaluations for 2021 TA webinars to date shows that 89.2 percent of respondents rated the TA valuable or very valuable and 95.5 percent of respondents planned to take an action as a result of the TA.

TC staff reviewed and evaluated CCOs' health information technology (HIT) for VBP submissions within their required HIT Roadmap reporting. CCO's provided details on current state and future planning for health IT for VBP and population management as well as planning for HIT tools and workforce support.

TC staff refined required VBP reporting processes in contract as well as ongoing monitoring and evaluation. The Phase 2 CCO VBP roadmap evaluation plan was developed with OHSU's Center for Health Systems Effectiveness, and contracted work will begin early next quarter.

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 47 signatories, covering 73 percent of the people in Oregon. Signatories include commercial, Medicaid and Medicare Advantage payers.

The VBP Compact Work Group, charged with ensuring the Oregon VBP Compact is successfully implemented, met monthly during the last quarter. The work group selected chairs and added three new members with equity and safety net health care expertise. The work group learned about provider perspectives on VBP from a recent survey and focus groups, identified barriers to implementing the Compact and began discussing strategies to address the barriers.

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's Implementation and Technical Assistance Workgroup met in July and September to learn about activities the Patient-Centered Primary Care Home Program is taking to address equity, identify payment models for sustainably supporting traditional health workers to recommend for consideration by the collaborative, and identify recommendations for the collaborative to coordinate with and influence the work of the Value-based Payment Compact Workgroup. The collaborative will meet in October to discuss the work group recommendations.

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

Statewide Performance Improvement Project

Coordinated Care Organizations went through an External Quality Review validation for the design state in September 2021. That report is not yet final but will be included in future reporting.

Roadmap to Oral Health

In July, OHA welcomed its new dental director, Kaz Rafia, DDS MBA. Dr. Rafia joins OHA with a combined 25 years of experience spanning international non-profit work at Partnership for International Medical Access-Northwest, academics at OHSU, private practice, and leadership at Permanente Dental Associates. Dr. Rafia is a graduate of the Ohio State University College of Dentistry, OHSU hospital dental residency, and the MBA program at University of Illinois. He will earn his MPH from Johns Hopkins University in early 2022.

During this time period, OHA also joined 13 other states as part of CMS's Advancing Prevention and Reducing Childhood Caries in Medicaid and CHIP Affinity Group. Eleven of Oregon's coordinated care organizations (CCOs) as well as a number of dental care organizations (DCOs), local public health offices and a tribal clinic have joined us in this effort. A spike in COVID-19 cases has led OHA to put the project on hold with a commitment to restarting in January 2022. The project's aim is to reduce childhood caries by spreading the practice of having primary care providers apply topical fluoride varnish as part of well child visits. Additionally, the project seeks to improve referrals to dental homes.

The OHA Public Health Division's Oral Health Unit conducted an annual Clinical Training for school dental sealant programs on August 6, 12 & 26, 2021. Technical assistance was provided to dental hygienists and assistants around infection prevention and control during COVID-19, CCO incentive metrics for 2021 and 2022, and health equity approaches to school dental sealant programs. Most of the children they serve are covered by Medicaid.

The OHA Public Health Division's Oral Health Unit convened a rules advisory committee (RAC) from August 26 through October 7, 2021 to amend the certification rules for school dental sealant programs (Oregon Administrative Rules 333-028-0300 through 333-028-0350). In response to the COVID-19 pandemic, the certification rules for school dental sealant programs must be modified to incorporate specific guidelines to safely provide dental sealant services in the school setting. Permanent amended rules should be effective in January 2022.

Beginning in July of 2021, OHA's Primary Care Office began discussions with Capitol Dental, Oregon's largest dental contractor, on partnering to expand their teledentistry program. The project is focused on integrating oral health services into a behavioral health facility located in the underserved coastal town of Brookings, Oregon, which currently has a dental HPSA score of 17. OHA has allocated funds from their HRSA Oral Health

Workforce Grant to procure teledentistry equipment and provide recruitment incentives to the providers who will staff the project. OHA hopes to use the framework from this project to bring oral health services into other Oregon communities that lack the basic infrastructure to support a traditional brick and mortar dental clinic.

