Oregon Health Plan

Section 1115 Quarterly Report

7/1/2022 – 9/30/2022

Demonstration Year (DY): DY 21 (7/1/2021 – 6/30/2023)

Demonstration Quarter (DQ): DQ 1

Oregon Health Authority

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I. Introduction

A. Letter from the State Medicaid Director

Oregon's 1115 Oregon Health Plan Demonstration waiver was originally approved from January 1, 2017, through June 30, 2022. On February 18, 2022, Oregon submitted an application to renew the 1115 OHP waiver, and began formal negotiations with the Centers for Medicare and Medicaid Services (CMS) that continued through the summer of 2022. On June 8, 2022 the CMS State Demonstrations Group approved a temporary extension of the OHP waiver through September 30, 2022 to accommodate ongoing negotiations. This report covers the approved extension period and represents the final reporting period of the 2017-2022 OHP waiver.

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: 7/1/2022 – 9/30/2022
Demonstration Year (DY): DY 21
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III. Overview of the current quarter

During this reporting period enrollment in the Oregon Health Plan continued to grow, as it has during the COVID-19 Public Health Emergency. In July, the Healthier Oregon program began providing full medical coverage for eligible individuals ages 19-26 and 55 or over who would have previously only been eligible for Citizenship-Waived Medical (CWM) emergency-only coverage.

During this quarter OHA staff competed a review of 2021 Health-Related Services spending reported by Oregon's Coordinated Care Organizations (CCOs). The results were communicated back to CCOs and shared with OHA's Office of Actuarial and Financial Analytics for use in the CCO Performance Based Reward calculations. A HRS spending summary report and analysis is being published separately.

OHA also held a virtual convening focused on housing with alignment across HRS, SHARE (Supporting Health for All through REinvestment) and in lieu of services.

A. Enrollment progress

1. Oregon Health Plan eligibility

In July 2022, Oregon implemented the Healthier Oregon program which provides full medical coverage for eligible individuals ages 19-26 and 55 or over who would have previously only been eligible for Citizenship-Waived Medical (CWM) emergency-only coverage. Oregon already previously allowed full coverage for CWM children under the Cover All Kids program up to age 19, however, those children were not included in quarterly enrollment counts for Title XIX or Title XXI reporting. With the implementation of Healthier Oregon, the Cover All Kids population is now being included in the Title XIX and Title XXI data; therefore, it appears to create a larger-than-normal jump in enrollment between June 2022 to July 2022 by about 12,000 new individuals. In reality, only about 6,000 of those individuals were new enrollees. The other approximately 6,000 were a reflection of the Cover All Kids individuals being rolled into the figures.

Oregon is finding itself in increasing backlogs of work again. In an integrated eligibility system and a shared workload model across the state, eligibility staff have seen increases in the SNAP-related work, which creates longer delays in processing medical-related work. However, processing priority continues to be given to individuals currently without coverage (new applicants), and continued effort is being directed toward strategizing ways to streamline, automate, and simply work in order to best manage ongoing and upcoming workloads within staffing allocations.

2. Coordinated care organization enrollment

Total Coordinated Care Organization (CCO) enrollment for July 2022 – September 2022 grew by 2.9%, across all plan levels (CCOA, CCOB, CCOE, CCOG). Specific CCO membership growth ranged between 1.4% – 3.6%, with the exception of Trillium Community Health Plan in the Portland metro tri-county area, which continued to experience greater enrollment growth at 20.6% as it continued to establish itself in this new market.

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

DY20Q4 Member Growth Zone	CCO Service Areas
Greater than 5.00%	1
3.00%-4.99%	3
2.00%-2.99%	10
0.00%-1.99% Growth	2
Reduction in Enrollment	0

Overall enrollment growth was higher than the previous quarter, but slightly lower than the same period in 2021. Please see the table below for a comparison of enrollment growth across all quarters.

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 10/21-12/21	DY20Q3 1/22-3/22	DY20Q4 4/22-6/22	DY20EP 7/22-9/22
3.3%	3.9%	3.5%	2.4%	2.2%	2.4%	2.6%	1.4%	2.9%

As noted in previous reports, on May 1, 2020, the Oregon Health Authority waived the requirement to limit each CCO'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 –required adjustments above their 2021 contract limits in order to sustain auto-enrollment algorithms. New enrollment limits have been established for 2022. Between July 2022 and September 2022, one CCO required adjustment above its 2022 contract limit in one county service area in order to sustain auto-enrollment algorithms.

B. Benefits

The P&T Committee:

For the recent period of **July 1 – September 30, 2022** the P&T Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: Proprotein Convertase Subtilisin Kexin type 9 (PCSK9) Modulators; Nasal Allergy Inhalers; and Sedatives.

The committee also recommended the following changes to the preferred drug list (PDL): make oral Prempro®, Premarin®, Premphase® and Angeliq®; topical Elestrin®; and vaginal Femring®, Estring®, estradiol cream, and Estrace® all preferred; add the Thyroid Hormone class to the PDL and make levothyroxine preferred; designate acebutolol non-preferred; make Hemangeol® open access for children up to six months old; designate propranolol SA 24-hour capsules, generic oral propranolol solution, and nadolol tablets preferred.

Health Evidence Review Commission (HERC):
No significant changes during this reporting period.

C. Access to care (ANNUAL)

D. Quality of care (ANNUAL)

E. Complaints, grievances, and hearings

1. CCO and FFS complaints and grievances

The information provided in the charts below is a compilation of data from the current 16 coordinated care organizations (CCO) and fee-for-service (FFS) data. This quarterly report covers July 1 through September 30, 2022.

Trends

	Oct – Dec 2021	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
Total complaints received	4,152	4,262	4,398	4,938
Total average enrollment	1,427,347	1,452,054	1,475,164	1,514,019
Rate per 1,000 members	2.91	2.94	2.98	3.26

Barriers

The number of complaints reported for the July – September 2022 quarter shows an overall 12.28% increase from the previous April – June 2022 quarter. The Access to Care category continues to have the highest number of complaints with a 23% increase from the previous quarter. The Interaction with Provider or Plan category shows the next highest number of complaints with an 8.6% increase from the previous quarter. Quality of Care continues to be the third highest category of complaints with a 16.86% increase over the previous quarter. FFS data shows the highest number of complaints are Billing issues, with Quality of Care issues being the next highest category.

Interventions

CCOs – CCOs are reporting That NEMT issues continue to be where the highest numbers of complaints are filed. CCOs report they are continuing to work with their NEMT providers to increase communication about NEMT issues and ensuring NEMT providers are performing as required under their contracts. CCOs continue to report that the implementation of automated systems, increased communication and listening to community input are helping. Some CCOs say their NEMT brokerages are continuing to hold town halls with members, providers, and stakeholders. There seems to be continued concern over the shortage of NEMT drivers who are willing to take Medicaid members especially in the rural areas. One CCO reports they send out an NEMT "how to" guide to members. Some CCOs are utilizing case management to help resolve some NEMT issues. Dental issues are also an area where a high number of complaints are filed. Some CCOs report they are continuing to work with dental offices to help resolve scheduling and communication issues to improve services. CCOs continue to report they have established committees and taskforces specifically to address provider capacity within their networks. Some CCOs are reporting they are improving their auditing processes to ensure services are delivered in a timely manner and that member grievances are being forwarded to the CCO. CCOs continue to report they are increasing care coordination and are providing more health navigators to assist members in making appointments, attending appointments, etc. to improve services to members. Some CCOs report they are continuing to establish committees to focus on improving the member experience. CCOs report they are continuing to monitor trends and working to find ways to improve services to the members.

Fee-For-Service – The number of complaints from members who were on Fee for Service coverage during the July – September 2022 quarter was 250. An additional 686 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 147 complaints from members enrolled in Dental Care Organizations. 8927 informational calls were received asking for a variety of information, such as information about their coverage, CCO enrollment, request ID cards, etc.

Statewide rolling 12-month Complaints totals

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

Complaint category	Oct – Dec 2021	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
Access to care	1,395	1,559	1,618	1,990
Client billing issues	390	381	416	411
Consumer rights	475	344	436	386
Interaction with provider or plan	1,210	1,256	1,277	1,337
Quality of care	538	549	510	596
Quality of service	144	173	141	218
Other	0	0	0	0
Grand Total	4,152	4,262	4,398	4,938

Related data

Reports are attached separately as an Appendix B.

Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs during the July – September 2022 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 the July - September 2022 quarter, CCOs report that the highest number of NOABDs issued were Pharmacy related. Specialty Care was the next highest and issues with Diagnostics were the third highest. CCOs report that eligibility remains one of the highest reasons for denials. Some CCOs are working to provide information about OHP members who are terminating to assist the provider in reducing confusion and the numbers of requests for services that end in denials. CCOs continue to monitor NOABDs to ensure written notices are sent to members in easily understood language and includes the appropriate citations. Tracking for timeliness, as well as reviewing for utilization and appropriateness of care are processes CCOs report they are doing to ensure NOABDs are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	Oct – Dec 2021	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
a) Denial or limited authorization of a requested service.	26,931	26,862	28,669	26,379
b) Single PHP service area, denial to obtain services outside the PHP panel	820	835	680	658
c) Termination, suspension, or reduction of previously authorized covered services	153	109	126	73
d) Failure to act within the timeframes provided in § 438.408(b)	3	9	9	12
e) Failure to provide services in a timely manner, as defined by the State	84	82	101	52
f) Denial of payment, at the time of any action affecting the claim.	63,703	54,606	52,775	56,727
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	91,694	82,503	82,360	83,901
Number per 1000 members	79.5	70.03	68.43	67.66

2. CCO and FFS appeals and hearings

The table below shows the number of appeals the CCOs received during the July – September 2022 quarter. CCOs reported the highest number of appeals were for Pharmacy services. Outpatient services was the next highest category of appeals with Specialty Care the next highest. CCOs report they review the overturn rates which leads to more in-depth discussions and reviews, monitoring, and process changes. Some CCOs are reporting that Peer Reviews with Providers is resulting in improvements to services. CCOs report they are continuing to do activities such as staff education and monitoring for providers to improve understanding of the appeal process. CCOs also work with members to assist them in finding services they need or assist them with finding alternative covered options.

CCO Appeals	Oct – Dec 2021	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
a) Denial or limited authorization of a requested service.	1,041	1,072	1,193	1,159

b) Single PHP service area, denial to obtain services outside the PHP panel.	23	34	22	34
c) Termination, suspension, or reduction of previously authorized covered services.	10	2	5	2
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.	1	0	0	0
f) Denial of payment, at the time of any action affecting the claim.	222	244	331	433
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	1,297	1,352	1,551	1,628
Number per 1000 members	1.12	1.15	1.29	1.31
Number overturned at plan level	444	401	524	579
Appeal decisions pending	10	8	0	1
Overturn rate at plan level	34.2%	29.7%	33.78%	35.57%

F. CCO activities

1. New plans

There have been no significant changes in this area since the annual report. 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 was subject to a Corrective Action Plan (CAP) effective March 5, 2021; the CAP was closed on May 31, 2022.

2. Provider networks

No significant changes during this reporting period.

3. Rate certifications

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

eligibility category. In addition to CCOs, OHA also retains five Dental Only (Dental Care Organizations) contracts where capitation rates are developed separately.

OHA met with CCOs from May to August 2022 to discuss the CY2023 rate development process. At the end of the process, OHA delivered the final CY23 rate packages to CCOs in early August 2022 and met with each CCO, individually, to discuss their rates and request feedback. The CY2023 CCO capitation rates were submitted to CMS October 19, 2022 and are posted on our website: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/OHP-Rates.aspx

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

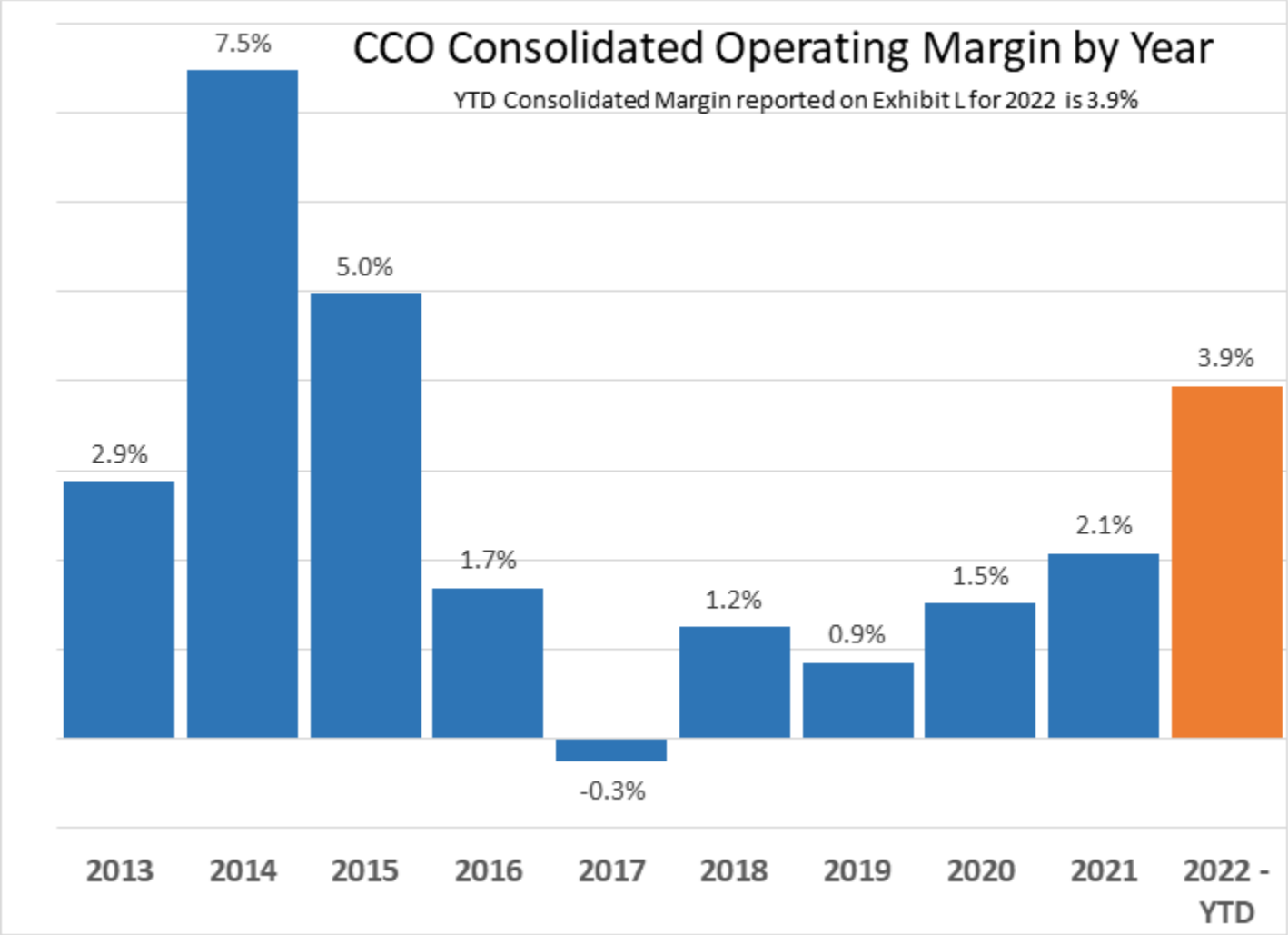
4. Enrollment/disenrollment

All progress included in other sections of this report.

