Oregon Health Plan

Section 1115 Quarterly Report

1/1/2023 – 3/31/2023

Demonstration Year (DY): 21 (10/1/2022 – 9/30/2023)

Demonstration Quarter (DQ): 2

Federal Fiscal Quarter (FQ): 2/2023

Oregon Health Authority

Table of contents

I. Introduction **1**
- A. Letter from the State Medicaid Director 1
- B. Demonstration description 1
- C. State contacts 2

II. Title **3**

III. Executive Summary **3**
- A. Enrollment progress 3
- B. Benefits 5
- C. Access to care 5
- D. Quality of care 5
- E. Complaints, grievances and hearings 5
- F. CCO activities 11
- G. Budget neutrality 14
- H. Legislative activities 14
- I. Litigation status 14
- J. Public forums 15

IV. Progress Toward Demonstration Goals **16**

V. Appendices **18**
- A. Quarterly enrollment reports 18
- B. Complaints and grievances 20
- C. CCO appeals and hearings 20
- D. Neutrality reports 20

I. Introduction

A. Letter from the State Medicaid Director

During this quarter, the Oregon Health Authority (OHA) continued to work with our partners in the Medicaid system to meet our program goals and statewide health equity goals. Governor Kotek took office early in this quarter. As expected during a governor transition, this quarter was focused on solidifying agency leadership and establishing expectations related to policy priorities and decision-making processes. During this quarter, OHA also experienced leadership changes and a related series of organizational changes relevant to 1115 waiver management. While this will not have long-term effects on waiver implementation, it did impact the progress of some activities during the quarter.

In January 2023, Governor Kotek released the proposed budget for the 2023 – 2025 biennium, which included funding for Oregon's 1115 Demonstration waiver initiatives. Progress toward implementation plans, timelines and waiver staffing proposals continued with the new administration during this period.

Dana Hittle, State Medicaid Director

B. Demonstration description

On September 28, 2022, the Centers for Medicare & Medicaid Services (CMS) approved Oregon's renewed 1115 Demonstration waiver, which is effective October 1, 2022, to September 30, 2027. This most recent approval included significant eligibility expansion authority as well as new services for individuals who have health-related social needs (HRSN) and are experiencing life transitions. Collectively, these reforms are expected to further OHA's goal to eliminate health inequities by 2030 by connecting underserved populations with effective health care and supports.

Several of Oregon's proposals are still being negotiated with CMS. These provisions include Tribal-related requests, a limited Medicaid benefit package for individuals in a state hospital or a carceral setting, and community investment collaboratives to fund local health equity efforts.

Voluminous and complex changes are included in the waiver, impacting many populations and creating new opportunities to address historical health inequities. Children who are enrolled in Medicaid at any time prior to their 6th birthday will remain enrolled until age 6. People over age 6 will automatically remain enrolled for two years (instead of one). These eligibility changes help members remain covered longer and be less likely to lose coverage because of short-term changes in eligibility, e.g., temporary income fluctuations.

The approved waiver includes some benefit changes for youth. All federally required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children and youth to age 21 will be available. Additionally, for youth with special health care needs (YSHCN), eligibility criteria will allow access to expanded benefits, including EPSDT, until age 26.

The waiver also includes significant and nationally innovative service expansions for target populations. Effective 2024, Oregon will provide HRSN benefits (such as housing and nutrition

services) to people who are experiencing specific transitions in their lives. Eligible populations include the following:

- YSHCN aged 19 – 26
- Youth who are child welfare involved, including those leaving foster care at age 18
- People who are experiencing homelessness or at risk of homelessness
- Older adults who have both Medicaid and Medicare health insurance
- People being released from custody
- People at risk of extreme weather events due to climate change

Under the new waiver, Oregon Health Plan (OHP) members will get increased care and social supports in more situations. OHA is committed to working collaboratively with Tribal governments, communities of color and members of other historically underserved populations to design a benefit and implementation approach that expands health care access and quality and improves the lifelong health of everyone in Oregon.

C. State contacts

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

Interim Deputy Director/Eligibility Policy Business Director
Vivian Levy, Eligibility Policy Business Director
503-519-3512 phone
503-945-5872 fax

Demonstration and Quarterly and Annual Reports
Tom Wunderbro, Medicaid Demonstration Waiver Manager
503-510-5437 phone
503-945-5872 fax

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

Coordinated Care Organizations (CCO)
David Inbody, CCO Operations Manager
503-756-3893 phone
503-945-5872 fax

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

Oregon Health Authority
For mail delivery, use the following address:
Oregon Health Authority
Health Policy and Analytics
500 Summer Street NE, E54
Salem, OR 97301-1077

II. Title

Oregon Health Plan Section 1115 Quarterly Report
Reporting period: 1/1/2023 – 3/31/2022
Demonstration Year 21—Quarter 2
Federal Fiscal Year 2023—Quarter 2

III. Executive Summary

This quarterly report summarizes OHA activities for Demonstration Year 21 Quarter 2 from January 1, 2023 through March 31, 2023. This quarter focused primarily on a statewide overview of progress toward operationalization of the approved waiver demonstration. The report includes implementation updates as well as summary reports regarding key Oregon Medicaid programmatic areas.

