Oregon Health Plan

Section 1115 Quarterly Report

10/1/2021 – 12/31/2021
Demonstration Year (20): (7/1/2021 – 6/30/2022)
Demonstration Quarter (DQ): 2

Table of contents

I. Introduction

A. Letter from the State Medicaid Director

This report shows that 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. Although the increase in membership during this quarter in 2021 was not as great as during the same quarter in 2022.

During this reporting period, the Oregon Health Authority (OHA) worked with Dental Care Organizations (DCOs) and Coordinated Care Organizations (CCOs) to explore alternative models for contracting to provide dental services to CCO members. A transition is planned to begin in 2023, and we have begun planning the work needed in 2022 to ensure a smooth transition for members, providers, CCOs, and DCOs.

Also, during this reporting period, OHA worked extensively with partners across the state to seek feedback on publicly posted materials related to renewing the 1115 Oregon Health Plan waiver, including lessons learned from our current waiver. OHA continues its dialogue with CMS to propose additional policies and program improvements in order to continue to best serve the members of the Oregon Health Plan.

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.

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II. Title

Oregon Health Plan
Section 1115 Quarterly Report
Reporting period: 10/1/2021 – 12/31/2021
Demonstration Year (DY): 20 – Quarter 2

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, although the rate of increased enrollment was less during this period than during the same period in 2020.

During this reporting period, OHA worked with Dental Care Organizations (DCOs) and Coordinated Care Organizations (CCOs) to explore alternative models for contracting to provide dental services to CCO members. OHA has begun the planning work to ensure that members currently covered by DCOs will be covered by CCOs beginning January 1, 2023. OHA will work closely with CCOs, DCOs, providers and members to minimize the disruption to members during this transition.

OHA released a summary of 2020 spending by CCOs on Health-Related Services. Accepted CCO spending on HRS more than doubled from 2019 to 2020.

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 medical 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 Federal Marketplace open enrollment period has also resulted in increased referrals and enrollment.

An ongoing backlog of work has continued to be a challenge. Aggressive measures are being taken to evaluate and maximize staffing resources, implement as much system automation as possible, and apply focused strategies for how work is being assigned. Reducing the backlogs and stabilizing processing times is the state's highest priority.

2. Coordinated care organization enrollment

Total CCO enrollment for October 2021 – December 2021 grew by 2.4%, across all plan levels (CCOA, CCOB, CCOE, CCOG). Specific Coordinated Care Organization membership growth ranged between 0.6% – 3.0%, with the exception of Trillium Community Health Plan in the Portland metro tri-county area which continued to experience greater growth at 8.2% as it established itself in this new market.

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

DY20Q2 Member Growth Zone	**CCO Service Areas**
Greater than 5.00%	4
3.00%-4.99%	12
2.00%-2.99%	18
0.00%-1.99% Growth	14
Reduction in Enrollment	0

Overall enrollment from October 2021 – December 2021 enrollment growth was slightly higher than the previous quarter, but a slow-down from the same period in 2020.

DY19Q1 7/20-9/20	DY19Q2 10/20-12/20	DY19Q3 1/21-3/21	DY19Q4 4/21-6/21	DY20Q1 7/21-9/21	DY20Q2 !0/21-12/21
3.3%	3.9%	3.5%	2.4%	2.2%	2.4%

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, was extended for contract year 2021 and has since been extended through contract year 2022 (December 31, 2022).

During 2021, 14 CCO county service areas – representing three distinct CCOs – have required adjustments above their 2021 contract limits in order to sustain auto-enrollment algorithms. New enrollment limits have been established for 2022.

B. Benefits

The P&T Committee:
The P&T Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: Oncology Agents; Orphan Drugs; Targeted Immune Modulators; Multiple Sclerosis Oral Agents; Calcitonin Gene-Related Peptide (CGRP) Inhibitors; Hepatitis C, Direct-Acting Antiviral (DAA); Pulmonary Arterial Hypertension; Alzheimer's Disease; Evinacumab; Esketamine; Ravulizumab; Biologics for Rare Diseases; Gonadotropin-Releasing Hormone (GnRH) Modifiers; Growth Hormone; and Obeticholic acid.

The committee also recommended the following changes to the preferred drug list (PDL): make Combivent® Respimat® and Incruse® Ellipta® preferred; make Cosentyx® preferred; make Aimovig® preferred and Emgality® non-preferred; make branded Epclusa® non-preferred; make donepezil, rivastigmine, memantine, and Namzaric® preferred; make Vanalice™ non-preferred; and make tobramycin NaCl nebulized solution preferred and Kitabis® Pak and its generic alternative - tobramycin nebulizer solution - non-preferred.

Health Evidence Review Commission (HERC):

The Notification of Interim Changes for the January 1, 2022 Prioritized List was published December 1, 2021. Errata to the prioritized list were published December 3, 2021.

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 16 coordinated care organizations (CCO) and fee-for-service (FFS) data. The quarterly reporting period covers October 1, 2021 through December 31, 2021.

Trends

	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021
Total complaints received	3,437	3,895	4415	4152
Total average enrollment	1,344,628	1,389,453	1,394,117	1,427,347
Rate per 1,000 members	2.56	2.80	3.17	2.91

Barriers

The fourth quarter of 2021 shows an overall decrease in the number of grievances from the third quarter. The Access to Care category decreased 12.9% from the third quarter of 2021. The Interaction with Provider/Plan category shows a 16% decrease from the third quarter of 2021. Quality of Care continues to be the third highest category of complaints holding steady with the third quarter total. 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 Quality of Care the next highest category.

Interventions

CCOs – CCOs continue to report grievances due to COVID precaution protocols. Some CCOs continue to report increases in membership and decreasing available providers causes an increase in grievances. CCOs are reporting continued work on NEMT issues including Covid19 safety precautions and some indicate staffing issues are problematic in some areas. 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 Oct– Dec fourth quarter was 133. An additional 361 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 77 complaints from members enrolled in Dental Care Organizations. 7319 informational calls were received asking for a variety of information, such as information about their coverage, CCO enrollment, request ID cards, etc.

Statewide rolling 12-month Complaints totals

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

Complaint category	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021

Access to care	1,086	1,324	1566	1395
Client billing issues	236	278	394	390
Consumer rights	247	301	288	475
Interaction with provider or plan	1,186	1,281	1451	1210
Quality of care	487	498	539	538
Quality of service	195	213	177	144
Other	0	0	0	0
Grand Total	3,437	3,895	4,415	4152

Related data

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

Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs during each quarter. The NOABDs are listed by reason, as per 42 CFR 438.400(b)(1-7) and are the total number of NOABDs issued, regardless of whether 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 Mental Health issues were the third highest. CCOs report that eligibility remains one of the highest reasons for denials. Some CCOs are working to provide information about OHP members who are terminating to assist the provider in reducing confusion and the numbers of requests for services that end in denials. CCOs continue to monitor NOABDs to ensure written notices are sent to members in easily understood language and includes the appropriate citations. Tracking for timeliness, as well as reviewing for utilization and appropriateness of care are processes CCOs report they are doing to ensure NOABDs are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	**Jan – Mar 2021**	**Apr – Jun 2021**	**Jul – Sep 2021**	**Oct – Dec 2021**
a) Denial or limited authorization of a requested service.	28,984	29,931	27,636	26,931
b) Single PHP service area, denial to obtain services outside the PHP panel	771	490	897	820
c) Termination, suspension, or reduction of previously authorized covered services	118	129	224	153
d) Failure to act within the timeframes provided in § 438.408(b)	12	15	7	3

e) Failure to provide services in a timely manner, as defined by the State	43	28	59	84
f) Denial of payment, at the time of any action affecting the claim.	56,909	64,915	46,204	63,703
g) Denial of a member's request to dispute a financial liability.	1	0	0	0
Total	86,838	95,508	75,027	91,694
Number per 1000 members	81	86.8	66.6	79.5