5. Contract compliance

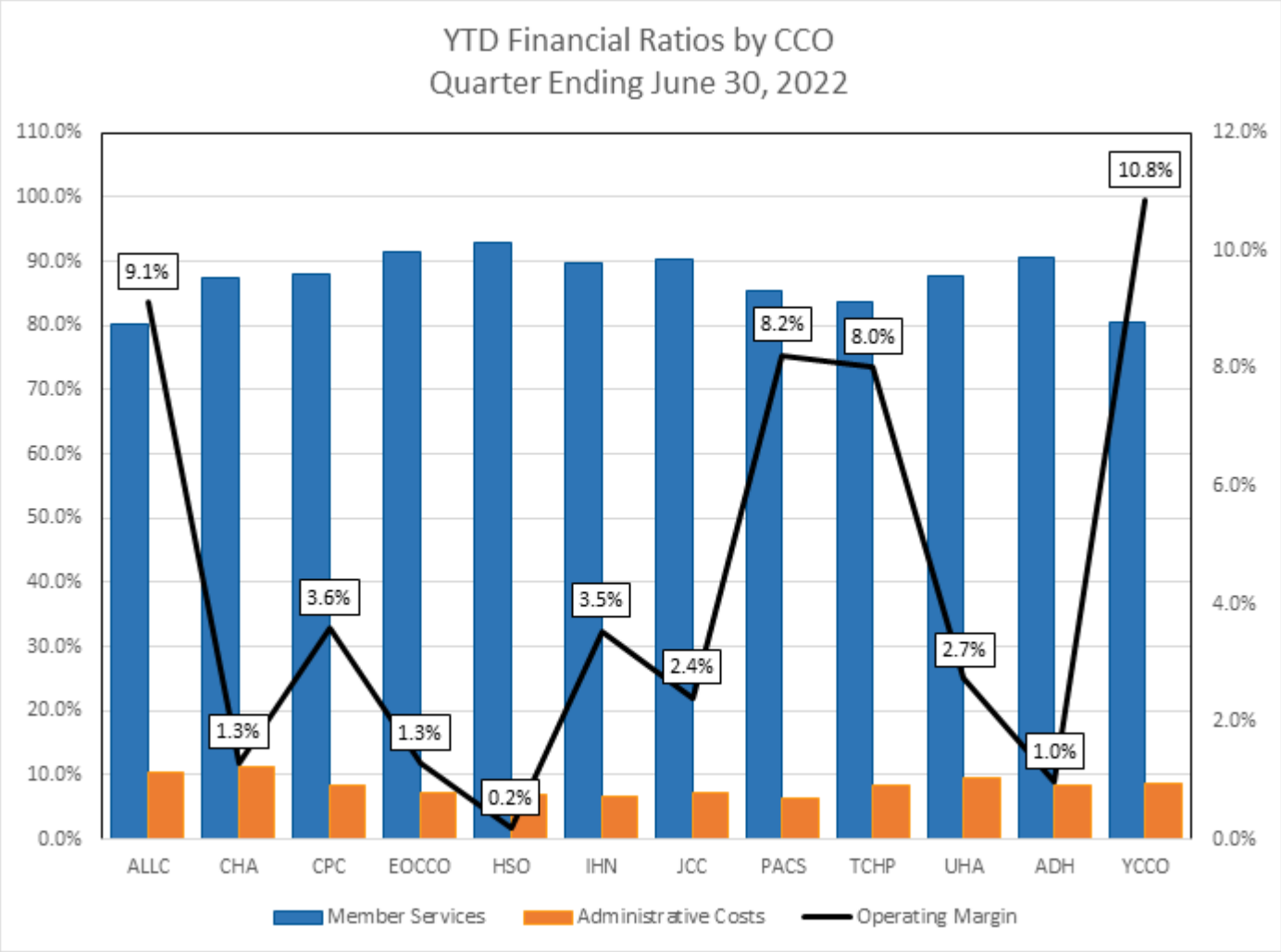
There are no issues with CCO contract compliance other than as described in the Corrective Action Plans section.

6. Relevant financial performance



In summarizing the Financial Results of our 16 CCO entities, there were a few items to specifically highlight. 2022 is an important year for financial reporting. The CCOs have moved from submission of the Exhibit L detail in Report L5 and Reports L6 from quarterly to semi-annually. Measuring the Operating Margin by CCOs reported on the Q2 Exhibit L, the CCOs achieved a statewide operating margin of 3.9%, or $135 million Operating Net Income on $3.427 billion of Operating Revenue. This is an increase from 2021's 2.1% statewide operating margin or $130 million Operating Net Income.

CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (this includes medical, behavioral, dental, and health-related services, reinsurance premiums and recoveries, and other adjustments) as a percentage of total revenue. A breakdown of key statewide financial ratios by year indicates that the Member Services component as a percent of the payments which CCOs received has remained relatively consistent over the last two years. Through the first six months of 2022, spending on Member Services was at 88.7%. Administrative costs of 7.4% through the first half of 2022 is in line with the 2021 CCO-wide average, which was 7.5%.



For the 6-months ended June 30, 2021, the majority of the 16 CCOs met or exceeded the 85% target for MSR, a key indicator for MLR (5 CCOs were below the 85% MSRs, and 2 5f the CCOs had MSRs above 90%). For additional CCO financial information and audited financials please follow the link below - http://www.oregon.gov/oha/FOD/Pages/CCO-Financial.aspx

7. Corrective action plans

For the current quarter, one CCO continues to be on a Corrective Action Plan (CAP):

• 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. Weekly reporting changed to monthly reporting effective for the report due in February 2021.

• Progress during quarter: The areas for improvement identified in the CAP are provider (driver) no-shows, on-time (pick-up) performance, call wait times, call abandonment, and member grievances. In a letter dated January 29, 2021, OHA formally notified HSO that it is satisfied with the improvements made in four of the five areas; the CAP is considered "closed" for those areas. HSO is required to continue to submit monthly progress reports for the area of member grievances as well documentation relating to specific NEMT concerns identified through member grievances. During the current quarter, HSO submitted monthly progress reports demonstrating continued improvement for the area of member grievances. HSO continues to meet the target grievance metric set by OHA, shows improvement in data collection and validation methods, and quality improvement efforts. OHA will maintain the CAP open and continue quarterly monitoring.

8. One-percent withhold

This quarterly report is for data from July 1, 2022, through September 30, 2022. OHA analyzed encounter data received for completeness and accuracy for the subject months finalized for December 2021 through February 2022.

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of December 2021 through February 2022. All CCOs except for one met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

One CCO did not meet the Administrative Performance (AP) standard for the months of December 2021 and January 2022 subject months no 1% withhold was taken as the CCO put remediation in place to ensure ongoing compliance and a decision was made by OHA leadership that due to the current pandemic affecting recent submissions, no withhold would be applied.

9. Other significant activities

All significant activities are included in other sections of this report.

G. Health Information Technology

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 how they will support physical, behavioral, and oral health providers with EHR adoption, health information exchange (HIE) for care coordination and hospital event notifications (as well as CCO use of hospital event notifications), and HIT to support social determinants of health (SDOH) needs. CCOs submit their HIT Roadmaps to OHA annually on March 15th for review and approval.

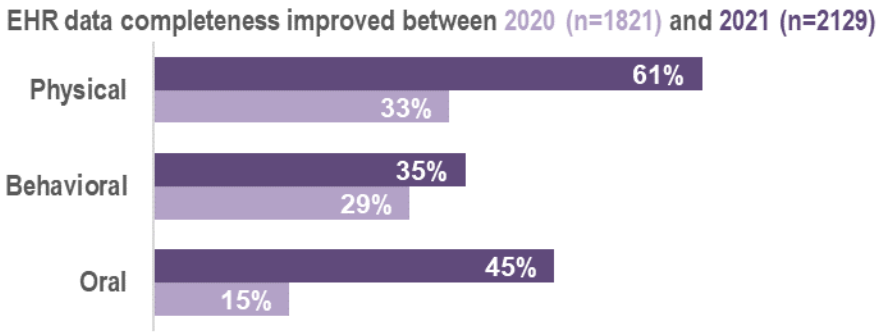
OHA held the quarterly CCO Health IT Advisory Group meeting in July 2022. Highlights from the meeting include:

- Drivers and Policies that Support Community Information Exchange including the CCO SDOH Social Needs Screening & Referral Measure, HIT Health-related services, and House Bill 4150 (2022)

- CIE Workgroup update including four Legislative concepts and recommendations with CCO discussion and input
- HIE Workgroup Update including scope (current and future state of HIE as well as gaps and strategies) and progress

Also in July, OHA completed review of the 2022 HIT Roadmaps, approving most, and requesting additional information from three CCOs. OHA anticipates that all CCOs will have an approved Roadmap by October 2022.