Significant accomplishments and milestones include, but are not limited to, the following:

- Increased CCO enrollment
- Improved CCO financial performance
- Established the level of effort expected for the Oregon Eligibility (ONE) system change to support the continuous eligibility (CE) policy
- Developed design work plan, including key dates of implementation to expand Medicaid eligibility and benefits for YSHCN up to age 26
- Submitted proposed Designated State Health Programs (DSHP) list and claiming protocol to CMS to advance progress on expanding access to HRSN-related supports

A. Enrollment progress

1. OHP eligibility

Because the Consolidated Appropriations Act delinked continuous Medicaid coverage allowances from any ongoing declarations of the Public Health Emergency (PHE) related to the COVID-19 pandemic, Oregon began preparing systems and processes for PHE unwinding activities starting April 1, 2023. This preparation included putting eligibility renewals on hold in the months of February and March 2023 while the eligibility system was being updated with functionality to support post-PHE renewals and determinations. During this quarter, no other significant policy or system changes were implemented. Slight variances in overall enrollment numbers can be attributed to continued PHE eligibility protections and simplified eligibility rules, the Federally Facilitated Marketplace (FFM) open enrollment period ending, and public media campaigns related to the ending of the PHE period.

2. CCO enrollment

Total CCO enrollment for January 2023 – March 2023 grew by 2.4% across all plan levels (CCOA, CCOB, CCOE, CCOG). Specific CCO membership growth ranged between 1.4% and 4.5%. During this quarter, enrollment growth for Trillium Community Health Plan in the Portland metro Tri-County area started to stabilize as it has established 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.

DY21 Q2 (Jan – Mar 2023) Member Growth Zone	CCO Service Areas
Greater than 5.001%	0
3.00% – 4.99%	1
2.00% – 2.99%	12
0.00% – 1.99%	3
Reduction in enrollment	0

Overall enrollment growth was slightly lower than in the previous quarter and lower than in the same period in 2022. Please see the table below for a comparison of enrollment growth across all quarters.

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	DY21Q1 10/22 – 12/22	DY21Q2 1/23 – 3/23
3.5%	2.4%	2.2%	2.4%	2.6%	1.4%	2.9%	2.5%	2.4%

As noted in previous reports, on May 1, 2020, the OHA 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 2023 (December 31, 2023).

Between January 2023 and March 2023, two CCOs required adjustment above their 2023 contract limit in 23 county service areas in order to sustain auto-enrollment algorithms.

B. Benefits

The Pharmacy &Therapeutics (P&T) Committee: The P&T Committee developed new or revised prior authorization (PA) criteria for the following drugs: oncology agents; orphan drugs; gonadotropin-releasing hormone antagonists (GnRH); spinal muscular atrophy (SMA) drugs; buprenorphine and buprenorphine/naloxone; long-acting opioids; inebilizumab-cdon (UPLIZNA); ravulizumab (ULTOMIRIS); eculizumab (SOLIRIS); satralizumab-mwge (ENSPRYNG); and efgartigimod (VYVGART).

The committee also recommended the following changes to the preferred drug list (PDL): designate Combivent Respimat® preferred; nefazodone preferred; and protriptyline and trimipramine voluntary non-preferred.

Health Evidence Review Commission (HERC): For the January – March 2023 time period, the Notification of Interim Changes for the February 1, 2023 Prioritized List was published January 1, 2023. Errata to the prioritized list were published January 29, 2023.

C. Access to care

This information will be updated in the annual monitoring report.

D. Quality of care

This information will be updated in the annual monitoring report.

E. Complaints, grievances and hearings

1. CCO and FFS complaints

The information provided in the charts below is a compilation of data from the current 16 CCOs and fee-for-service (FFS) data.

Trends

	Apr – Jun 2022	Jul – Sep 2022	Oct – Dec 2022	**New: Jan – Mar 2023**
Total complaints received	4,398	4,938	4,402	5,103
Total average enrollment	1,475,164	1,514,019	1,533,995	1,537,181
Rate per 1,000 members	2.98	3.26	2.87	3.32

Statewide Rolling 12-Month Complaint Totals

Complaint category	Apr – Jun 2022	Jul – Sep 2022	Oct – Dec 2022	**New: Jan – Mar 2023**
Access to care	1,618	1,990	1,676	1,894
Client billing issues	416	411	392	435
Consumer rights	436	386	314	376
Interaction with provider or plan	1,277	1,337	1,329	1,585
Quality of care	510	596	496	610
Quality of service	141	218	195	203
Other	0	0	0	0
Grand Total	4,398	4,938	4,402	5,103

Barriers

CCO data illustrate that the number of complaints reported for the January – March 2023 quarter shows a 16% increase from the previous October – December 2022 quarter. The access to care category continues to have the highest number of complaints, with a 13% increase from the previous quarter. Complaints associated with the interaction with provider or plan category increased 19% compared with the previous quarter. Quality of care continues to be the third-highest category of complaints, with a 23% increase from the previous quarter.