CCO Appeals

The table below shows the number of appeals the CCOs received over the fourth quarter of 2021. In the fourth 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	**Jan – Mar 2021**	**Apr – Jun 2021**	**Jul – Sep 2021**	**Oct – Dec 2021**
a) Denial or limited authorization of a requested service.	1,031	1,145	1,116	1,041
b) Single PHP service area, denial to obtain services outside the PHP panel.	36	7	29	23
c) Termination, suspension, or reduction of previously authorized covered services.	1	10	5	10
d) Failure to act within the timeframes provided in § 438.408(b).	0	0	0	0
e) Failure to provide services in a timely manner, as defined by the State.	0	1	0	1
f) Denial of payment, at the time of any action affecting the claim.	293	357	245	222

g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	1,361	1,520	1,395	1,297
Number per 1000 members	1.27	1.38	1.24	1.12
Number overturned at plan level	379	436	388	444
Appeal decisions pending	0	9	0	10
Overturn rate at plan level	27.85%	28.68%	27.8%	34.2%

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 (DCO) contracts where capitation rates are developed separately.

OHA also delivered the final CY22 CCO and DCO rates package to the Centers for Medicare & Medicaid Services (CMS), which included the Oregon CY22 rate certifications and contract rate Sheets. OHA continues to monitor the COVID-19 pandemic closely and working with CCOs in a partnership in maintaining our healthcare system.

In December 2021, OHA underwent a procurement process for an Actuarial Firm to assist in developing the 2023 capitation rates. The procurement is scheduled to close in mid-January 2022 and the contract will be awarded by the beginning of February 2022.

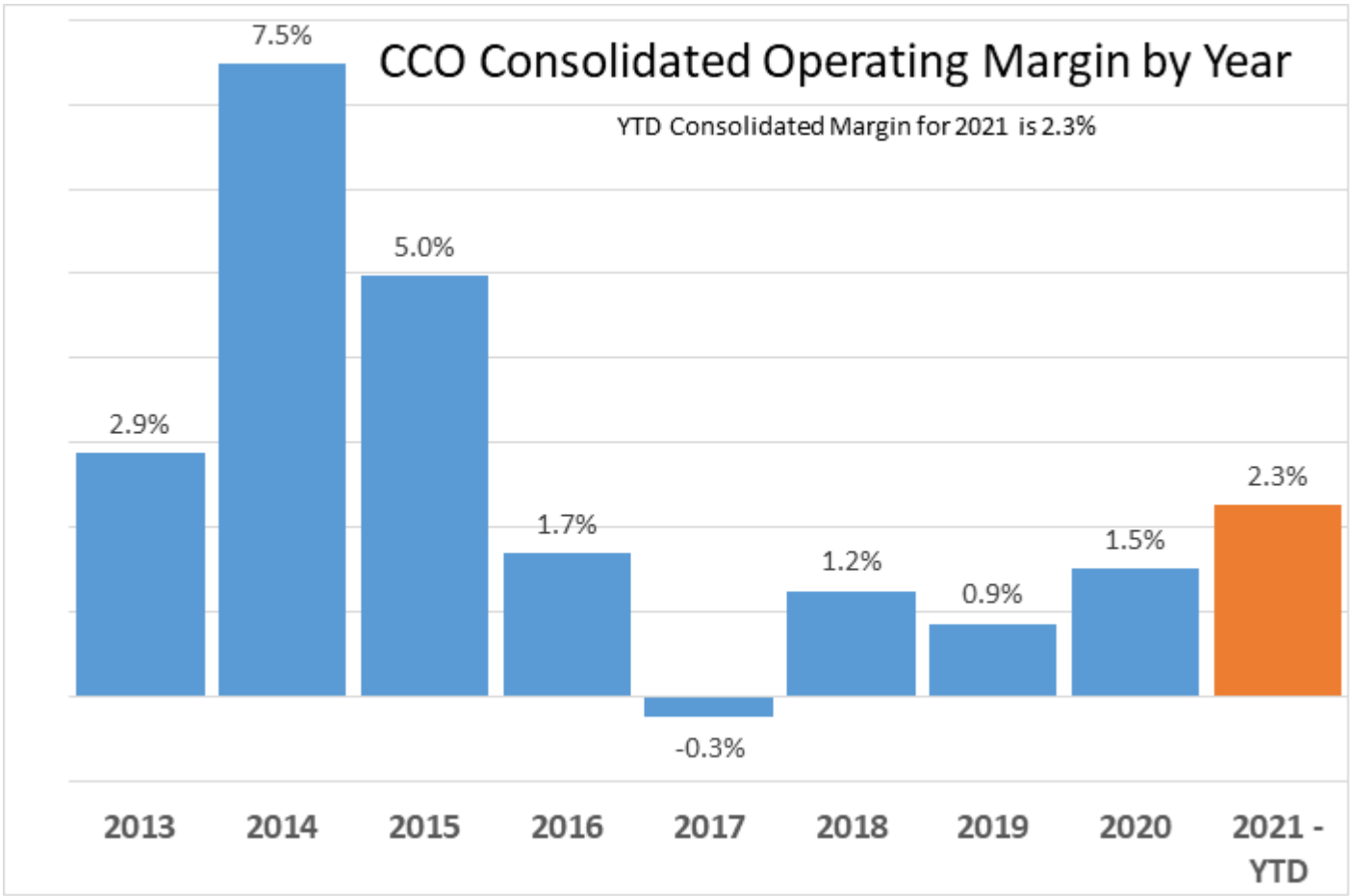
4. Enrollment/disenrollment

All changes reported in other sections.