OHA has begun summarizing the collected EHR data as well as adoption support strategies submitted within the CCO Roadmaps. Available EHR information for CCO contracted entities increased in 2021 compared to 2020:



CCOs reported plans to collect missing EHR information via a variety of already existing processes in 2022. In 2021, CCOs pursued various strategies to increase EHR adoption and optimize use among their contracted providers, including training/TA, education, incentives and other financial support, and requirements in contracts/provider agreements. CCOs also reported on barriers to supporting/increasing EHR adoption. The primary barrier remained the COVID-19 pandemic which contributed to financial resource constraints and healthcare workforce shortage among other challenges.

HIT Commons

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

EDIE and the Collective Platform (formerly known as PreManage)

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

The Collective Platform (formerly known as PreManage) is a companion software tool to EDIE. The Collective Platform brings the same real-time hospital event notifications (ED and Inpatient Admit, Discharge, and

Transfer [ADT] data) to those outside of the hospital system, such as health plans, Medicaid coordinated care organizations (CCOs), providers, and care coordinators. In Oregon, Portable Orders for Life-Sustaining Treatment (POLST) forms are available to view for clinics, Skilled Nursing Facilities (SNFs), payers, and hospitals who receive EDIE alerts through paper/fax.

EDIE and the Collective Platform are in use statewide and adoption for Collective continues to grow. All of Oregon's CCOs receive hospital notifications through the Collective Platform (and all CCOs are extending their Collective subscriptions down to their contracted providers), as are most major Oregon health plans, and all of Oregon's Dental Care Organizations. About 75% 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 programs. A recent highlight includes:

- The HIT Commons EDIE Notification Advisory Committee (ENAC) met on September 29, 2022. The group reviewed the results of a statewide survey of EDIE users on the value of different types of information within ED notifications and discussed potential updates to the types of controlled substances that trigger notifications based on data in the Prescription Drug Monitoring Program (PDMP) registry. Made up of ED physicians, care managers, and Chief Information Officers, the ENAC is charged with reviewing, updating, and managing EDIE ED notifications in Oregon. The Committee meets quarterly.

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. The latest PDMP Integration implementation report can be found on the HIT Commons website. Recent highlights include:

- 25 new organizations went live with PDMP Integration in Q3 2022.
- 385 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). Twenty-two retail pharmacy organizations are also live. In the 18 months leading up to September 30, 2022, 20,216 users (prescribers and pharmacists) and 1,385 facilities have successfully accessed data via PDMP Integration.

Health IT Stakeholder Groups

Health IT Oversight Council (HITOC)

HITOC is tasked with setting goals and developing a strategic health information technology plan for the state, as well as monitoring progress in achieving those goals and providing oversight for the implementation of the plan. The HITOC HIT 2017-2020 Strategic Plan was approved by the Oregon Health Policy Board (OHPB) in October 2017 and provides a roadmap for Oregon's HIT work ahead. Work on updating the Strategic Plan was paused in 2020 due to the COVID-19 pandemic. Starting in August 2021, HITOC began updating Oregon's strategic plan for health IT for 2022 and beyond. The strategic plan focus is statewide and not exclusive to

Medicaid. Its statewide strategies touch state agencies, hospitals, health systems, CCOs and health insurance companies, clinicians and clinic staff, technology partners, consumers/patients, and more.

Highlights from HITOC's meetings this quarter:

- Heard presentation from health equity consultants at Collective Health Strategies on Community Based Organization (CBO) interviews and a survey that were conducted to inform legislative recommendations

- Reviewed and discussed preliminary recommendations from the CIE Workgroup to inform their HB 4150 draft report. The draft report was submitted to the legislature in September 2022. For additional detail on the recommendations see the CIE Workgroup Section below.

Strategic Plan Update: HITOC resumed Strategic Plan Update work in the summer of 2021 and that work has continued into 2022 with discussing an updated vision, refining goals, and developing EHR adoption and usability strategies.

The Strategic Plan Update will center equity in its recommendations and process, and it will 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. The list of topics identified for the strategic plan currently include:

- EHR Adoption
- Health Information Exchange (HIE) and leveraging new federal rules and policies (Cures Act, TEFCA)
- Social Determinants of Health (SDOH)
- Community Information Exchange (CIE)
- Health IT and health equity with a focus on demographic data (REALD/SOGI)
- Consumer/Patient access/engagement through health IT (patient portals, consumer apps)
- Telehealth and Broadband
- Public health preparedness
- Behavioral health

Once drafted, the plan will be submitted to the Oregon Health Policy Board. Target date for completion is late 2023.

Health Information Exchange (HIE) Workgroup

HITOC chartered the HIE Workgroup in April 2022 to provide recommendations to HITOC and OHA on strategies to accelerate, support, and improve HIE across the state. Recommendations should reflect perspectives from all interested parties and partners, specifically including those serving communities that face health inequities. The HIE Workgroup recommendations will inform HITOC's HIT Strategic Plan for Oregon and other OHA efforts. See the goals and full scope in the HIE Workgroup Charter. For more information on HIE, see the HIE Overview and the OHA HIE Workgroup website. The Workgroup met in July and September of 2022 and will continue to meet monthly at least through May 2023.

Highlights from July and September meetings:

July, 2022

- Reviewed initial vision statement for HIE and set of HIE considerations for the HITOC strategic plan and gathered additional feedback from members
- Reviewed and discussed recent data on the adoption of EHRs and HIE solutions in Oregon. Brainstormed tactics that could be taken by the legislature, OHA, and the private sector to improve the current state.
- Reviewed and discussed the upcoming 1115 Medicaid Waiver concept of improving health outcomes by stabilizing life and coverage transitions, and how HIE can support these efforts.

September, 2022

- Reviewed a draft HIE vision and list of priority focus areas for further study presented to HITOC at its August meeting.
- Representatives from HIT Commons presented on the history and scope of the HIT Commons, including its support and governance of the Collective Medical platform and the Prescription Drug Monitoring Program EHR/HIE integration work.
- Representatives from Reliance eHealth Collaborative presented on their work as a regional HIE in Oregon.

Community Information Exchange (CIE) Workgroup

The CIE Workgroup was chartered by HITOC in October 2021, aligning with HB 4150, and is tasked with providing recommendations on strategies to accelerate, support, and improve statewide CIE in Oregon. The Workgroup meets monthly between March 2022 through November 2022. The Workgroup and OHA define CIE as a network of collaborative partners using a multidirectional technology platform to connect people to the services and supports they need.

- Partners may include human and social service, healthcare, and other organizations.
- Technology functions must include closed loop referrals, a shared resource directory, and informed consent.
- Other functions may include reporting, social needs screening, and other features to electronically connect people to social services and supports.

The CIE Workgroup's Preliminary Recommendations were developed between April and July 2022:

- Preliminary Recommendations: Support for CBOs to Participate in CIE
- Preliminary Recommendations: Support for Additional Partners to Participate in CIE
- Preliminary Recommendations: OHA and ODHS Roles in CIE
- Preliminary Recommendations: Statewide CIE Data Program

HITOC and the CIE Workgroup sought input from community-based organizations (CBOs) on CIE to further inform the recommendations. In May through July 2022 OHA engaged health equity consultants from Collective Health Strategies to conduct CBO interviews and a survey.

- CIE: Community Engagement Findings and Recommendations

In August 2022, the CIE Workgroup Preliminary Recommendations and CBO input were presented to HITOC to inform their HB 4150 draft report. The draft report was submitted to the legislature in September 2022. A final report is due to the legislature January 31, 2023. The report reflects the work of the CIE Workgroup, community perspectives via CBO input, and HITOC comment.

- House Bill 4150 Draft Report: Supporting Statewide Community Information Exchange
- Executive Summary: House Bill 4150 Draft Report

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 (complete; included in 2022 measure set and learning collaborative launched).
3. Replace the existing developmental screening metric with a new follow-up to developmental screening metric in after development work completed.

The first three measures are now included in the CCO Quality Incentive Program (well-visits for children ages 3-6; preventive dental visits for children ages 1-5, and the new system level CCO metric focused on children's social-emotional health). In this quarter year, OHA's Transformation Center continued a year-long learning collaborative supporting the new measure focused on improving the social-emotional health of young children. Information on the Learning Collaborative and other supports for the measure offered through OHA's Transformation Center are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Emotional-Health-Metric.aspx.