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

Sustainable Relationships for Community Health program

Activities: Sustainable Relationships for Community Health (SRCH) is a grant funded opportunity for clinical and community partners to address 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.

The final reporting period from FY20-21 illustrated that the SRCH teams with the most momentum and success were implementing projects focused on diabetes prevention and/or management. The successes and learning from the SRCH teams led OHA-HPCDP to direct this fiscal year's funding for SRCH toward a sub-set of the teams implementing diabetes prevention and management projects, further focusing the funding opportunity. Five (5) of the SRCH teams will receive funding and technical assistance from OHA-HPCPD from July 1, 2021 to June 30, 2022.

During Q1, the five (5) SRCH teams continued work on diabetes prevention and self-management. The project strategies include local health systems and community partners implementing a plan for Traditional Health Workers to support diabetes prevention and self-management and expanding systems, infrastructure, and programming across a tri-county area for diabetes prevention (National DPP). OHA-HPCDP and contractors provide technical assistance to support innovations in chronic disease disparities prevention and management to SRCH teams per their request. The technical assistance includes: practice facilitation from Comagine Health for workflow development, EHR and other tool development and support for general collaborative/partner development and facilitation as well as support from OHA-HPCDP surveillance and evaluation staff for planning and implementation of evaluation activities.

Progress and Findings:

Following are some examples of what teams have continued working on with the flexible SRCH funding opportunity, training, and technical assistance to prevent and address diabetes prevention and management.

The Confederated Tribes of Siletz Indians (CTSI) 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 pilot is scheduled to launch in November 2021. Additionally, the CTSI SRCH team is complementing this ongoing work with activities that support tribal based practices and social determinants of health for CTSI. This work includes addressing food access, physical activity options, traditional medicine, and trauma informed care and healing.

The Central Oregon SRCH Team is building off last year's successes which included Deschutes County executing an Umbrella Hub agreement with Crook County for delivery and billing for the National DPP and transitioning to a new Welld platform for data management and billing. With Welld platform live and the Umbrella Hub agreement established, the Central Oregon SRCH Team is expanding capacity for delivering Chronic Disease Self-Management Programs (CDSMP) and the National Diabetes Prevention Program (National DPP) in both English and Spanish, including billing private insurance, Medicare and the Oregon Health Plan. The project specifically aims to increase program access and reach to more rural, Latinx and underserved populations in the tri-county area through community engagement and work with community-based organizations.

The Tillamook SRCH team is implementing a Community Health Worker Framework, developed in partnership with clinics, health systems and community-based organizations to identify sustainable systems for CHWs to address chronic disease prevention and management. During Q1, they are working to identify early implementation locations, partnering with community-based organizations and other partners to develop clinic workflows and plan for CHW education. The goal of this work is to have a sustainable model for CHW work in medical and non-medical settings, increased referrals to and participation in National DPP, improvement in the health of people with Type 2 diabetes, and increased referrals addressing social determinants of health (SDOH) and social needs.

OHA-HPCDP partnered with and awarded SRCH funding to the Multnomah County REACH (Racial and Ethnic Approaches to Community Health) program. REACH is planning for National DPP delivery throughout the county with community-based organizations and clinical partners . The REACH program is also in collaboration with OHA-HPCDP and Comagine Health implementing a blood pressure self-monitoring initiative, Healthy Hearts Ambassador (HHA) program. During Q1, the REACH team and partners created a HHA pilot program launch and draft evaluation plan, defined all partner role/responsibilities, trained REACH team members as HHA lead trainers and began recruitment for a new REACH staff position which will coordinate HHA and DPP activities. OHA-HPCDP in coordination with Comagine Health conducted outreach to clinical and community partners and initiated planning to expand the HHA program beyond pilot phase.