5. Contract compliance

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

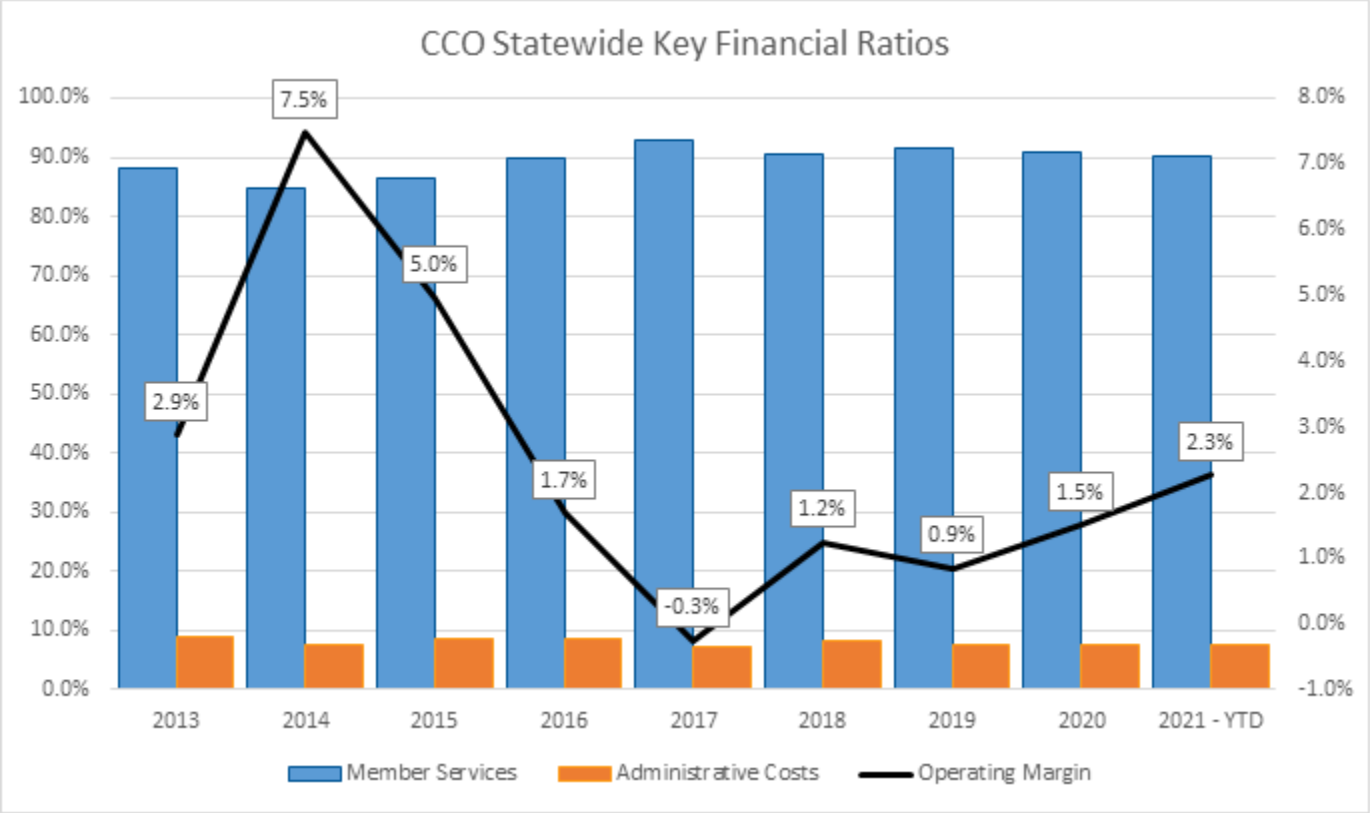
6. Relevant financial performance



CCOs achieved a statewide operating margin of 2.3% through the nine months ending September 30, 2021. This is 2.3% of the year-to-date gross premiums reported on Exhibit L of $5.57 billion. The YTD margin has decreased by 6 points from 3.2% reported in Q1, but is still an increase from 2020's 1.5% statewide margin.

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.



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 nine months of 2021, spending on Member Services was at 90.1%, which is 0.7% higher than the average Member Services expense from the previous 8 years of 89.4%. Administrative costs of 7.6% tracks with prior years' percentage.

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

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

7. Corrective action plans

For the current quarter, two CCOs continue to be on Corrective Action Plans (CAPs):

CONTINUING CAPs

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 October-December 2021, HSO continued to exceed the performance target for the member grievances metric. In November 2021, OHA sent a letter to HSO with follow-up questions about the member grievance documentation provided by HSO earlier in 2021. HSO responded to the follow-up questions in December 2021; the response is under review by OHA.

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 1, 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 October-December 2021 indicates progress in all areas of the CAP. OHA and Trillium staff have meet frequently to discuss progress and steps necessary to resolve the finding areas within the CAP.

8. One-percent withhold

This quarterly report is for data from October 1, 2021 through December 31, 2021. OHA analyzed encounter data received for completeness and accuracy for the subject months finalized for March 2021 through May 2021.

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of March 2021 through May 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 March, April, and May 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

OHA has had long-standing contracting relationships with dental care organizations (DCOs) to provide oral health services to Medicaid members. As part of the original CCO plan implementation, OHA created a structure enabling CCOs to provide different benefit levels based on a member's choice or eligibility under the integrated system. This allowed for various combinations of physical, behavioral health and oral health benefit. However, the option for "oral health only" services remained outside the CCO contractual relationship. Instead, these services, for approximately 60,000 members, were provided by a direct contract between OHA and DCOs.

A number of challenges have been identified in relation to this relationship. First, under this model, DCOs are held to federal and state requirements that are substantial for an organization of their size. The cost to support the necessary staffing and resources is significant negatively impacting DCO ability to offer these services at a reasonable rate. Secondly, the current DCO contract has not gone through an RFP process since 2008. Instead, this contract is renewed on an annual basis. Finally, this current arrangement is inconsistent with Oregon's CCO model. Until recently, much of the contract changes year-to-year were driven by changes to the CCO contract, with minimal DCO input. This resulted in some contract requirements being less applicable to DCOs.

Working with DCOs, OHA explored alternatives to the current model. This resulted in the decision to have these members be covered by CCOs beginning January 1, 2023. During 2022, OHA will close out the current contractual relationships with DCOs, operationalize access for to CCOs for qualified individuals and work closely with CCOs, DCOs, providers and members to minimize the disruption to members during this transition.

G. Health Information Technology

Medicaid Electronic Health Record (EHR) Incentive Program

After eleven years, the Medicaid EHR Incentive Program (also known as the Promoting Interoperability Program), concluded December 31, 2021. The program offered qualifying Oregon Medicaid providers federally-funded financial incentives for the adoption or meaningful use of certified electronic health records (EHR) technology. Eligible professional types included physicians, naturopathic physicians, pediatric optometrists, nurse practitioners, certified nurse-midwives, dentists, and physician assistants in certain settings. By the end of the program, more than $213 million in federal incentive payments were paid to 60 Oregon hospitals and 3,865 Oregon providers. Between October 2021 and December 2021, 66 providers received $561,000 in incentive payments. A program closure summary will be available later this year.

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. Starting in 2022, CCOs will also be required to report how they use/will use and support/will support providers with social needs screening and referrals for addressing social determinants of health (SDOH).

Between March and October of 2021, OHA completed reviews of each CCO's 2021 Updated HIT Roadmap. While some CCOs received approval of their HIT Roadmap, OHA requested additional information and meetings with other CCOs to gain further clarity on HIT strategies. By October 29, 2021 all CCOs achieved an approved 2021 Updated HIT Roadmap.

In the last quarter of 2021, OHA collaborated with CCOs and DCOs to collect HIT information from contracted provider organizations via an online survey. The survey was distributed in October of 2021 to all available contacts at CCO-contracted physical, oral, and behavioral health organizations to collect EHR, HIE, and other HIT information. This information will be used to inform CCO efforts to support their providers with HIT 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 (https://orhealthleadershipcouncil.org/hit-commons/).

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 (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 2/3rds of Oregon's Patient-Centered Primary Care Homes, many behavioral health and community mental health program clinics, tribal clinics and others are participating, as well as state programs

for Oregon's Department of Human Services' Aging & People with Disabilities and Developmental Disabilities.

Recent highlights:

- OHA partnered with HIT Commons to sponsor a Behavioral Health Learning Collaborative on December 3, 2021 for health care and community partners across Oregon with interests in behavioral health care coordination and supporting HIT/HIE tools. The Collaborative included keynote speaker Steve Allen, OHA Director of Behavioral Health, who highlighted state priorities for behavioral health as a result of Oregon's 2021 Legislative session. Additionally, various break-out sessions hosted targeted discussions of behavioral health HIT/HIE tools in the state, including EDIE/Collective Platform, Prescription Drug Monitoring Program Integration (see below), and Reliance eHealth Collaborative (a community HIE in the state). Attendees included state policy-makers, payers, CCOs, health systems, behavioral health agencies and providers, and physical health providers. Slide decks and recordings can be found here.

- HIT Commons hosted two learning webinars in Q4 2021, "Skilled Nursing Facilities Best Practices with the Collective Platform" and "HIT Commons Website Resources and Collective Community". Materials and recordings for both webinars can be found here.

- The HIT Commons EDIE Steering Committee met on December 10, 2021. Topics of discussion included review of quarterly EDIE dashboards, product and support updates from Collective Medical, EDIE/Collective Platform use cases under development, and strategic planning for the Committee in 2022. Materials from that meeting are available here.