FFS data continue to show that the highest number of complaints are billing issues, with quality of care issues being the next-highest category.

Interventions

Under the managed care delivery system, CCOs report that nonemergency medical transportation (NEMT) issues continue to be where the highest numbers of complaints are filed. CCOs are continuing to work with their NEMT providers to increase communication about NEMT issues and ensure NEMT providers are performing as required under their contracts. CCOs report that the implementation of automated systems, increased communication and listening to community input are helping to address complaints. According to some CCOs, NEMT brokerages are continuing to hold town halls with members, providers and stakeholders. Some CCOs are reporting that the driver shortage is beginning to ease.

Dental issues continue to generate a high number of complaints. Some CCOs report they are continuing to work with dental offices to help resolve scheduling and communication issues to improve services.

CCOs have established committees and task forces specifically to address provider capacity within their networks. CCOs are also improving their auditing processes to ensure services are delivered in a timely manner and that member grievances are being forwarded to the CCOs. CCOs continue to report that they are increasing care coordination and are providing more health navigators to assist members in making appointments and attending appointments, and other steps to improve services to members. Some CCOs report establishing committees to improve the member experience. CCOs report that they continue to monitor trends and are working to improve services to their members.

Under the FFS delivery system, 158 complaints were received from members during this quarter. An additional 523 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. Informational calls (8,197) were received asking for a variety of information, such as information about member coverage and CCO enrollment, and to request ID cards.

2. CCO Notice of Adverse Benefit Determinations and Appeals (NOABD)

NOABD

The following table lists the total number of NOABDs issued by CCOs during this quarter. The NOABDs are listed by reason, as per 42 C.F.R. 438.400(b)(1 – 7) and are the total number of NOABDs issued, regardless of whether or not an appeal was filed. During this quarter, CCOs report that the highest number of NOABDs issued were pharmacy-related, followed by dental care and issues with specialty care. CCOs report that eligibility remains one of the most common reasons for denials. This quarter, some CCOs report on fluctuations in denials from quarter to quarter, but overall denials reported this quarter are at normal levels. The increase in denials from prior quarters also reflects adjustments some contracted partners have made in their reporting to the CCOs. Some CCOs are working to provide information about OHP members who are terminating to assist providers in reducing confusion and requests for services that will end in denials. CCOs continue to monitor NOABDs to ensure written notices are sent to members in easily understood language and include the appropriate citations. CCOs report instituting processes related to tracking for timeliness, as well as reviewing for utilization and appropriateness of care, to ensure NOABDs are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	Apr – Jun 2022	Jul – Sep 2022	Oct – Dec 2022	New: Jan – Mar 2023
a) Denial or limited authorization of a requested service	28,669	26,379	25,077	58,595
b) Single pre-paid health plan (PHP) service area, denial to obtain services outside the PHP panel	680	658	709	1,455

c) Termination, suspension or reduction of previously authorized covered services	126	73	79	136
d) Failure to act within the time frames provided in Section 438.408(b)	9	12	19	6
e) Failure to provide services in a timely manner, as defined by the state	101	52	60	60
f) Denial of payment, at the time of any action affecting the claim	52,775	56,727	57,162	83,280
g) Denial of a member's request to dispute a financial liability	0	0	0	0
Total	82,360	83,901	83,106	143,532
Number per 1,000 members	68.43	67.66	66.00	107.8

CCO Appeals

The table below shows the number of appeals the CCOs received during the January – March 2023 quarter. CCOs report that the highest number of appeals were for pharmacy services. Outpatient services was the next most common category of appeals, followed by specialty care. CCOs report they review their overturn rates, which prompts more in-depth discussions and reviews, monitoring and process changes. Some CCOs report that peer reviews with providers are resulting in service improvements. CCOs report they are continuing to implement activities such as staff education and monitoring for providers to improve understanding of the appeal process. CCOs also report working with members to assist them in finding needed services or alternative covered options.

CCO Appeals	Apr – Jun 2022	Jul – Sep 2022	Oct – Dec 2022	New: Jan – Mar 2023
a) Denial or limited authorization of a requested service	1,193	1,159	1,016	1,045
b) Single PHP service area, denial to obtain services outside the PHP panel	22	34	16	14

c) Termination, suspension or reduction of previously authorized covered services	5	2	0	0
d) Failure to act within the time frames provided in Section 438.408(b)	0	0	0	0
e) Failure to provide services in a timely manner, as defined by the state	0	0	3	0
f) Denial of payment, at the time of any action affecting the claim	331	433	396	243
g) Denial of a member's request to dispute a financial liability	0	0	0	0
Total	1,551	1,628	1,431	1,302
Number per 1,000 members	1.29	1.31	1.14	.98
Number overturned at plan level	524	579	471	602
Appeal decisions pending	0	1	5	19
Overturn rate at plan level	33.78%	35.57%	32.91%	46.24%

CCO and FFS Appeals and Hearings

The following information is a compilation of data from 16 CCOs[1] and FFS.