Trends, Successes, or Issues:

In the last fiscal year, Rede Group conducted an evaluation of the SRCH model. This was a helpful first step for OHA-HPCDP to reexamine how the current SRCH model is meeting the needs of local and regional partners and also which aspects of the SRCH initiative are valuable in the current context of health systems transformation and public health modernization in Oregon. In particular, the evaluation revealed the need to focus future SRCH efforts on scaling, sustainability and transferability of the model so that grantees are not dependent on the small amount of discrete funding from OHA-HPCDP to maintain the needed systems and infrastructure for delivering National DPP and other CDSMPs. As the COVID-19 public health emergency evolves, OHA-HPCDP is assessing when and how best to adapt the SRCH model to support communities beyond the 2021-22 fiscal year.

Process Improvement (workflow) Technical Assistance

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

Public Health Modernization

With the Oregon Legislature's additional investment of $45 million in public health modernization for the 2021-23 biennium, Oregon is continuing and expanding its work to ensure a nimble, community-based and equity-centered public health system. This investment leverages changes to the public health workforce and system that have occurred throughout the COVID-19 pandemic, including by sustaining new investments into communities experiencing the greatest harm from COVID-19.

The majority of public health modernization funding is allocated to local public health authorities, federally-recognized tribes and community-based organizations. Funding supports public health interventions that are equitable, community-driven and address historical and contemporary injustices. Priorities in this biennium include communicable disease and environmental health threats planning and response; communicable disease prevention; and strategies to address impacts of climate change on health.

OHA continued implementation of Healthier Together Oregon, the State Health Improvement Plan. During this reporting period, the PartnerSHIP met three times; meeting outcomes included continued onboarding and learning about priorities and strategies of the plan, development of the charter, and identification of focus strategies for 2022.

In addition to the convening of the PartnerSHIP, OHA communicated about the plan through hosting of two HTO in action events; one focused on behavioral health and the other focused on housing and food. Over 200 participants attended to learn about the plan, hear about examples in action and contribute ideas via jamboard. OHA staff and PartnerSHIP members also facilitated discussion about HTO with faith communities across Oregon and shared monthly HTO updates with 7800+ subscribers via the listserve.

Innovator Agents

An Innovator Agent (IA) has been asked by the OHA Medicaid Director to lead work related to internal processes which contain delays for determining OHP eligibility and enrolling eligible individuals into the CCO in their area. There is currently a "gap" of several days-2 weeks where eligible individuals are in an open card/FFS status in our state process. That gap is a barrier for members to receive care and for CCOs to be able to reach out to support that member in addressing needs. Convening the right OHA and ODHS leaders and assuring leadership support to request the resources necessary to accomplish this change will help those on OHP access needed services more quickly. This connects to both the implementation of Cover All People (effective July 1, 2022) and the proposals in our 1115 CMS Waiver.

Work continued and participated with the Communications Team of the COVID Recovery and Response Unit (CRRU) to inform product development and assure distribution of communication materials to other Innovator Agents/CCOs and other partners.

Locally, an IA continued to participate with COVID-Response partners at the LHJ and community level. Recently she was able to provide a group of 5 school district administrators and school nurses in one county with timely information and strategies around childhood COVID vaccine best practices to assist with planning for the 5-11-year-old vaccine rollout. She participated in and contributed to a Vaccination Strategy workgroup hosted by one of her CCOs with the delivery network and LPHA on a monthly basis.

An IA has worked over this past quarter with the OHA PH Division Immunization Section to resolve some information gaps/inaccuracies in the information that CCOs were receiving about childhood vaccinations. The IA began that work as an advocate for one of her CCOs, but in the process of quality

improvement, it was determined that the data glitch was affecting data for all CCOs. The problem was able to be corrected and updated accurate data then distributed to all CCOs.