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 met on November 10, 2021 for a brainstorming session around future priorities and topic areas.

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:

- 20 new organizations went live with PDMP Integration in Q4 2021.

- 312 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 September 30, 2021, 19,466 prescribers and 1,299 facilities have actively accessed data via PDMP Integration.

- The PDMP Integration Steering Committee met on October 14, 2021. Topics of discussion included PDMP Integration metrics, Q3 2021 progress on integrations, updates from Public Health PDMP staff, and new reporting functionality available to prescribers and clinical leaders.

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.

Strategic Plan:

Updating the Oregon HIT Strategic Plan is a HITOC priority in 2022. HITOC 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 a vision statement for the Strategic Plan and chartered a CIE workgroup. In the December meeting HITOC approved the development of an additional workgroup focused on HIE. Once drafted, the plan will be submitted to the Oregon Health Policy Board. Target date for completion is January 2023.

Other focus areas:

Additional priorities for HITOC in 2022 include HIT needed to support COVID response and recovery, recruiting for three open HITOC member seats, and further work related to HIT and social determinants of health and health equity.

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 November 2021, the HITAG convened to discuss CCO Updated HIT Roadmap requirements, the HITOC Strategic Plan Update, and CCOs' strategies for supporting EHR adoption for their contracted physical, behavioral, and oral health providers. OHA shared a summary on CCOs' strategies for supporting EHR adoption, available here. A summary on CCOs' HIE adoption strategies and barriers will be available later this year.

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 last PIC meeting was held on November 9, 2021; the collaborative has concluded as payers are awaiting further regulation from CMS on the payer-to-payer data exchange.

HIE Onboarding Program

Oregon's HIE Onboarding Program launched in January 2019 and concluded September 30, 2021 with the ending 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. A summary of the program with additional information is available here.

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: findhelp and Connect Oregon (powered by Unite Us). To learn more, see the OHA CIE webpage.

At HITOC's direction, OHA developed a draft CIE Workgroup charter after interviewing stakeholders and working with a HITOC liaison. HITOC approved the CIE Workgroup charter at their October 2021 meeting and approved the CIE Workgroup members at their December 2021 meeting. The CIE Workgroup's role is to provide recommendations to HITOC and the OHA on strategies to accelerate, support, and improve CIE across the state. The workgroup will begin meeting monthly in March 2022.

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 (complete):

• 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 (specified and now included in 2022 measure set).

3) Replace the existing developmental screening metric with a new follow-up to developmental screening metric in after development work completed.

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 completed final updates to the specifications for the social-emotional health measure. In addition, the partnership team worked to create accompanying supporting materials for the measure, including:

- The development of a fillable asset map with CCOs can use to identify opportunities and gaps in social-emotional health services and supports for young children and their families and
- Finalizing code set and creating the social-emotional health reach metric report. This report will be shared with CCOs in the next quarter. It provides information on trends in access to both social-emotional assessments and services for children ages 1-5, including stratifications by health complexity. This is a tool which the measure requires CCOs review and consult with community partners on as they use this information – as well as that from the asset map they must complete – to create co-create an action plan to improve the social-emotional health of young children in their service areas.

In addition, OHA's Transformation Center continued to work on a technical assistance plan related to the social-emotional health measure.

2. SDOH/Health-related Social Needs Measure

OHA presented about the measure during a joint meeting of the Health Plan Quality Metrics Committee and Metrics and Scoring Committee in October. OHA sought additional feedback on the measure from a committee of Traditional Health Workers on November 22, community partners engaged through the Community Partner Outreach Program (CPOP) on December 7, and staff from OHA's Ombuds program on December 15. OHA also planned focus groups for January. The pilot test and additional input are being incorporated into the

measure specifications. This will be followed by presentation and consideration of the finalized metric by the Health Plan Quality Metrics and Metrics & Scoring Committees in 2022 for potential implementation in 2023.

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 no 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. A judgement affirming the denial was issued in December 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). Defendants appealed the district court ruling, but the appeal was held in abeyance (an administrative stay). The abeyance was set to expire on February 1, 2022, but it was recently extended to May 2, 2022.

L. Public forums

Health Evidence Review Commission

October 7, 2021

There was no public comment at this meeting.

November 18, 2021

This testimony concerned Expanded Carrier Screening (ECS):

> **Devki Nagar**, Myriad Genetics laboratory, testified. She said her lab provides expanded carrier screening. Ms. Nagar said the American College of Medical Genetics and Genomics published a practice resource to update their carrier screening guidance, given the recognition that their 2004 and 2008 guidelines predated data that has shown that an ethnicity focused approach to carrier screening no longer provides equitable screening, given the diversity of the US population and especially Medicaid programs. She expressed her excitement to see the policy proposed today as it will allow more providers to align carrier screening approaches or to choose a more limited approach based upon their personal preferences and values. Given how expanded carrier screening can really ensure more equitable carrier screening, she applauds the committee's proposed policy to allow access to ECS for Oregon Medicaid beneficiaries and providers who elect to utilize this more equitable approach.

This testimony concerned Whole Gene Sequencing (WGS):

> **Leslie Rogers** offered testimony on behalf of the rare disease community. He spoke about his personal experiences with diagnosing his child and the hardships endured by his and many other families. He said

the delays in getting the correct diagnosis led to his child being bedridden and suction dependent for life. He implored the Commission to make WGS widely available.

Dr. John Fox, a pediatrician and epidemiologist, offered testimony. He stated he is an employee of Illumina which manufactures devices that do genomic sequencing. He said there are as many as 15 times as many kids who would have one of the 7,000 diagnosed and even more undiagnosed genetic disorders, who wouldn't be captured because they're not critically ill and not hospitalized in the NICU or PICU. He said he is thankful that the Commission has decided to cover this rapid whole genome sequencing in the inpatient setting and exploring for kids over age one and also in the outpatient setting. He said the typical sequence in the outpatient setting is to do a chromosomal microarray under specific conditions. In the 20% of kids you test, they have a positive result, you're done. You have a chromosomal abnormality that's detectable on chromosomal microarray. In the 80% of kids who don't have a finding a non-chromosomal microarray, then the typical standard of care is to go on and do a whole exome sequencing which is about the cost of a whole genome sequencing. Establishing a diagnosis earlier on, it makes sense to look at whole genome sequencing as the standard of care

This testimony concerned Handicapping Malocclusion:

Dr. Manu Chaudhry, President of Capital Dental Care, spoke. He has experience as a provider and a plan manager in California when they enacted a plan to cover this condition for Medicaid. He said he is not against increasing the benefit to include components of handicapping malocclusion and as a clinician, he agrees that the benefits should be expanded. However, handicapping malocclusion is not well defined. With this type of subjectivity, he feels that it's very important and critical that these qualifiers should be well defined prior to advancing with approval through the HERC. He said the best approach would be to postpone the implementation until January of 2024.

This testimony concerned Continuous Glucose Monitoring (CGM):

Renee Taylor, Director of Medical Science at Dexcom, which is a manufacturer of continuous glucose monitoring (CGM), gave testimony. She said she wanted to call attention some important evidence that was not fully considered in the MED review for CGM that was presented at last month's subcommittee meeting. Specifically, there was evidence omitted which supports coverage of CGM for persons with type two diabetes on intensive insulin, meaning use of three or more daily injections of insulin or an insulin pump. She said it should be noted that this subgroup represents less than 15% of the broader type two diabetes population. She said a clinically significant reduction in A1C is defined by the FDA as 0.3%. A JAMA study showed CGM met a 0.6% mean reduction in A1C and a 50% reduction in the rate of severe hypoglycemic events. The ADA 2021 practice guidelines now strongly recommend the use of therapeutic CGM in all persons with diabetes using intensive insulin. Medicare covers therapeutic CGM for beneficiaries using intensive insulin. She said all local, regional, and national private payers serving Oregon residents, including Kaiser, MODA regions, Providence, Aetna and Cigna cover their members with type one and type two diabetes using intensive insulin.