2. SDOH/Health-related Social Needs Measure

The Metrics & Scoring Committee voted to include the measure in the 2023 CCO incentive measure set in May 2022. OHA's Transformation Center has contracted for technical assistance to support CCO work related to the measure.

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

Further work on this measure continues to be delayed by other priorities, particularly COVID response.

I. Budget neutrality

No issues during this reporting period.

J. Legislative activities

No significant activities during this reporting period.

K. Litigation status

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 remains pending.

L. Public forums

Medicaid Advisory Committee

July 27, 2022
Topics discussed:
- CCO Updates
- DHS Update
- Bridge Program Update
- PHE Unwinding Update
- Healthier Oregon Plan Update
- Community Partner Outreach Workgroup
- Advancing Consumer Experience Subcommittee Workgroup

Public comment:
This is public comment on the Member Handbook. Thank you for the renewed attention on the issue of confusing and non-standardized member handbooks across Oregon CCOs and Open Card. This work is much appreciated. Families of children with exceptional health needs continue to request that member handbooks 1) avoid vague language that sounds and reads like 'marketing material' and 2) increase the amount of language that sounds and reads like actual instructions. They would urge you to use language that is clear and directive, for example: "if this....do this..." The Oregon Center for Children and Youth with Special Health Needs would welcome an opportunity to help find consumer families for the upcoming workgroups. on readability and USEABILITY. thank you, Tamara Bakewell, former MAC member and current ACE member.

August 31, 2022
Topics discussed:

1. ODHS Update
2. OHA Update
3. Provider Directories
4. 1115 SUD Waiver
5. Community and Partner Workgroup
6. CCO Metrics Committee Transition
7. Member recruitment and expectations

Public comment:
There was no Public Testimony.

September 28, 2022
Topics discussed:
1. Consumer Assessment of Healthcare Providers and Systems Update
2. ODHS Update
3. OHA Update
4. ONE System Update
5. Quality Strategy – Update from May
6. Community and Partner Workgroup
7. OHA Legislative Update

Public Comment:
1. Mary Ellen Greenlaw, 1greenlaw1951@gmail.com. Mary Ellen spent a year and a half in a number of rehab facilities. It is badly run and managed. For example, staff were walking away with food and there were no showers. The Nursing Board did unannounced visits, and only then did they find out what was going wrong. Maybe the answer is to allow the Nursing Board to make more unannounced visits to hold them accountable. Also, the penalties cannot be just monetary because they will pay and continue doing the same thing. There should be some sort of Agency to hold them accountable. Mary Ellen is going to write a letter to the Legislators, Jeff Merkley and Ron Wyden.

Additionally, some of these facilities are held by Hedge Funds outside of Oregon and they are only concerned about their Quarterly reports.

2. Written testimony from Helen Bellanca, MD, MPH re the fee schedule for Doula's in Oregon. Notice of Intent to submit SPA to increase fee-for-service reimbursement for doula services.

3. Maryanne-Cassera, RN, CM mccassera@gmail.com. Emergency funding re: hospital capacity. Would love to schedule a Teams meeting to discuss barriers transitioning patients to a lower level of care in the community; the need to streamline Medicaid application process, the need to expand adult care home program (especially the specific needs complex care ACH), patients are residing in the hospitals and taking acute care beds. Thank you for your time.

Metrics and Scoring Committee

July 15, 2022

There was no written or verbal public testimony for this meeting

August 19, 2022

There was no verbal testimony.

There was written testimony from Oregon's Coordinated Care Organizations requesting that the committee revisit the 2022 CCO Incentive Measure targets and benchmarks due to the effects of the COVID-19 Pandemic.

https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/3.-Public-comment_COMED.pdf

September 16. 2022

There was no verbal testimony.

There was written testimony from Avery Horton, Chair of the Coos County Community Advisory Council, Board member of Advanced Health (CCO) regarding metrics for the committee to consider.

https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/9.%20public%20comment_Horton.pdf

HPQMC

July 26, 2022

There was verbal testimony from Julie Harris from Children's Health Alliance in support of the language access measure.

There was written testimony from Cameron Coval, the Executive Director of Pueblo Unido PDX about the need for Indigenous language interpretation and the lack of availability of qualified Indigenous language interpreters.

https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Meeting%20Documents/6%20OHA%20HPQMC%20testimony%207-19-22.pdf

There was no August meeting.

September 27, 2022

There was no written or verbal public testimony for this meeting.

IV. Progress toward demonstration goals

A. Improvement strategies

Oregon's Triple Aim: Better health, better care, and lower costs

To meet the goals of the three-part aim, Oregon's coordinated care model and fee-for-service (FFS) delivery systems rely on six key levers to generate savings and quality improvements and accelerate spread across the delivery system. These levers drive Oregon's transformation. Along with the actions that the Oregon Health Authority will take in the form of the stimuli and supports described below, they comprise a roadmap for achieving Oregon's vision for better health, better care, and lower costs.

Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient- centered primary care homes (PCPCH)

Patient-Centered Primary Care Homes

As of September 30, 2022, 634 primary care practices were recognized as PCPCHs. This is approximately three-quarters of all primary care practices in Oregon. Ninety-nine 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. This quarter the program conducted a site visit to 21 PCPCHs. 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 is convening an advisory committee to make recommendations on the next iteration of the PCPCH standards 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. The committee work is informed by information receiving during listening sessions the PCPCH program conducted with over 30 community-based organizations, primary care practices and those experiencing health inequities. The committee convened in August and September will continue to meet monthly through January 2023.

Community Behavioral Health Clinic

During this past year, Oregon Health Authority (OHA) continued participating in the federal Certified Community Behavioral Health Clinic (CCBHC) demonstration program. Following a one-year planning grant (2015- 2016), the CCBHC demonstration program was launched in Oregon on April 1, 2017 and though originally set to end March 31, 2019 has been extended to through 2025.
CCBHCs must meet numerous federal requirements, such as the ability to directly provide outpatient mental health and substance-use disorder (SUD) services to the full age range, regardless of payer. There are also nine Oregon CCBHC Standards, which enhance or expand on the federal requirements.
For this demonstration period, Oregon continued to pay a daily rate to participating clinics, using the selected the Prospective Payment System (PPS-1) model and through federal legislation was granted an extension to participate for additional years. The rate for each CCBHC is unique to each organization and was developed based on analysis of cost reports submitted to OHA during the planning grant. Among the key successes for 2022:

- OHA has re-absorbed all original CCBHCs (3 exited during the pandemic)
- OHA has completed comprehensive program analysis/compliance checks/site visits of all 12 CCBHC's
- CCBHC Medicaid specialist is negotiating scope of work for PPS re-base (commence in January)
- Legislative Workgroup is drafting model legislation to expand CCBHC program statewide; state team is advising the draft with "no position"
- OHA has launched a consumer-driven steering committee to advise statewide expansion of the model with community insight
- OHA is initiating metric collection for DY5

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 2022, 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 sixth 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). IMCEs provide care coordination to AI/AN members using the Primary Care Case Management (PCCM) model. The first IMCE operations began in September 2022. Approximately 4,500 AI/AN OHP members are currently receiving care coordination services through an IMCE. This number is expected to grow to approximately 15,000 AI/AN OHP members as additional tribes begin IMCE program operations.

Lever 2: Implementing value-based payment (VBP) models to focus on value and pay for improved outcomes

Comprehensive Primary Care Plus (CPC+)

The Transformation Center manages the Medicaid fee-for-service implementation of CPC+. Per-member, per-month (PMPM) care management fees and performance-based payments are key components of the CPC+ payment model. Track 2 alternative comprehensive primary care payment launched in January 2021. The quarterly hybrid payment includes a prospectively paid PMPM payment and a corresponding FFS claims reduction on payments for specific claims submitted during the program year. Track 2 practices selected their hybrid payment ratio for CMS in the fall of 2020, and OHA is using the same payment ratio.

The Oregon CPC+ payers met six times in the reporting period to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers discussed telehealth, opportunities to reduce low-value care,

evaluation, equity, and opportunities to align with the Primary Care Payment Reform Collaborative. The payers reviewed quality data trends for 2015–2018 which indicate that primary care quality measure performance in Oregon is improving for CPC+ practices and non-CPC+ practices. The payers also discussed and finalized Data Bytes documents including the comparison data on quality, cost, and utilization across commercial and Medicaid payers for 2019. The payers discussed sustainability of the CPC+ payment model beyond the model completion at the end of 2021. Payers plan to continue, and in some cases go beyond, components of the model. Medicaid fee-for-service is still evaluating options. Only one Oregon CPC+ payer is participating in Primary Care First and no additional payers applied for the second RFA.