An IA worked with the OHA PH Division Immunization Section to identify solutions for missing COVID-19 Vaccination data on residents in a border county in Oregon who may have been vaccinated in Washington State. In doing so, the IA was able to support larger conversations between states about Immunization Data Registry interoperability/file transfers and encourage a national solution to this challenge for those who travel across state lines for clinical services which involve administration of any vaccination.

An IA served in an advisory capacity with an initiative proposed by the Portland Fire Department to create a pre-transport response system called the Community Health Assessment and Response Team or CHART. Care Oregon recently awarded a grant to Portland Fire and CHART for implementation. Projections include significant savings to Medicaid and CCOs by CHART responding to non-urgent 911 calls. The CHART team has the skills, training, and supervision to do appropriate assessment of an individual and providing some care/case management and SDOH supports instead of transporting unnecessarily to an ED/hospital setting.

An IA meets monthly with the Executive Leadership of each of my 4 CCOs. IAs participate in monthly or bi-monthly Clinical and Quality Advisory Panels with 2 CCOs. I present monthly in 7 CAC meetings at the community level of the 7 counties of my 4 CCOs. These presentations focus on COVID updates for their county/region, broader COVID information at the state and national level, and information about developments in OHA or in partnering systems (i.e. increases in SNAP benefits, increases in Employment Related Day Care supports, rental assistance during the pandemic, etc.).

IAs participated on the Telehealth workgroups that are engaging community members, advocates and those who do not speak English as a primary language to develop culturally and linguistically appropriate services for Oregon Health Plan members to access primary care and behavioral health (including substance use disorder) services. Telehealth services provide a more effective model of care during the current pandemic for those who chose to ensure their personal safety by not exposing themselves to people who could be ill at provider offices. Telehealth services are also proving to be helpful for those in rural communities that find it difficult to come into an urban center for routine care and would prefer to stay closer to home. Anyone who has been exposed to COVID and needs to isolate has also found the options of telehealth services to be helpful in their recovery, should their symptoms be manageable at their home.

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, 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.

IAs acted as quasi local experts in the communities where the CCO they work with are located. They used relationships to connect OHA, local community organizations, and the CCO's they work with and ensure coordination across these groups. They helped good news travel faster by sharing innovation and successful

practices with other CCO's with the OHA, and with national audiences. They played a key role in leading OHA's strategic priority of eliminating health inequalities by taking this statewide priority and worked with CCO's and local communities to translate statewide priorities to local adaptation and implementation. In particular they elevated and ensured that communities in Oregon who face health inequalities because of their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances are engaged in CCO and community health work.

IAs ensured safety and health equity across the state of Oregon. 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.

IAs 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.

IAs 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 and worked 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.

An IA continued to ensure collaboration between LPHAs and the CCOs on COVID and would add Flu shots as Flu season has arrived. The telegraphy services continue to be a large part of this work with ensuring access, including those in more rural parts of the state.

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 completed a final assessment of the 2020 CCO-reported HRS spending to determine if spending met HRS criteria. In 2019 OHA accepted $16,163,747 of CCO HRS spending as meeting HRS criteria, which more than doubled to $34,153,552 in 2020. This represents an improved acceptance rate of 87% of all reported CCO HRS spending in 2020 compared to 62% for 2019 spending. The spending also represents increases in per member per (PMPM) month HRS spending ($1.51 PMPM in 2019 and $2.93 PMPM in 2020) and percent of total CCO spending (0.36% in 2019 and 0.70% in 2020). The final analysis and summary of 2020 HRS spending will be released in November 2021.

To improve future use of and support potential increases to HRS spending, staff contracted with the Oregon Rural Practice-based Research Network (ORPRN) to hold a webinar for CCOs focused on CCO HRS policies and procedures. The webinar recording is available here: https://us02web.zoom.us/rec/share/Y5Qd1Sf5QFqDM5T4mlg99rhmA946qX6RD_EXPGeAXIbhyRNNbMzXlho84z20maCv.or8jLdG7ktawBA5v?startTime=1630004122000. In addition to the ORPRN TA, HRS team members began hosting quarterly HRS office hours to allow CCO staff an open forum for various HRS-related questions. The first session was held in September.