HERC Value-based Benefits Subcommittee

October 7, 2021

This testimony concerned Cranial Electrical Stimulation:

Josh Briley, PhD, Science and Education Director for EPI (manufacturer), clinical psychologist: Dr. Briley testified regarding his experience using Alpha Stim to treat thousands of patients. He noted that the HERC staff literature reviewed included only a small portion of the literature on Alpha Stim. He personally has seen clinically significant improvement in depression, anxiety, and insomnia. User surveys show very significant improvement in symptoms as well. Alpha Stim is very safe, side effect rate is <1% and are mild and self-limiting. This technology is also less expensive than extensive therapy and has fewer side effects than medications. It also works faster than therapy.

Jay Halaj, PhD, Senior Consultant for Allevia Health (manufacturer): Dr. Halaj testified that the Portland VA and other VAs cover Alpha Stim. Hundreds of practitioners use this device and thousands of patients are using it. After about 20 minutes of using the device, patients have a response and are able to push through barriers in processing trauma. It brings on a sense of calm and reduces arousal. Device use can avoid costly emergency visits for situations like panic attacks. It's also especially useful in addition treatment as a non-chemical way to reduce anxiety and insomnia from treatment in that population.

This testimony concerned Minimally Invasive Lumbar Decompression for Spinal Stenosis:

Vishal Khemlani, MD, anesthesiologist, Vertos Medical affiliate (manufacturer): Dr. Khemlani gave a brief presentation of the MILD procedure and said he has done over 150 procedures. His presentation gave an overview of the procedure's effectiveness and included patient success stories.

Paul Konovodoff, Director for Market Access, Vertos Medical (manufacturer): Mr. Konovodoff began his testimony by addressing cost of the MILD procedure, stating the procedure has a Medicare cost of $4,000 for an ambulatory surgical center, or $6200 for hospitals charges and $600-700 cost for the physician fee. He said that the MILD procedure is covered for 92 million lives, including many commercial lives. He said 41,000 procedures have been done nationwide and 1500 certified providers are currently doing this procedure, 15 or 20 of which are in Oregon. Ohio and Illinois Medicaid have recently added coverage. MILD has been FDA approved since 2005.

This testimony concerned Vitiligo:

Drs. Julie Dhossche and Sara Leitenberger, OHSU pediatric dermatology: Dr. Dhossche began the brief invited presentation by declaring no conflicts of interest. She gave an overview on vitiligo, current therapies for repigmentation, and maintenance therapies.

November 18, 2021

This testimony concerned Expanded Carrier Screening:

Peggy Flanigan, parent: Ms. Flanigan testified she is a carrier of the fragile X gene and was unaware of her carrier status when her daughter was born in the 1980s. Her daughter is also a carrier. There are effects for female carriers as well as for boys affected by fragile X. She wanted to bring awareness to screening for rare genetic disorders. She testified that discovering her carrier status influenced her decision to not have additional children.

Taylor Kane, Executive Director of Remember the Girls: Ms. Kane testified she is a carrier of a rare genetic disorder. Knowledge of her carrier status has empowered her in terms of reproductive planning. She wanted to stress that learning of one's carrier status is not overwhelming, rather it is empowering.

Ashley Svenson, genetic counselor with Myriad Genetics (manufacturer): Ms. Svenson expressed support for the proposed changes which align with ACMG's recommendation. Ms. Svenson said these changes will help to eliminate racial bias in testing.

Yael Weinstein, genetic counselor in Springfield, Oregon: Ms. Weinstein testified that expanded carrier screening is the only approach that allows adequate screening for patients. Not using the expanded carrier screening approach gives the patient a false-negative result. In her experience, she educates couples on their results. She can offer consults by phone. In many cases, she sees patients who have only a partial carrier screening and then needs to do additional testing. Her clinic uses a panel of 176 genes. Many screens use 14-20 conditions. In her opinion, Oregon has the resources to offer and counsel for expanded carrier screening. 80% of children born with genetic conditions have no family history. She also noted that the labs have genetic counselors available to assist patients/families. She will send information on the specific panels she uses in her practice to HERC staff to distribute to members.

Samantha Coover, parent: Ms. Coover testified she has a son with fragile X syndrome, but she was never offered prenatal screening. Expanded carrier screening could have helped her by allowing her to get early interventions in place for her child from infancy.

Mike Flanigan, parent: Mr. Flanigan testified that expanded carrier screening will reach so many more patients. Genetic counseling is now more available than ever due to telehealth and other advances developed during the pandemic.

Haywood Brown, OB/GYN and Medical Director for ACCESS (carrier screening advocacy group): Dr. Brown testified that an expansion in screening is a very powerful tool. He agreed with the GAP recommendation and felt it is more equitable coverage.

This testimony concerned Whole Genome Sequencing:

John Fox, pediatrician, former medical director of a Michigan state health plan in Michigan, and current employee of Illumina (manufacturer): Dr. Fox testified that there is a large unmet need in both the inpatient and outpatient setting. He said that whole exome is similar in cost to whole genome sequencing. Michigan found clinical utility in WGS as it changes management in 95% of patients as well as changes reproductive decisions. Without WGS, microarray testing is generally done first, which adds cost. Michigan decided to add coverage for WGS as it is overall less expensive. In his health plan, the cost of WGS was $5,100 versus $4,900 for whole exome sequencing.

This testimony concerned Handicapping Malocclusion:

Christian Moller-Anderson, Executive Director for Smile for Kids (orthodontics non-profit): Mr. Moller-Anderson testified that state Medicaid programs are required to cover dental treatment, including handicapping malocclusion. There is a massive barrier to health for low-income populations with non-coverage, which goes against OHA's triple aim. Without equitable access to orthodontic care, low-income kids have deleterious health outcomes.

Manu Chaudhry, dentist, and President of Capital Dental Care: Dr. Chaudhry testified that he initially supported moving this forward at the OHAP meeting. However, he has since revised his position on this issue. Dental disease that is caused by handicapping malocclusion is worsened when treatment is applied

and there is a lack of pristine hygiene post-treatment. He recommended against adding this as a benefit currently and felt cost could be better spent to address and prevent inequities in oral health.

HERC Evidence-based Guidelines Subcommittee

December 2, 2021

This testimony concerned High-Frequency Chest Wall Oscillation Devices:

Gary Hansen, Director of Scientific Affairs for RespirTech (manufacturer of devices): Hansen thanked the subcommittee for their work on the revised report but has concerns about ambiguous language in Section D of the second paragraph of the revised draft report's box language, including use of the term "standard of care." He suggested alternative language of "failure" of chest physiotherapy and positive expiratory pressure devices (PEPs) to make the box language clearer.

This testimony concerned PANDAS/PANS:

Christina Cronin-Vejar: Ms. Cronin-Vejar ceded her time to Dr. Earl Harley.
Deborah Miller: Ms. Miller ceded her time to Dr. Harley.
Kym McCornack: Ms. McCornack ceded her time to Dr. Beth Latimer.
Ivan Vejar: Mr. Vejar ceded his time to Dr. Beth Latimer.
Diana Pohlman: Ms. Pohlman ceded her time to Dr. Harley.

Rachel Morse, parent: Ms. Morse began her testimony by thanking the subcommittee. She is the mother of two PANDAS/PANS patients. She said that these families have PTSD scores like combat veterans. She said the lack of data for this condition is because of the minor age of the patients. She warns that testing protocols can add to long wait times and prevent timely access to care. Morse asked for an emergency task force to be formed and a multidisciplinary clinic to be established. She said that long COVID is a form of PANS by definition.