Value-Based Payment Innovations and Technical Assistance

The Transformation Center continues to partner with Bailit Health to facilitate a monthly CCO VBP Work Group. The purpose of the work group is to provide CCOs with information, strategies, and peer learning opportunities around challenging areas in value-based payment (including specialty payment attribution, social and medical risk adjustment, and specific care delivery settings). The work group will be hosted through June 2023.

The Transformation Center worked with the Center for Health Systems Effectiveness (CHSE) to evaluate the VBP contract deliverables that CCOs completed in May and June 2022. These deliverables include a Patient-Centered Primary Care Home (PCPCH) care delivery area VBP data spreadsheet, a VBP pre-interview questionnaire and a 90-minute interview. These materials provide OHA with rich sources of information to monitor CCO progress toward VBP goals and assess needs for technical assistance. During this period, CHSE began drafting a VBP Roadmap Interim Report, as well as a series of best-practice briefs that highlight CCO efforts to develop VBP strategies in hospital, behavioral health, and maternity settings.

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 twice this quarter. The group discussed dissemination of the *Roadmap for Implementing the Oregon VBP Compact*, which details strategies to spread VBP, including the development of a toolkit for implementing VBPs. The work group formed a Toolkit Subcommittee and confirmed Bailit Health's help in drafting content. The toolkit will focus on practical guidance for providers and payers to implement VBP in primary care including core financial and clinical skills. Payer-specific guidance will include empanelment, provider-specific dashboards, and a common metric set. The Toolkit Subcommittee had their first meeting and agreed the toolkit should help providers use data to confirm patient lists with payers, analyze quality and produce reports for improved patient care and reporting to payers.

The work group also learned about Cambia Health Solutions' VBP journey and is collaborating with the Oregon Health Leadership Council to engage more commercial payers in the compact.

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.

In August, the Collaborative's VBP Payment Model Development Workgroup presented preliminary design recommendations for the VBP model. Members then discussed options for promoting health equity in the model and how to protect against negative consequences.

The VBP Payment Model Development Workgroup met monthly and discussed risk adjustment, attribution, rate development methodology, value incentives and rewards and aligned quality metrics. The Workgroup agreed on the importance of both benchmarks and improvement targets and a limited (perhaps 8) set of metrics comprised of core metrics and those selected from a menu. A subgroup of the Workgroup will recommend a measure set. Staff sent a survey to all VBP Compact payers asking for CPT codes included in their prospective primary care VBP models to inform a discussion of services to include in the VBP model in development.

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

Roadmap to Oral Health

- OHA's Transformation Center continued its work with the CMS Oral Health Reducing Childhood Caries Affinity Group, meeting with representatives of four coordinated care organizations to provide technical assistance supporting their projects to spread the practice of applying topical fluoride varnish among their primary care providers.

- OHA's Primary Care Office was recently awarded the maximum amount for the 2022 HRSA Oral Health Workforce Grant. The purpose of the Grant is to expand access to oral health care in specifically targeted underserved counties. Over the next four years, OHA will be working with sub-awardees, Capitol Dental Care and Oregon Health & Science University, to expand the oral health workforce pipeline and expand the use of innovative modalities of care, such as teledentistry.

- OHA's Public Health Division held a virtual and in-person clinical training for dental hygienists working in certified school dental sealant programs on August 4-5, 2022. Training topics included federal and state updates; infection prevention and control practices; triaging during screenings; sealant determination; HIPAA and FERPA; and health equity key messages. Medicaid covers many students who receive screening and dental sealant services.

- On September 8, 2022, OHA's Public Health Division held one of three trainings for dental hygienists contracting with OHA to be screeners for the 2022 Oregon Smile and Healthy Growth Screening. OHA conducts a statewide oral health needs assessment and body mass index assessment on Oregon elementary school children (grades 1, 2, and 3) every five years. The data collected describes the extent

of oral health problems and overweight/obesity among Oregon 6- to 9-year-olds children from a representative sample of schools around the state.

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

Sustainable Relationships for Community Health program

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

To adapt to the COVID-19 pandemic, OHA released a flexible SRCH funding model as an opportunity to apply lessons learned from the COVID-19 pandemic to chronic disease prevention and management efforts and focus these efforts on addressing disparate health and social impacts experienced by communities in Oregon who are affected by higher incidences of chronic disease and COVID-19 The successes and learning from the Sustainable Relationships for Community Health (SRCH) grant teams in FY21 led OHA-HPCDP to direct this year's funding for SRCH toward a sub-set of the teams implementing diabetes prevention and management projects, further focusing the funding opportunity. Four (4) of the SRCH teams received funding and technical assistance from OHA-HPCDP during this reporting period.

OHA-HPCDP and contractors provided technical assistance to support innovations in chronic disease disparities prevention and management to SRCH teams per their request. The technical assistance included: practice facilitation from Comagine Health for workflow development, EHR and other tool development and support for general collaborative/partner development and facilitation as well as support from OHSU-HSDHC to pilot a Diabetes Self-Management Education and Support cohort with the Confederated Tribes of Siletz Indians.

Progress and Findings:

Following are some examples of what teams were able to accomplish with the flexible SRCH funding opportunity, training, and technical assistance to use innovative methods to prevent and address chronic disease disparities.

The *Confederated Tribes of Siletz Indians (CTSI) SRCH team* piloted a virtual Diabetes Self-Management Education and Support (DSMES) Native cohort with the OHSU-Harold Schnitzer Diabetes Health Center. This work includes tribal adaptations to the DSMES curriculum, establishing a closed loop referral between Siletz Tribal Health and OHSU, and piloting a Tribal DSMES cohort. CTSI determined that while collaboration with OHSU-HSDHC was successful, there was more client and clinic readiness to address prediabetes via the National Diabetes Prevention program and have the program be Native-led. The technical assistance from Comagine Health supported CTSI with planning and connecting to similar efforts among the Navajo tribal areas as well as conducting National DPP assessment to assess readiness to begin offering National DPP cohorts in next fiscal year. In this period, The Confederated Tribes of Siletz Indians launched a tribal DPP cohort in July 2022.

The *Central Oregon SRCH Team* fully transitioned from using Compass Platform and EPIC EHR to Welld for program data management and billing for the National Diabetes Prevention Program. With the Welld platform being live, the Central Oregon SRCH team worked to partner with other entities to deliver National DPP and bill for the program. Their work also included training and onboarding of new lifestyle coaches to using Welld for new National DPP cohorts. The Central Oregon team is assessing how to maintain services with staffing changes and plans to continue SRCH work to address prediabetes and diabetes in the next fiscal year.

The *RHEHub (Regional Health Education Hub*)/IHN-CCO team created a sustainability roadmap for the systems and structure needed to support National DPP and other self-management education efforts. Comagine Health provided facilitation and support among the RHEHub members to develop the roadmap In this reporting period, the RHEHub began working with partners to identify regional needs (e.g., coordination, additional funding, referral pathways, etc.) and support regional partners to align and work together to deliver national DPP and other evidence-based health education programs.

The *Tillamook County* team focused on supporting long-term sustainability of the CHW position(s) in medical and non-medical settings across the county. They created a comprehensive CHW job description for Tillamook Community Health Centers that provides pathways for internal promotion and growth as well as an entrance point for those in the community to become a CHW. This process included delays in approval and posting the new CHW position, part of which is due to limited current staff availability as a result of COVID-19 response In Q4, The Tillamook SRCH team received approval for the CHW job description with all entities (e.g., county, the union, board of commissioners) and is currently recruiting for this position.

Trends, Successes, or Issues:

While all 4 SRCH teams continue to make progress, SRCH teams were challenged by COVID-19 and hMPXV (Monkeypox) pandemic impacts on program delivery (in-person and virtual), health care and social service workforce fatigue, staffing challenges and staff turnover. These challenges necessitated flexible program plans to adapt to changing staff capacity and COVID-19 and hMPXV pandemic response needs. ends.