During the second quarter (January 1, 2023 – March 31, 2023), the OHA received 179 hearing requests related to the denial of medical, dental and behavioral health services, including NEMT. Of those received, 160 were from CCO-enrolled members, and 19 were from FFS members.

[1] Effective January 1, 2023, OHA assigned all members who had been enrolled in a dental care organization (DCO) to a CCO through a new CCOF (dental-only) plan type in order to better service the needs of our members and relieve the administrative burden for DCOs.

Of the cases, 180[2] were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing.

OHA dismissed 82 cases that were determined not-hearable cases. Of the not-hearable cases, 59 were forwarded to the member's respective CCO to process as an appeal. Per Oregon Administrative Rule, OHP members must exhaust their appeal rights at the CCO level and receive notice of appeal resolution (NOAR) before they can request a contested case hearing at the state level. Hearing requests received by OHA prior to the appeal being exhausted are dismissed as not hearable with a letter to the member explaining their appeal rights through the CCO and their hearing rights after receiving an NOAR.

Of the 82 cases that were determined to be hearable, 27 were approved prior to hearing. Members withdrew from 31 cases after an informal conference with an OHA hearing representative. Twenty-two cases went to hearing, where an administrative law judge upheld the OHA or CCO decision, and 14 cases were dismissed for the member's failure to appear. The administrative law judge reversed the decision stated in the denial notice in three cases and set aside the denial notices in one case.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	27	15%
Client withdrew request after pre-hearing conference	31	17%
Dismissed by OHA as not hearable	82	46%
Decision affirmed*	22	12%
Client failed to appear*	14	8%
Dismissed as non-timely	0	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	3	2%
Set aside	1	1%
Total	180	

* Resolution after an administrative hearing.

Reports are attached separately as an appendix.

[2] In every quarter, there is an overlap between processed cases and those received. For instance, cases processed and resolved in January of 2023 may be cases OHA received as far back as November and December of 2022.

F. CCO activities

1. New Plans

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

One of the previously existing plans—Trillium Community Health Plan—had applied to continue in its historical Lane County service area and to expand into Clackamas, Multnomah and Washington Counties (the Tri-County). OHA denied Trillium a notice to proceed in the Tri-County and gave until June 30, 2020, for Trillium to demonstrate a sufficient provider network in the Tri-County, or that service area would be removed from its contract. On August 14, 2020, OHA approved Trillium's expansion into the Tri-County, effective September 1, 2020. This expansion was subject to a Corrective Action Plan (CAP), effective March 5, 2021; the CAP was closed on May 31, 2022.

2. Provider Networks

Nothing to report for this quarter.

3. Rate Certifications

OHA pays CCOs to cover individuals eligible for Medicaid using capitation rates. Capitation rates set the levels of predetermined payments that depend on each individual's OHP eligibility status and are paid to CCOs on a monthly basis, dependent on enrollment.

These capitation rates are developed and certified by OHA's contracted actuaries on a yearly basis. The process and methodology used to develop capitation rates are governed by federal and state regulations.

OHA has continued planning efforts around the HRSN services implementation for 2024. This includes refining the CCO contract language to allow non-risk payments and evaluating changes needed for the Medicaid Management Information System (MMIS) system design. OHA is developing a survey to gather more information about fee schedules and cost data to inform the HRSN fee schedule.

OHA has also provided several items to assist CCOs in their data validation for CY22 activities. CCOs are expected to submit their data validation later in this quarter. In addition, OHA provided the annual rates package to CCOs to prepare for the CY24 rate development year. This package included key deadlines and described the data grouping process utilized by OHA and Mercer for categories of services to aid CCOs.