Paul Ryan, PACE Foundation (PANDAS/PANS advocacy group): Mr. Ryan said his group is involved with clinics around the country, and his group includes IVIG as a standard of care. He said that Option 1 should be expanded to include infectious disease doctors and cited Dr. Daines as one such medical expert. He said his concern about requiring subspecialists and requiring pre- and post-testing is something that a mature multidisciplinary clinic is capable of but has concerns that Oregon will need educational programs to facilitate awareness of these conditions.

Sarah Lemley, Director of the Northwest PANDAS PANS Network: Ms. Lemley said she has no conflicts. She said she was concerned with requiring two subspecialists as outlined in Option 1. She said there is a lack of expertise and support for PANDAS/PANS within these specialties and said that out of the two local children's hospitals that have such specialists, one will not see PANDAS/PANS patients due to the controversial nature of the disorders. Lemley identified other Oregon hospitals and departments that will not take OHP, diagnose or treat PANDAS/PANS patients, or which have a long wait time. She asked the subcommittee to remove the two-physician subspecialist requirement as it would only increase the burden of accessing care for vulnerable families.

Earl Harley, MD, Professor of Otolaryngology and Pediatrics at Georgetown University: Dr. Harley began his testimony by describing his 28-year practice and association with Dr. Beth Latimer in working on

PANDAS/PANS research. He would like the subcommittee to consider tonsillectomy and adenoidectomy as treatment options of PANDAS/PANS. Tonsillectomy is very controversial in the world of PANDAS/PANS as well as the field of pediatrics. He cited a 2018 red book recommendation against tonsillectomy or any PANDAS/PANS treatments by the American Academy of Pediatrics. He has seen almost 300 PANDAS/PANS patients, half of whom received tonsillectomy, and has done CME conferences on the topic of these disorders. Harley said he has an ongoing trial funded by the PANDAS PANS Network that is looking at tonsil tissue samples and conducting various analyses. His theory is that strep infection is one of many triggers of the disorder, and that almost any bacteria can trigger this disorder, many of which are found in the tonsils and in the gut microbiome. He said he is continuing this research in the current pilot study and is conducting other retrospective analyses. He recommended tonsillectomy, treating the gut microbiome, and having access to IVIG as treatment options for PANDAS/PANS. He said tonsillectomies are safe and should be considered for select children.

Sarah Zeman, parent: Ms. Zeman introduced herself as a former disability attorney and parent of a child likely affected by PANS. She said she has no conflicts. Zeman said she supports increasing access to IVIG with only one physician consultation and recommendation, not two, as she said that places unnecessary burdens on families and currently treating providers. She said her family's trauma and burdens are exponential and echoed earlier testimony that her family has PTSD. Zeman attempted to secure care for her gravely ill child and said that Oregon is a doctor desert. Doctors in Oregon tend to lack awareness of PANS and refuse to treat PANS. She said while we wait for national treatment standards that access to care should not be made burdensome on overtaxed and traumatized families.

Beth Latimer, MD, d/b/a Latimer Neurology Center: Dr. Latimer began her testimony by describing her 20-year practice in pediatric neurology. She said she agrees that current published studies for PANDAS/PANS have not been done well, citing limitations of inherent bias, not enough differential between intervention and placebo groups, and not enough children enrolled in the studies. She said the American Academy of Apheresis approves of treating PANDAS/PANS. Latimer said that symptoms of OCD, depression, suicidality, and sleep deprivation were outlined in two international studies as a result of low REM sleep in these affected children. She said the subcommittee's recommendation of two subspecialists agreeing on IVIG might be possible if these providers were in the same hospital but that it is too burdensome for families to make two separate consultations. She also expressed concern that requiring less-invasive therapies may exacerbate symptoms of suicidality, such as the use of SSRIs. Parents are desperate for a treatment option for their children. She said it is more cost effective to treat these children than treating their symptoms. Access to care is a financial burden. She said of the 25% of children that received IVIG in her clinic and showed no improvement; she would consider those children as candidates for tonsillectomy.

Oregon State House Representative Rachel Prusak: Representative Prusak began her testimony by thanking the subcommittee. She stated her concern of watching her community members not having access to care. She said she was a 20-year family nurse practitioner and that we need to improve access to care for the community to decrease suffering. Requiring two subspecialists may be harmful and other types of providers, such as nurse practitioners, should be considered. She said that her own adult patients face at least six month wait times to see a specialist, and assumes it is worse for the pediatric population. She understands requiring one subspecialist. She is working to strengthen Oregon's investments to solve these problems.

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.

September 22, 2021 Meeting:
Agenda Topics

- DHS Updates /OHA Updates
- 1115 Waiver Interim Evaluation
- Ombuds Quarterly Report
- Waiver Renewal Update
- Advancing Consumer Experience – Subcommittee Update

Public Comment:

1. Beth Englander from the Oregon Law Center shared concerns about how health-related services (HRS) are run in general. Beth states 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 wanted to know what the road map is to integrate the recommendations into the waiver.

October 27, 2021 Meeting

Agenda Topics

- OHA and OHDS Updates
- REALD Requirements
- Waiver Renewal Update

No Public Comment

December 15, 2021 Meeting

- Agency Updates for OHA and DHS
- 1115 Waiver Application Public Comment Forum
- REALD Implementation
- OHPB Committee Membership Workgroup Findings
- Office of Health Information Technology Strategic Plan and Community Information Exchange

Public Comment

1. Sarah Spansail, Chair, Jackson County Community Advisory Council "Thank you so much Jackie and hello Medicaid Advisory Committee members. My name is Sarah Spansail. I live in Medford and I am the chair of the Jackson County Community Advisory Council with Allcare. While we support the extra focus on HealthEquity and other positive changes in the waiver, like children staying insured until the age of 6. I'm here today to speak in opposition to the draft waiver as written. House Bill 3353 is seen as a way to

increase the accountability of CCOs especially when it comes to supporting and serving those who are typically underserved. It's a way to continue to build on the community relationships we've already established, enabling us to create more sustainable and long-term projects in order to create real community transformation. Unfortunately, the draft presented is siloing out dollars into a new undefined entity with no specific geographic or membership makeup. And while I understand some community partners were engaged in the drafting of the waiver and many of the changes in it are positive, it is disappointing that the community advisory councils were not invited to participate more deeply in the internal process and offer feedback. Our councils have been working hard to support the health of our communities for more than 7 years and have invested over $ 1.2 million dollars in that effort. We've accomplished this through a collaborative process that ensures our OHP members, representatives like myself and others have an equal voice to our community partners. Our request to this community is that the draft 1115 waiver is changed to reflect House Bill 3353 as it is written and secondly as these changes are made to the waiver, OHA should work with our community advisory councils on these internal processes as we are important stakeholders. The flexibility and sustainability of these funds are critical to supporting otherwise underfunded programs that focus on the most vulnerable and underserved people in our communities, so please change the waiver and ensure that our community advisory committees are partners in that process. I appreciate your time. Thank you."

2. Patti Maloney, Soundview Medical Supply "My name is Patti Maloney, I work with Soundview Medical Supply. We are an incontinence supplier and we do a lot of business with beneficiaries who have CareOregon, OHP and the managed care programs. I will be writing something up, but I wanted to put in a comment. Because when you're putting in the waivers and there's a lot of talk about opening up care, the care inequity and, allowing people, the eligibility to be longer periods of time.