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

In lieu of services

Starting in 2022, CCOs will be able to offer in-lieu-of-services (ILOS), which aim to address gaps for which HRS is not the appropriate mechanism. ILOS are services determined by the state to be medically appropriate and cost-effective substitutes for covered services or settings under the State Medicaid Plan. ILOS must meet requirements outlined in 42 CFR 438.3(e)(2). Coordinated care organizations (CCOs) are not required to offer ILOS to members. A member cannot be required to use the alternative service or setting. ILOS supports health system transformation through key services, such as the Diabetes Prevention Program and traditional health care workers and enables covered services to be provided in non-traditional settings.

The Transformation Center is supporting CCO ILOS guidance and technical assistance through a contract with ORPRN to provide webinars, guidance documents and direct CCO TA. The first webinar, an introduction to ILOS, was held in September and office hours are planned for October. The webinar recording is available here: https://us02web.zoom.us/rec/play/4aeQd4LIvO1dxHj0ogX8FKhT7YVDKs4QUTQXV1xoNOQM_NgdmMqysdpZ4qH0zbwI3ZwOW-cCqWa6UWNx.IfwqVFp8AwShuU6C?startTime=1631310854000&_x_zm_rtaid=VNgYrt4vSHKHoF_2J4gwrw.1633450693243.e9d24137a1960184ade1aeafed524925&_x_zm_rhtaid=305

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

Community Advisory Committee activities

The Transformation Center continued to host peer-to-peer meetings with community advisory council (CAC) CAC coordinators. Meeting topics this quarter included: Hybrid CAC meetings, Oregon Health Plan member material's review process, CAC Demographic Report submissions, and OHA Medicaid Advisory Committee consumer subcommittee recommendations. The center also completed review of the first annual CAC Demographic Report submissions and provided feedback to CCOs.

In addition, the center continued planning for a CAC member learning series focused on the social determinants of health and equity. This learning series will take place from November 2021 through February 2022.

Transformation Center activities

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

The Transformation Center reviewed CHP progress report submissions, as well as new CHA and CHP submissions from CCOs. Additional deliverable feedback was provided to CCOs and will continue through November 2021.

In addition, the center continued planning for a new operations-focused CHA/CHP learning collaborative for CCOs and their collaborative CHA/CHP partners. This learning collaborative will start in the first quarter of 2022.

Social Determinants of Health Measurement Workgroup

Pilot testing wrapped up for the proposed SDOH measure concept ("Rate of social needs screening in the total member population using any qualifying data source"). On the whole, CCOs are supportive about the overall vision for this measure, and the potential for it to transform the system and address members' social needs. CCOs shared that implementing the measure with the current technical specifications is possible, but that it would take time to implement the systems needed and that implementing the structural measure would take significant effort. CCOs differ significantly on how much screening is currently being conducted, who conducts the screening, which tools are being used, and their plans for implementing this measure. CCOs expressed appreciation for the approved list of screening tools. The requirements to document screener roles, track screening, and develop screening policies to avoid re-screening garnered both support and concerns from CCOs. Input from the pilot testing was incorporated by OHA into draft measure specifications.

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. CCOs submitted their 2021 spending plans (based on their 2020 financials) on September 30. Technical assistance for CCOs included the start of a learning collaborative, facilitated by ORPRN.