4. Enrollment/Disenrollment

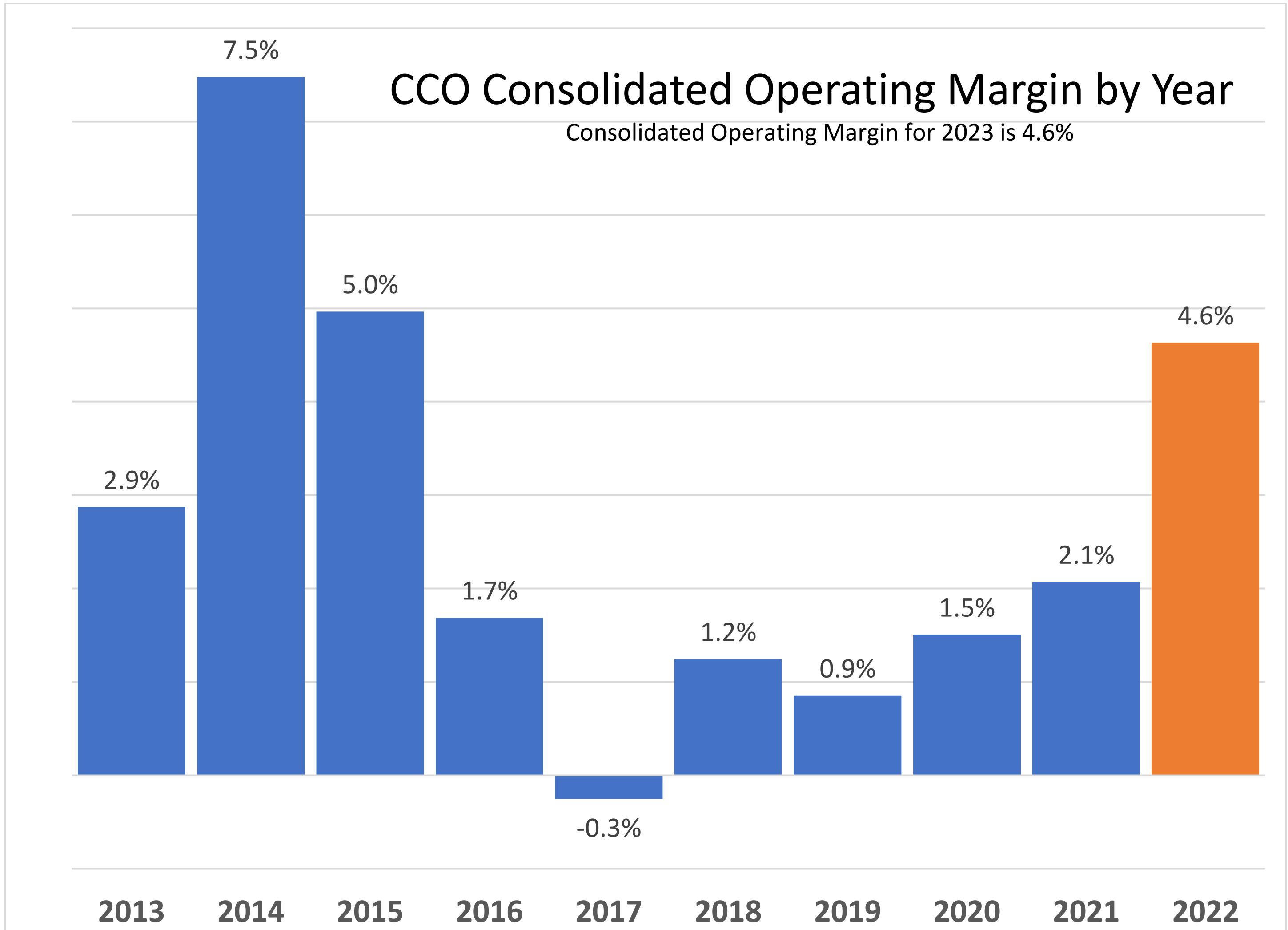
All significant enrollment and disenrollment trends are discussed in other sections of this report and in Appendix A.

5. Contract Compliance

There are no additional issues with CCO contract compliance aside from those discussed in subsection 7 (CAPs) of this section.