But we're really concerned about is the continued care and within the continued care is those can continued care requirements, especially during COVID, the 1135 waiver was very vague and it's pretty simple. It does say that sufficient health care items and services are available to meet the needs of individuals enrolled which is something that you had up on the OHA website, that also includes that providers you know who give these services are in good faith get reimbursed. I'd like to drill down a little bit on that and talk about those requirements for the continued care. We work with customers or beneficiaries that have permanent lifelong conditions and there was never anything in the language for the waivers about not being able to go to the doctor, the Telehealth was something that was talked about. But when you're talking about a population that is mentally or physically disabled, they really have to rely on somebody else to do those things for them. The pandemic had things shut down. Certain things, their care providers could not bring them to appointments or have the ability to have a Telehealth appointment. Uhm. We were unable to get these continued care requirements as renewals; they're considered prescriptions. Uhm doctors whose offices were closed so one of the things that I wanted to, and I will address. It is and I know you want to keep things under the 2 minutes. Oh, you're muted do you want me to stop? It's just really they're looking at the requirements for the continued care and I think that falls right into you know the health equity. Thank you."

Metrics and Scoring Committee

Health Plan Quality Metrics Committee (HPQMC)

October 15, 2021

This was a joint committee meeting between HPQMC and Metrics and Scoring (MSC).

There was no written or oral public testimony.

November 30, 2021

There was no written or oral public testimony.

December meeting was cancelled

Metrics and Scoring Committee (MSC)

October 15, 2021

This was a joint committee meeting between HPQMC and Metrics and Scoring (MSC).

There was no written or oral public testimony.

November 19, 2021

- Kati Sánchez**,** Oregon Rural Practice-based Research Network (ORPRN)

Re: In support of move of Screening, Brief, Intervention and Referral for Treatment (SBIRT) from reporting-only measure to incentive benchmark measure

- Melinda Davis, Oregon Rural Practice-based Research Network (ORPRN)

Re: In support of move of Screening, Brief, Intervention and Referral for Treatment (SBIRT) from reporting-only measure to incentive benchmark measure

December meeting was cancelled

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 December 31, 2021, 642 primary care practices were recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Ninety PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model.

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 23 virtual site visits this quarter. Site visits include verification that the practice 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. In 2021 the PCPCH program conducted listening sessions with over 40 community-based organizations, primary care practices and those experiencing health inequities. A report summarizing the community feedback was published in December 2021. The PCPCH program will convene an advisory committee in 2022 to review the report and make recommendations on the next iteration of the PCPCH standards.

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). 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. We have submitted our IMCE operational readiness review and IMCE contract to CMS for review and approval.

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 (PBIP) are key components of the CPC+ payment model. OHA prospectively pays the PBIP at 50% of eligible. 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. OHA calculated PBIP for 2020 and reconciled the prospectively paid payments. The majority of participating practices outperformed the 50% prospective payment and earned additional PBIP.

The Oregon CPC+ payers met for their final meeting in December to review the final data documents. The payment model concluded at the end of December.

Value-based payment (VBP) innovations and technical assistance (TA)

TC staff surveyed CCOs on technical assistance needs and topical interest for the CCO VBP work group that will be convened in 2022. TC staff also scheduled required annual CCO VBP interviews and refined the process for 2022 with OHSU's Center for Health Systems Effectiveness. Contracted work will begin early next quarter.

OHA published a VBP resource library. Resources covers a wide range VBP topics, including risk stratification, attribution, evidence-based care and workflows, performance measurement, promoting health equity and emerging trends. The library also includes sections on each of the five care delivery areas required in CCO contract (hospital, maternity, behavioral health, oral health and children's health).

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 provided feedback on potential strategies to address challenges to VBP implementation and spread; discussed recommendations from the Primary Care Payment Reform Collaborative; finalized VBP adoption survey questions and a distribution plan; and discussed prioritization of strategies to address challenges to VBP adoption.

Primary Care Payment Reform Collaborative

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

The collaborative's Implementation and Technical Assistance Workgroup finalized recommendations to the collaborative for payment models to sustainably support and integrate traditional health workers, and recommendations to the VBP Compact Workgroup for primary care VBP models. The VBP Compact Workgroup requested the collaborative develop a primary care payment model incorporating the recommendations.

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

Roadmap to Oral Health

- OHA's Health Evidence Review Committee approved Handicapping Malocclusion as a benefit to implement on January 1, 2023. OHA is consulting with external partners and state dental and Medicaid directors to gather prevalence data, approval workflow, network adequacy, and clinical guidelines for offering this benefit.
- Collaborated with the Rule Advisory Committee of the Oregon Board of Dentistry to refine clinical parameters of practice for Dental Therapists in Oregon.
- Integrated oral health service coordination into dental rules to increase integration of care efforts between primary care physicians and dental providers for preventive health.
- Ensured managed care contracts incorporate detailed benefit coverage of preventive and medically necessary oral health care for children and pregnant women.
- Provided training and education to oral health and dental providers on meaningful language access services and reimbursement for clients with Limited English Proficiency (LEP) in order to ensure culturally competent workforce and increase equal access to participate in program services.
- Began development of improved data capture method for analyzing managed care claims data. New data collection method will assist in collecting utilization rates and costs by dental disease / oral health treatment (rather than by payment code). In turn, population health may be improved by enhanced surveillance and monitoring of such claims.
- Revised OHA's workplan for the CMS-led oral health affinity group to account for need for OHA partners to take a step back from the project during surges of COVID cases in the state.
- Launched an oral health workforce learning collaborative to understand better the challenges facing Medicaid managed care entities' ability to contract with or hire adequate numbers of oral health professionals and staff.

Sustainable Relationships for Community Health (SRCH) program

In January 2022, all four (4) SRCH grantees submitted interim reporting for work accomplished 7/1/2021-12/31/2021 and new 6-month action plans for 1/1/2022-6/30/2022. In general, all SRCH teams were challenged by COVID-19 pandemic impacts on program delivery (in-person and virtual), health care and social service workforce fatigue, staffing challenges and staff turnover. In addition, OHA-PHD staff continue to be assigned to pandemic response roles and capacity is diverted from usual program activities like SRCH. There are also Statewide contracting delays due to the pandemic which affects the OHA-PHD timeline to provide contractual funds to SRCH grantees and technical assistance contractors for SRCH grantees. Despite these numerous, ongoing challenges, SRCH grantees made some progress toward project goals which are outlined below.

SRCH team success and challenges:

The *Central Oregon* team continued successfully to engage with and train bi-lingual community members and staff to offer Tomando Control and plan to launch a cohort in Spring of 2022 depending on impact from the pandemic. In addition, the team worked with a creative agency (contractor) on program promotion to adapt website content to plain language and plan to translate into Spanish. The Central Oregon team has opted not to continue with the CDC Umbrella Hub arrangement established in 2020 between Crook County PH and Deschutes County PH, but will work to join Oregon Wellness Network (OWN) which will allow more support for coordinated training and resources for Central Oregon partners.

Confederated Tribe of Siletz Indians (CTSI) team worked with Harold Schnitzer Diabetes Health Center (HSDHC) and Comagine Health (CH) on the three-touch campaign to adapt and offer a diabetes management curriculum to a small group of participants in November of 2021. In response to low participation from tribal members and the evolving needs of the CTSI, the CTSI team plans to shift the project to focus on diabetes and other chronic disease prevention efforts. OHA-HPCDP and implementation partners plan to work with the Northwest Portland Indian Area Health Board (NPIAHB) to and identify another tribal health partner who may be interested in implementing the diabetes management curriculum.

The *RHEHub (Regional Health Education Hub*)/IHN-CCO team continues to develop standardized workflows and tools to support referrals to National DPP among multiple referring and provider organizations. In addition to a focus on this infrastructure work for National DPP, there is traction with RHEHub partners on referring to another program, Walk With Ease (WWE). REHub is planning to utilize learnings and process for WWE referrals and translate to National DPP.