Innovator Agents

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

- Current work with CAC's includes ongoing recruitment of members, the review and awarding of community benefit investment funds, and engagement in CHA and CHIP work.

- Innovator Agents attended all CAC meetings and presented updates from OHA on relevant topics such as: OHA programs, rules, and resources; medical eligibility; the 1115 Waiver; community based-resources; COVID-19, Monkeypox and public health information. Innovator Agents answered questions and concerns from the CAC related to service access such as NEMT and immigrants' access to care.

- Innovator Agents have supported OHA in the distribution of information and information sessions around the 1115 Waiver, with specific emphasis on understanding the Community Investment Collaborative (CIC) proposal for the new waiver and how CACs can understand, engage, and inform the work as it moves forward.

- Innovator Agents are supporting collaboration of community health assessment for multiple CCOs. CCOs are working individually or with other CCOs on finalizing the community questionnaire and determining specific outreach to populations for focus groups. The IAs have been critical in supporting this work as many of the CCO staff that had previously supported this work in the past are no longer with the CCO and the CHA requirements have changed in the CCO contract. The new staff have relied heavily on the IA's work in this area and IAs have helped identify partners, the various data sources as well as development of the community questionnaire, making sure to include both REAL D and SOGI information.

- IA has regularly attended the regional alignment meetings for the Community Health Improvement Plan workgroup within a CCO region. This particular workgroup (that is CCO led) has managed to gain representation from Local Public Health Authorities, Hospital Systems, Tribal health center, a non-profit organization, jointly representing a 3-county region. All parties have come together to work on a joint Community Health Assessment and Community Health Improvement Plan Process. This participation has allowed for an in depth understanding of the challenges and successes that communities are experiencing related to aligning these big buckets of work. The IA representation, along with CAC Coordinator representation, has leveraged the voice of CAC members and served to clarify the role of the CAC in the CHA and CHIP work. Additionally, the IA has provided feedback on the approach of other CCOs in moving forward the CHA and CHIP work in an effective way, while continuing to leverage and validate CAC involvement and participation throughout the process.

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

- Health Care Transformation: Continued work to support behavioral health, primary care, and oral health integration. Identifying clinics and partners who have successfully partnered to create dental chairs in behavioral health clinics that already have ARNPs.

- Innovator Agent served as part of the Agency's core group for NEMT system improvement. This role included and not limited to: reviewing quarterly CCO NEMT metrics data; providing input on data accuracy and reporting improvement; review relevant agency policies, OARs, and contracts; participate in meetings with CCOs to discuss systemic challenges and successes; and take lead on updating NEMT mileage reimbursement rates statewide.

- IA shared best practices on the use of Race, Ethnicity, Language and Disability (REALD) to identify gaps in coverage and services related to health equity among members receiving NOABD notices.

- IAs have helped bridge connection between the CCO and the OHA team working on the Basic Health Program (BHP). These connections have led to the scheduling of ongoing meetings between the OHA BHP team and CCO leaders and have acted as a platform to discuss operational and systemic pieces of information that will be necessary in the planning and implementation phases.

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

- Innovator Agents frequently answer time sensitive questions and urgent member related access to care cases. This included urgent member needs for behavioral health residential access, substance use

disorder facilities access, and non-emergent medical transportation needs, access to Health-Related Services and provider shortage issues.

- Since the new 5-year 1115 waiver has just been approved, CCOs have started reaching out through IAs to understand the specific and immediate needs of those changes that need to be implemented quickly. The focus has been on HRNS/HRS and the ability for OHP members to appeal any denied services. CCOs are in need of understanding what rules OHA will put in place so they are able to respond appropriately to OHP members' requests.

- Other questions include:
  - Healthier Oregon Program,
  - dental coverage expansion, including new COFA and Veteran's programs,
  - SHARE Initiative
  - Health literacy levels of NOABD notices and the ability deliver these to members in at reading level that is understandable to members, while maintaining OHA and CMS requirements in place.
  - Advisory Council (CAC) involvement in the 1115 Waiver Renewal process, including best ways for CAC members to provide feedback to the OHA.
  - Provided Public Health Emergency Unwinding updates to the CCOs and feedback to the OHA on CCO involvement in the process, including connection between the CCOs and the OHA Community Partner Outreach Team for outreach coordination related to the end of the Public Health Emergency.

- Elevate concerns from local FQHC regarding systems constraints; connect leadership with CCO and OHA to identify opportunities to support

- Support local community housing systems partners, including funders, legislators, and city partners with an OHA lens and resources for housing agency in potential collapse. Ongoing communication between partners to assure houseless population is supported as system creates new avenues of support.

- Engage with local FQHC related to concerns of member assignment as elevated by CCO to identify possible root cause issues of network adequacy

- Hold debrief on complex out of state case with CCO and Ombuds staff to identify best practices, and constraints as related to changes the system can make to best care for members in similar situations, including OHP and FFS lens on engagement.

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

- Flexible services dollars were exhausted in some regions due to covid and other needs, so utilizing some community benefit funds through the CAC, flexible service dollars were reallocated.

- The Innovator Agent worked with CCOs to share better understanding of Measure 110 and to strategize on the implementation of intersectional pieces with Medicaid. The purpose of Measure 110 is to make screening health assessment, treatment, and recovery services for drug addiction available to all those who need and want access to those services; and to adopt a health approach to drug addiction by removing criminal penalties for low-level drug possession. An example of steps taken by the Innovator Agent is sharing the lists of local M110 grantees with the CCOs to understand if the grantees were

contracted providers under the CCOs' networks. This helps promote better coordination between the Measure's implementation and improvement of current services under Medicaid.

- Facilitated the involvement of CCO representation in the Early Learning Council.
- Innovator Agent also took lead on the air conditioners distribution program under SB1536 to internally help with coordinating the project and collaborate with the CCOs to promote better understanding of the project and resources available to the community. Additionally, several IAs supported CCOs in the distribution of Air Conditioners (A/C) to high-risk members in need. IAs compiled feedback from the CCOs in implementing this program and made recommendations to the OHA on future improvements that could be made to program, including enhanced member and at large community communication around the eligibility of receiving an AC unit.
- IAs are working with School Based Health Care centers and CCOs to identify ways that young people that are gender questioning, LGBTQIA+, and/or transgender can be safe and well supported at school. Many of these young people are not well supported at home and the SBHCs and CCOs are identifying ways they can be safely referred to supportive providers for both physical and behavioral health care without causing concern or alienating their friends and families. In some regions of the state this continues to be the most difficult barrier to care for young people who are exploring their own identities.
- Support CCO staff looking at innovative community outreach ideas by connecting them with programs for assistive devices for disabled members; connecting with CPOP ROCs for outreach ideas and support; and additional research on good ideas from other CCOs to engage members in their own care

5. **Community partnerships supporting effective innovation.**

- An Innovator Agent connected CCOs with a community-based organization to provide free monthly bike subscriptions for OHP members in the area. The project is still under way to finalize the last steps of membership distribution from the CCOs. We expect this service to be available by the beginning of 2023.
- IA working to help implement the new South Coast Regional Health Equity Coalition. IA is helping to identify partnerships for the community health needs assessment and introducing the new staff SCRHEC to existing health equity partners in the region.
- The Innovator Agent engaged in community partnerships supporting effective innovation through the attendance of Local Community Health Partnership meetings. The IA engaged in conversation of SHARE initiative projects tied to Social Determinants of Health at these meetings. Over 20 applications were submitted by community-based organizations to the CCO for a request for funds to lead a project to benefit local communities and drive health equity.
- Work with local county commissioner to explain and champion support for CCO work, including governance, funding and innovation related to housing projects
- Respond to community concerns re: grant process from CCOs; engaging communities of color and tribes in equity work; engagement in specific projects like THW training, etc.

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 made final determinations of 2021 CCO HRS spending and shared results with CCOs and the OHA Office of Actuarial and Financial Analytics for use in the CCO Performance Based Reward calculations. OHA will release a spending summary report and analysis in October.

Staff presented at the Hospital Community Benefit Methodology Review annual meeting on HRS basics and alignment opportunities with hospital community benefit spending.