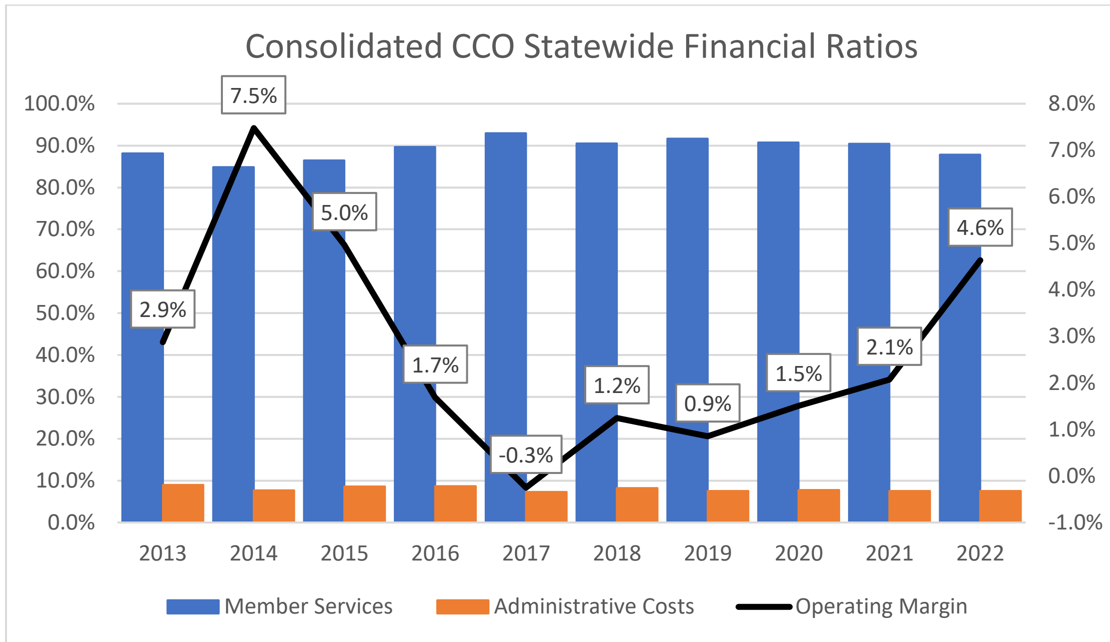
6. Relevant Financial Performance

CCOs achieved a statewide operating margin of 4.6% for the year ended December 31, 2022. This is an increase from prior years and a significant margin for the CCOs, as their membership has increased since March 2020. However, this may trend downward in the coming months due to redeterminations of members since the end of the PHE.



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (including 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 percentage of the payments that CCOs received has remained relatively consistent year over year, with a statewide minimum medical loss ratio (MMLR) of 85% as the benchmark for all CCOs to avoid

a rebate. Member services spending across all CCOs for 2022 was 87.8%. In 2021, the consolidated percentage for all CCOs was 90.4%. Administrative costs of 7.6% for 2022 are in line with the prior year average, which was 7.5%.



For 2022, five of the 16 CCOs met or exceeded the 85% target for MSR, a key indicator for MMLR. However, CCOs in Oregon also have the option to include certain additional spending as a part of their medical spending for the purposes of determining whether they have achieved this minimum.

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

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

7. CAPs

The continuing CAP for the Health Share of Oregon (HSO) addressed noncompliance with a CCO contract and Oregon Administrative Rule. Specifically, the HSO did not provide reliable NEMT services to covered appointments, resulting in disruption to members' access to care. This CAP started on October 14, 2019, and ended on February 1, 2023.
A plan was developed and implemented to correct issues identified by OHA. The CCO initially submitted weekly reports to OHA for the duration of the CAP, which changed to monthly reporting in February 2021.

OHA determined the remaining five areas of noncompliance have been remedied, as evidenced through the monthly reporting submitted by the HSO. OHA closed this CAP on February 1, 2023, and encouraged the HSO to establish ongoing monitoring of all CAP-related areas to detect any future issues in providing adequate access to NEMT services.

On February 16, 2023, OHA initiated three new CAPs with the following entities:

The HSO, Columbia Pacific CCO (CP CCO) and Jackson Care Connect CCOs did not require providers to use PA for intensive in-home behavioral health treatment (IIBHT) services and were consequently noncompliant with the CCO contract and Oregon Administrative Rule. The start date of the CAP was February 16, 2023, and the CAP will remain in effect until OHA determines it can be closed. The CCOs must demonstrate that they have established a PA process for IIBHT services and provide evidence of compliant behavioral health policies and procedures, provider communications, and trainings regarding the process.

8. One-Percent Withhold

The Health Systems Division within OHA analyzed encounter data received for completeness and accuracy for the subject months of June 2022 through August 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 June 2022 and August 2022. No withhold was taken, as the CCO put remediation in place to ensure ongoing compliance. OHA leadership determined that due to the pandemic affecting recent submissions, no withhold would be applied.

G. Budget neutrality

OHA is unable to report on the current waiver's new Budget Neutrality Workbook template. The agency is working to have 1115 system configurations implemented by October 1, 2023, to align with the current waiver reporting requirements. However, system configuration data is dependent on other system change requests, including continuous eligibility (CE) indicators, and may not be ready by October 1, 2023. OHA hopes to submit the report by February 2024 with available data retroactive to the beginning of the waiver.

H. Legislative activities

Oregon's state legislative session began during this period, and a summary of relevant passed legislation will be included in the next reporting period.

I. Litigation status

Connecticut v. Generic Drug Manufacturers* and *Wisconsin v. Indivior

These are multistate 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

Oregon Health Authority

This case concerns a petition for judicial review of OHA's PA criteria, as set out in rule, for the prescription medication Exondys 51. Petitioner Sarepta Therapeutics, Inc., argued that OHA exceeded its authority in adopting the criteria because the criteria conflicted with drug-coverage requirements under the federal Medicaid Act, specifically the Medicaid Drug Rebate Program. The parties submitted briefs regarding the validity of the PA criteria, and the case was argued before the Oregon Court of Appeals on March 12, 2021. In April 2023, the Court of Appeals issued a decision affirming the validity of the PA criteria for Exondys 51. The court construed the applicable Medicaid Act provisions and held that OHA's PA criteria for Exondys did not, on their face, contravene the Medicaid Act. Sarepta Therapeutics, Inc., has since petitioned that the Oregon Supreme Court take review of this case. A decision on whether the Oregon Supreme Court will undertake further review remains pending.