The *Tillamook County* team was successful in creating a unified CHW job description shared among three key partners (Tillamook County Public Health, Adventist Health and YMCA). The YMCA currently has two trained CHW team members. In the creation of these job descriptions, each organization faced its own organizational challenges including: 1) HR and union rules around job creation and hiring; and 2) Sustainable funding for CHW that would include reimbursement of services.

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

The Oregon Health Authority (OHA), Public Health Division, is making $31 million available to community-based organizations (CBOs) interested in supporting public health in their communities. OHA will fund work on specific public health issues (for example, HIV, climate change, overdose, commercial tobacco prevention), and provide opportunities for flexible funding for specific community health needs related to equity and the social determinants of health (for example, racism, colonialism, ableism, heterosexism, sexism). OHA seeks to center community strengths, wisdom, and priorities for health, and to support the work of CBOs to advance health equity in communities of color, Tribal communities, disability communities, immigrant and refugee communities, undocumented communities, migrant, and seasonal farmworkers, LGBTQIA2S+ communities, faith communities, older adults, houseless communities, and others.

Healthier Together Oregon

OHA continued implementation of Healthier Together Oregon, the State Health Improvement Plan. During this reporting period, the PartnerSHIP met three times. Primary accomplishment was identification of the following 7 strategies (from an original list of 62) that the PartnerSHIP would like to prioritize for 2022:

1. Increase affordable housing that is co-located with active transportation options.
2. Increase access to affordable, healthy, and culturally appropriate foods for communities of color and low-income communities.
3. Build a resilient food system that provides access to healthy, affordable, and culturally appropriate food for all communities.
4. Reduce systemic barriers to receiving behavioral health services, such as transportation, language, and assessment.
5. Provide culturally and linguistically responsive, trauma-informed, multi-tiered behavioral health services and supports to all children and families.
6. Improve integration between behavioral health and other types of care.
7. Increase affordable access to high-speed internet in rural Oregon.

These strategies will be used to inform OHA's investment of resources and policy planning for the 2023 legislative session.

Innovator Agents

An Innovator Agent, (IA), continued her work with the OHA team preparing our next 1115 CMS Waiver as a co-lead on the Transitions Concept Paper. Based on feedback from a variety of system partners, we have been able to create a focused concept paper in the Waiver proposal that addresses medical coverage, care/case management and SDOH services and supports for individuals and populations in transitions from one setting to another. The defined populations are those in federal, state, and local corrections systems transitioning to the

community, those youth in OYA custody, children with special health care needs transitioning to adulthood, foster youth transitioning to adulthood and those populations affected by climate change events/emergency events (like wildfires or heat emergencies).

An 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.).

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

Refugee Assistance programs and CCOs to ensure these new standards are made available through every pharmacy in Oregon.

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

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

Innovator Agents continued to "bridge" the work of the Oregon Incident Management Team for COVID and the development of the Covid 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.

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

Health-related services

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

Staff released the final 2020 HRS spending summary. Accepted CCO spending on HRS more than doubled from 2019 to 2020, totaling $16,163,747 and $34,153,552, respectively. The per member per month (PMPM)

spending also almost doubled from $1.51 PMPM in 2019 to $2.93 PMPM in 2020. Individual CCO HRS spending ranged from $0.48 PMPM to $15.51 PMPM.

HRS spending on health information technology (HIT), housing, prevention, education, family resources, substance misuse and addiction, and food access accounted for 71% of all HRS spending. Another 23% of CCOs' HRS spending was used to address community and member needs exacerbated by COVID-19, as well as emergency needs related to wildfire relief.

Staff finalized the HRS financial reporting requirements for 2022 (Exhibit L annual submission), including changes to reduce reporting burden and improve overall accountability. Staff reviewed all CCO HRS policies and procedures and shared evaluation results with CCOs.

To improve future use of and support potential increases to HRS spending, staff continued to work with the Oregon Rural Practice-based Research Network (ORPRN) on direct CCO TA. In addition to the ORPRN TA, HRS team members are hosting quarterly HRS office hours to allow CCO staff an open forum for various HRS-related questions.

All HRS guidance documents for CCOs and external partners are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx

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

Transformation Center activities

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

Population health

Community advisory council activities

The center continued to host peer-to-peer meetings with community advisory council (CAC) CAC coordinators (topics included hybrid CAC meetings and Medicaid Advisory Committee consumer subcommittee findings). As part of a learning series on the social determinants of health and equity, the center held learning sessions for CAC members on health equity and the 1115 Medicaid waiver. This learning series will continue through February 2022.

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

The center reviewed CCOs' CHA/CHP submissions, as well as CHA/CHP improvement plans to address gaps in meeting CHA/CHP requirements, and provided feedback to CCOs. 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

The proposed SDOH measure concept is "Rate of social needs screening in the total member population using any qualifying data source". This work is moving into the approval phase between March and June, with the following activities: (1) OHA staff presenting an educational webinar on the metric to the Oregon Health Policy Board; (2) Health Plan Quality Metrics Committee considering adding the measure to the core measure set; and (3) the Metrics and Scoring Committee deciding whether to add the measure to the CCO's 2023 incentive measure set.

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. This quarter OHA approved all CCOs' 2021 spending plans and provided feedback. After the rules process and public comment, staff finalized Oregon Administrative Rule updates, which sets the formula for SHARE spending starting in 2023 (based on 2022 financials).

Technical assistance for CCOs included two learning collaborative sessions and one webinar 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. While work with CCOs and other partners was on hold during surges of COVID-19 infections, OHA revised our workplan and developed a data plan. OHA also continued outreach to partners to gauge ongoing interest and capacity.

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 recruitment phase was expanded to neighboring states and extended through February 2022. Sixty-two clinics have been recruited, which makes Oregon one of the highest-participating states nationally.

Cross-cutting supports

COVID-19 vaccines: virtual learning series for providers

The Transformation Center, in partnership with the OHA Vaccine Planning Unit, held four learning series sessions to support COVID-19 vaccine rollout amongst pediatric clinics.

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.

Transformation and quality strategy (TQS) technical assistance

OHA held five TA webinars for CCOs focused on 2022 TQS guidance updates and components with the greatest opportunities for improvement. Staff also began monthly TQS office hours in November.

B. Lower cost (ANNUAL)

C. Better care and Better health (ANNUAL)

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately

2. State reported enrollment table

Enrollment	October/2021	November/2021	December/2021
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,184,474	1,191,809	1,199,294
Title XXI funded State Plan	118,702	121,615	124,374
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%	54,311	146,709	8.30%	19.55%
Optional	**Title XIX**	PLM women FPL 133-170%	N/A	N/A	N/A	N/A
	Title XXI	SCHIP FPL < 170%	133,300	356,791	4.47%	23.58%
Mandatory	**Title XIX**	Other OHP Plus	183,861	527,301	1.94%	9.72%
		MAGI adults/children	941,169	2,686,503	2.34%	13.27%
		MAGI pregnant women	11,234	26,238	2.82%	0.27%
		QUARTER TOTALS	1,323,875			

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

OHP eligible and managed care enrollment

		Coordinated Care				Dental Care	Mental Health
OHP eligible*		**CCOA****	**CCOB****	**CCOE****	**CCOG****	**DCO**	**MHO**
October	1,220,005	1,141,238	1,991	169	14,261	64,316	N/A
November	1,231,679	1,152,871	2,529	181	14,585	64,568	N/A
December	1,240,960	1,162,345	2,458	183	14,366	64,911	N/A
Quarter average	1,230,881	1,152,151	2,326	178	14,404	64,598	

** 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

Attached separately.