To improve future use of and support potential increases to HRS spending, staff continued to work with the Oregon Rural Practice-based Research Network on direct CCO TA. This quarter, that included holding a virtual convening focused on housing with alignment across HRS, SHARE (Supporting Health for All through REinvestment) and in lieu of services. Between 60 and 125 people attended each of the four days. Presenters represented local, state, and national efforts to increase housing availability for Medicaid members. Initial evaluation results were very positive.

In-lieu-of services

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

This quarter staff developed several ILOS services, which were proposed to CMS. In partnership with ORPRN, OHA held a virtual convening focused on housing with alignment across HRS, SHARE (Supporting Health for All through REinvestment) and ILOS.

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

Staff completed reviews and prepared a summary of the CCO CAC demographic reports.

The center hosted a peer-to-peer meeting with community advisory council (CAC) coordinators focused on tribal CAC member engagement. The center also hosted a CAC information session focused on the 1115 waiver and Community Investment Collaborative proposal.

Community health assessment (CHA) and community health improvement plan (CHIP)
The center hosted the third session in a new operations-focused CHA/CHIP learning collaborative for CCOs and their collaborative CHA/CHIP partners. This session focused on timelines and cycles. The center also reviewed and gave feedback on CCOs' CHIP progress reports and CHA/CHIP improvement plans. See a summary of CHIP Progress Report themes.

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.

Technical assistance for CCOs facilitated by the Oregon Rural Practice-based Research Network (ORPRN) included a learning collaborative session focused on implementing and scaling pilot programs. OHA also worked with ORPRN to hold a virtual convening focused on housing to support SHARE, health-related services and in lieu of services. Between 60 and 125 people attended each of the four days. Presenters represented local, state, and national efforts to increase housing availability for Medicaid members. Initial evaluation results were very positive.

Staff reviewed CCOs' SHARE spending reports for 2021, began planning for receipt of CCO SHARE spending plans due by the end of 2022, and offered office hours for CCOs needing support with development of spending plans.

CCO incentive metrics technical assistance

Diabetes (HbA1c control)
The Transformation Center continued a training series for Oregon Medicaid providers on using motivational interviewing for diabetes management. These no-cost virtual trainings (with continuing medical education credits) focus on improving providers' confidence and skills in conversations about sensitive behavior change topics required for diabetes management. Three types of trainings are available: level 1, level 2 and using motivational interviewing in diabetes management groups. This quarter the center hosted four trainings, with 111 participants total. All evaluation respondents (80) rated the training as valuable or very valuable.

Kindergarten readiness

- **Preventive dental** – The Transformation Center continued its two-year learning collaborative to increase rates of topical fluoride varnish applied in primary care and improve overall performance on the preventive dental care metric. Four CCOs are engaged in the work. This quarter, the center shifted to working one-on-one with the CCOs who participated in the collaborative. Staff also offered a set of office hours to help the CCOs develop their quality improvement efforts.
- **System-level social emotional health** – Implementation of this new CCO incentive metric began in January 2022 and is focused on improving the system of care and services for young children birth to five years old. The Transformation Center continued a 12-month learning collaborative for CCOs. Sessions focused on supporting CCOs to conduct cross-sector community partner engagement and asset mapping of services for young children. Learning collaborative sessions included presentations and support from Early Learning partners as well as pediatric and behavioral health clinicians with expertise in social and emotional supports for young children.

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. 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. Sixty-two clinics were recruited, which makes Oregon one of the highest-participating states nationally. ORPRN continues to provide technical assistance to participating clinics.

A protocol paper has been published in *PLOS ONE*, which can be found here: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0269635. Transformation Center staff worked in partnership with ORPRN, as part of the ANTECDENT team, to publish the paper.

Social determinants of health: social needs screening
The Metric and Scoring Committee adopted the SDOH measure concept (rate of social needs screening in the total member population using any qualifying data source) as part of the CCO incentive measure set. Measure implementation will begin January 1, 2023, and final measure specifications will be posted by the end of 2022. Staff have shifted toward planning and providing support to CCOs and their partners to implement the new SDOH metric in 2023. OHA finalized a technical assistance contract and scope of work with ORPRN to provide informational webinars, learning collaboratives and individual technical assistance to CCOs and their partners. Initial info sessions are scheduled for November 2022. Staff will also participate in an OHA cross-divisional alignment group aimed to coordinate many OHA efforts focused on SDOH across the agency.

Cross-cutting supports

Care coordination (CC) and intensive CC learning collaborative
The Transformation Center is hosting a monthly learning collaborative throughout 2022 to support CCOs and other organizations who provide care coordination to OHP members with the delivery of effective care coordination and intensive care coordination. This quarter, sessions focused on the Collective platform, care coordination activities report and children's health complexity data; CCO and PCPCH care coordination; and care coordination Oregon Administrative Rules.

COVID-19 vaccines: virtual learning series for providers
The Transformation Center continued its partnership with the OHA Vaccine Planning Unit & COVID-19 Response & Recovery Unit to host two learning sessions for providers in support of COVID-19 vaccine rollout. An average of 62 individuals attended each session. For the session focused on data and strategies for pediatric vaccine catch-up, 100% of evaluation respondents found the session to be valuable in supporting their work. Topics included navigating pediatric COVID-19 vaccine products and management, and data and strategies for pediatric vaccine catch-up. This learning series is now concluded.

COVID-19: Vaccines and equity
The Transformation Center is partnering with the Oregon Academy of Family Physicians, Boost Oregon, and Oregon Rural Practice-based Research Network to bring culturally and linguistically robust vaccine education to rural communities and communities of color. This project focuses on equity and motivational interviewing for providers, who will then become voices in their own communities to speak to vaccines and other emerging issues.

Boost Oregon has developed speaker training, culturally appropriate messaging, slide decks and supplemental materials in multiple language about COVID-19 vaccination to participating providers. Chosen trained

providers will give up to three 1–2 hour workshops. Workshops will be held at community gatherings, such as church events, community events and online events. Providers receive no-cost CME credits for the training and stipends for giving community workshops.

The consultants have trained 15 providers and are actively recruiting additional providers. Community workshops are being scheduled, with six locations identified across three regions in the state. Five community workshops have been held through September with data collected at four of the workshops. Data show that post-workshop, more participants (83% versus 52%) supported COVID-19 vaccines, with no participants continuing to oppose the vaccine. Additionally, the percent of participants who were vaccinated, but not boosted and did not plan to get a booster reduced from 28% to 17%. Overall, 97% of participants rated the workshops as excellent or very good.

Transformation and quality strategy (TQS) technical assistance

Staff held optional calls with five CCOs to discuss their 2022 TQS scores and feedback. Staff released requirements and guidance for 2023 submissions, including an updated template, guidance document, scoring criteria, FAQs, and example strategies. Many of the updates for 2023 support improved health equity, including the following:

- Requiring CCOs to use REALD (race, ethnicity, language, and disability) and SOGI (sexual orientation and gender identity) data for identifying and addressing disparities in all projects that use member-level data;
- Requiring CCOs to define the population for interventions, with encouragement to focus on prioritized populations (members eligible for intensive care coordination, populations identified in the state health improvement plan, or communities identified as having disparities); and
- Encouraging CCOs to use SMARTIE goals (SMART goals that are inclusive and equitable).

All guidance is available at: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

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	July/2022	August/2022	September/2022
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,254,251	1,260,413	1,258,395
Title XXI funded State Plan	130,809	132,744	134,318
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%	58,939	1,922	3.74%	18.35%
Optional	**Title XIX**	PLM women FPL 133-170%	N/A	N/A	N/A	N/A
	Title XXI	SCHIP FPL < 170%	138,182	368,992	1.96%	8.51%
Mandatory	**Title XIX**	Other OHP Plus	214,194	615,506	10.41%	18.81%
		MAGI adults/children	976,656	2,797,049	1.38%	6.26%
		MAGI pregnant women	18,595	46,770	-2.05%	70.33%
		QUARTER TOTALS	1,406,566			
** 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**
July	1,303,639	1,220,791	1,956	173	13,718	69,268	N/A
August	1,313,298	1,229,826	2,312	198	13,547	70,504	N/A
September	1,319,391	1,235,996	1,780	160	13,142	71,054	N/A
Quarter average	1,312,109	1,228,871	2,016	177	13,469	70,275	

** 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

Reported separately.