J. Public forums

During this quarter, general updates regarding the 1115 waiver were provided in various public forums. Governor Kotek's Administration took office in January, and the new team needed time to examine details of the waiver's special terms and conditions, understand OHA's progress to date, learn about the extent of inter-agency and inter-system involvement in planning, and identify opportunities to align decision-making processes with the governor's preferences. Given this context, the level of information provided to external audiences during the quarter remained relatively high-level. The following (non-exhaustive) list of meetings included the 1115 waiver as an agenda item:

- Public Health Advisory Board (PHAB): 1/12/2023
    - 1115 Medicaid Waiver Summary: Lori Coyner, Senior Medicaid Policy Advisor, OHA, shared overarching goals, authorities and funding of the 1115 Medicaid Waiver and connections and opportunities for Oregon's public health system.
        - PHAB members shared appreciation for focus on people in the carceral system and asked about connections between the CCOs and the Local Public Health Authorities related to the waiver benefits.
- Association of Oregon Community Mental Health Programs (AOCMHP) 1/24/23
    - 1115 Medicaid Waiver Overview: Dana Hittle, Medicaid Director, OHA, shared the innovations in the waiver, especially concerning transitions of care, housing, other health-related social needs benefits and EPSDT services.
- Medicaid Advisory Committee (MAC): 1/25/23
    - 1115 Medicaid Waiver Summary: Lori Coyner, Senior Medicaid Policy Advisor, OHA, shared details about the 1115 Medicaid Waiver implementation around services for the houseless, Medicaid to Medicare substance use disorder (SUD) treatments, and services related to climate change. The presentation sought input from MAC members about implementation plans.
- Health Information Technology Oversight Council (HITOC): 2/2/23
    - 1115 Medicaid Waiver Summary: Lori Coyner, Senior Medicaid Policy Advisor, OHA, presented on the four components of the Medicaid 1115 Waiver that support the primary focus of advancing health equity in Oregon, specifically:
        - Continuous Medicaid enrollment

    - HRSN benefits
    - Smart, flexible spending for health equity through extra federal funding dollars called DSHP Funding
    - Creating a more equitable, culturally and linguistically responsive health care system through creation of community investment collaboratives; approval of this component was still pending
  - Discussed opportunities for Health IT through the waiver work, specifically Health Information and Community Information Exchanges.
  - HITOC Member Panel on Waiver Implications: Susan Otter, Director of Health Information Technology & Analytics Infrastructure, OHA, facilitated a panel of four HITOC members who volunteered to speak about the waiver implications on their organizations' work and about how they believe it will help reduce health inequities.

IV. Progress Toward Demonstration Goals

This section contains updates regarding major components of the CMS-approved waiver. The format for this section will evolve when CMS guidance regarding a reporting template is made available.

CE for Adults and Children

Oregon received approval via the 1115 Demonstration waiver to expand CE policy provisions as follows:

- All children who are eligible and approved for OHP prior to turning 6 years old will maintain CE through the end of the month of their 6th birthday, or for 24 months, whichever is later.
- Individuals over age 6 who are eligible and approved for OHP will maintain CE for 24 months.

In January 2023, Governor Kotek released the proposed budget for the 2023 – 2025 biennium, which included funding for Oregon's 1115 Demonstration waiver initiatives.

In Q1 of 2023, Oregon worked with the technology contractor, Deloitte, to establish the level of effort expected for the Oregon Eligibility (ONE) system change to support the CE policy. Joint Application Design (JAD) sessions continued through Q1.

Expand Medicaid Eligibility and Benefits for YSHCN up to Age 26

Oregon was approved to expand Medicaid eligibility to YSHCN, a newly defined population that aims to support youth with preexisting health conditions as they transition into adulthood. Focus populations considered while designing the implementation include youth exiting carceral settings or the foster care system, as well as priority populations defined by OHA in the State Health Improvement Plan 2020 – 2024 (also known as *Healthier Together Oregon*).

Progress in Q1 (January – March 2023) includes the following:

- Shifted implementation date from July 1, 2024, to January 1, 2025, to allow for necessary technological system updates.

Oregon Health Authority

- Identified key implementation staff in OHA; Office of Health Policy and Analytics is responsible for program design.
- Identified key partners across OHA and partner agencies (Oregon Department of Human Services, Oregon Department of Education) in implementation and began relationship building.
- Developed design work plan, including key dates of implementation.
- Expanded biweekly YSHCN Policy Oversight Committee to examine policy choices to make or elevate decisions.
- Introduced a partnership with the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN).