CCO incentive metrics technical assistance

Kindergarten readiness

- **Preventive dental** – 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. The group held its kick-off meeting in July. Eleven CCOs, three DCOs, five county health departments, one tribal entity, the school of dentistry, a fee-for-service care coordination contractor, and the chief professional organization for primary care clinics in the state have joined the effort to date. In September, OHA decided to put the effort on hold until 2022 in response to stakeholder concerns about their capacity to engage in quality improvement during Oregon's greatest surge of COVID-19 infections, significantly impacting the health care system.
- **System-level social emotional health** – This is a new CCO incentive metric for 2022. In the first year, it will include four components: data review, asset map, community partner engagement and action plan. In year four it will transition to a child-level metric. The Transformation Center hosted two CCO needs assessment calls to provide an overview of the measure and gather input from CCOs on TA needed to be successful in this measure. CCOs requested a learning collaborative to walk through the process and share ideas as they go.

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 (AHQR). 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 worked with AHQR to extend the recruitment phase through November 2021, due to the barriers to recruitment over the past 18 months (due to COVID and clinical capacity). Forty-two clinics are participating.

Cross-cutting supports

COVID-19 vaccines: virtual learning series for providers

The Transformation Center, in partnership with the OHA Vaccine Planning Unit, started planning for a new learning series aim supporting COVID-19 vaccine rollout amongst pediatric clinics. This series will start in October 2021.

COVID-19: Vaccines and equity

The Transformation Center, in partnership with the OHA Vaccine Planning Unit and COVID Response and Recovery Unit, is developing a contract with ORPRN. This contract will focus on equity and motivational interviewing for providers, who will then become voices in their own communities to speak to vaccines and other emerging issues. The program planning and contract are in development.

Health information exchange

The Transformation Center, in partnership with the Office of Health Information Technology provided technical assistance to primary care clinics serving Oregon Medicaid members to produce reliable, accurate electronic clinical quality measures (eCQM) reports using the QRDA III standard (aggregated data), and to improve these metric performance rates. This work facilitated clinics' meeting current eCQM reporting needs for programs such as the Medicaid Electronic Health Record (EHR) Incentive Program, CPC+ and MIPS. Additionally, the technical assistance supported the implementation of workflows and the integration of health information exchange with EHRs to identify and target complex patients with recent transitions of care and reduce hospital readmissions.

Transformation and quality strategy (TQS) technical assistance

OHA held individual calls with seven CCOs to discuss their 2021 TQS assessments. These calls were optional and by CCO request.

OHA finalized TQS guidance for 2022 submissions, which are due March 15. All guidance documents and details about the fall technical assistance series are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

B. Lower cost

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

C. Better care and Better health (ANNUAL)

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately.

2. State reported enrollment table

Enrollment	July/2021	August/2021	September/2021
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,166,440	1,173,303	1,178,002
Title XXI funded State Plan	111,725	114,099	116,723
Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member months	% Change from previous quarter	% Change from previous year
Expansion	**Title XIX**	PLM children FPL > 170%	N/A	N/A	N/A	N/A
		Pregnant women FPL > 170%	N/A	N/A	N/A	N/A
	Title XXI	SCHIP FPL > 170%	49,802	136,249	4.99%	17.08%
Optional	**Title XIX**	PLM women FPL 133-170%	N/A	N/A	N/A	N/A
	Title XXI	SCHIP FPL < 170%	127,347	3,425,256	4.09%	19.37%
Mandatory	**Title XIX**	Other OHP Plus	180,287	517,571	1.13%	9.53%
		MAGI adults/children	919,136	2,630,583	1.65%	11.39%
		MAGI pregnant women	10,917	25,622	-3.76%	4.70%
		QUARTER TOTALS	1,287,489			

** 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
July	1,194,358	1,116,787	1,951	187	14,261	63,065	N/A
August	1,206,442	1,128,829	2,490	176	14,585	63,763	N/A
September	1,212,761	1,134,408	1,985	155	14,366	64,018	N/A
Quarter average	1,204,520	1,126,675	2,142	173	14,404	63,615	

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

B. Complaints and grievances

Attached separately.

C. CCO appeals and hearings

Attached separately.

D. Neutrality reports

Budget monitoring spreadsheets

Attached separately.