Expand Access to Supports That Address HRSN

The recently approved waiver includes the authority to establish a series of time-limited services to help address eligible members' HRSN services, including nutrition, housing, and specific state or federally declared climate events (e.g., wildfires, extreme temperatures.) Case management related to these new services is an additional component of the approved waiver.

As is the case with all states' governor transitions, adequate time and attention must be taken at the beginning of the term to solidify agency leadership and establish expectations related to policy priorities and decision-making processes. During this quarter, OHA experienced leadership change. James Schroeder, who had been appointed Interim Director in December 2022, left office in March 2023. At that point, Dave Baden, the agency's Chief Financial Officer, was appointed Interim Director. The relatively short tenure of Director Schroeder included a series of organizational changes to 1115 waiver management relative to the approach of the previous administration. Upon his departure, additional organizational changes were made. This series of events did not affect work on CMS deliverables related to waiver implementation, but it did have the effect of delaying the establishment of a permanent decision-making structure related to components of the waiver's programmatic framework and community and systems engagement strategies. While this will not have long-term effects on waiver implementation, it did impact the progress of some activities during the quarter.

To undertake this work in an organized and efficient manner, a series of workstreams were established with participation from subject matter experts representing OHA, the Oregon Department of Human Services (ODHS) and Oregon Housing and Community Services (OHCS). Staff from Manatt Health supported designated workstreams, as did members of OHA's project management team and Strategic Action Team.

In this quarter, the proposed DSHP list and claiming protocol were developed and submitted for approval.

DSHP

To date, Oregon has received approval for 15 programs to claim federal financial participation as DSHP.

In January and February 2023, OHA submitted 32 programs for approval by completing a financial template, separate narrative templates for each program and a claiming protocol.

Alignment with Tribal Partners' Priorities

Of note, there are several areas of 1115 waiver authority of specific interest to American Indian/Alaska Native beneficiaries that have not yet been approved by CMS. Specifically, two proposals remain outstanding, and a negotiation timeline has not been identified:

- Enable the Special Diabetes Program for Indians (SDPI) to be converted to a Medicaid benefit.
- Allow Tribal health care providers to receive reimbursement for the provision of Tribal-based practices.

Biweekly meetings between the OHA Office of Tribal Affairs and the Medicaid Director inform representatives of that office of new policy and operational developments. These meetings provide an opportunity for members of the Tribal Affairs team to indicate specific topical areas in which they would like to engage, and also to inform their team's regular updates to Tribal leaders. As implementation planning proceeds, formal Tribal consultation will occur for all topics identified as appropriate by Tribal leaders. In this quarter, HRSN and Tribal members' journeys will continue to be informed by ongoing discussions. The required Model Tribal Engagement and Collaboration protocol was developed and submitted for approval.

V. Appendices

A. Quarterly enrollment reports

1. Statistical Enrollment Data System (SEDS) reports

Attached separately.

2. State-reported enrollment table

Enrollment	January 2023	February 2023	March 2023
Title XIX-funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,270,274	1,298,149	1,309,935
Title XXI-funded State Plan	137,784	146,440	143,679
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	Poverty Level Medical (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%	63,895	5,238,325	2.04%	11.56%
Optional	Title XIX	PLM women FPL 133% – 170%	N/A	N/A	N/A	N/A
	Title XXI	SCHIP FPL < 170%	145,135	11,729,516	2.66%	6.32%
Mandatory	Title XIX	Other OHP Plus	226,736	19,541,457	2.84%	17.70%
		MAGI adults/children	1,011,714	86,904,902	1.36%	6.14%
		MAGI pregnant women	20,597	1,563,190	-1.22%	23.06%
		QUARTER TOTALS	1,468,077			

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

OHP eligible and managed care enrollment

OHP eligible*		Coordinated Care				Dental Care	Mental Health
		CCOA**	CCOB**	CCOE**	CCOG**	DCO	MHO
January	1,356,561	1,272,048	151	73	12,563	71,079	N/A
February	1,364,397	1,278,440	113	62	12,551	72,654	N/A
March	1,371,366	1,283,571	114	64	12,521	75,989	N/A

Quarter average	1,364,108	1,278,020	126	66	12,545	73,241	N/A

** Total OHP eligibles include Temporary Assistance for Needy Families (TANF), presumptive eligible with or without Medicare (GA), PLM-Adults, PLM-Children, MAGI Adults/Children, MAGI Pregnant Women, Old Age Assistance (OAA), Blind, Disabled and General Assistance Client (ABAD,) CHIP, foster care (FC) and foster care and sub-adoptive care (SAC). Due to retroactive eligibility changes, the numbers should be considered preliminary.*
***CCOA: Physical, dental and mental health; CCOB: Physical and mental health; CCOE: Mental health only; and CCOG: Mental and dental health*

B. Complaints and grievances

Attached separately.

C. CCO appeals and hearings

Attached separately.

D. Neutrality reports

Budget monitoring spreadsheets are attached separately.