CCO Behavioral Health Report 2020

Measures of Behavioral Health Service Delivery

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Contents

Acknowledgments

Staff at the Oregon Health Authority prepared this publication.

Executive Summary

Oregon's unique coordinated care model has made progress on the Triple Aim goals of better health, better care and lower costs. The Oregon Health Plan (OHP) is the source of health coverage for approximately one million Oregonians. The OHP and its 15 coordinated care organizations (CCOs) have improved access to primary care and reduced costly emergency room visits; however, there is work to do to ensure all Oregonians have access to comprehensive behavioral health services.

In 2017, Governor Kate Brown directed the Oregon Health Policy Board (OHPB) to provide recommendations to advance Oregon's healthcare transformation efforts, including to improve the behavioral health system and address barriers to integration of care. The Oregon Health Authority (OHA) worked in partnership with OHPB to develop policies for the 2020 CCO contracts. The policies aimed to make CCOs more accountable for developing a person-centered behavioral health system that members can count on, no matter who they are or where they live. These policies were incorporated into the 2020 CCO contracts. In October 2019, OHA signed contracts with 15 organizations to serve as CCOs for approximately 90% of OHP members. On Jan. 1, 2020, the 15 CCOs began service to OHP members across the state.

This report describes the progress of Oregon's coordinated care organizations (CCOs) on behavioral health measures for 2020. Measuring quality and access to care, and holding CCOs accountable to key metrics, is a cornerstone of Oregon's health system transformation. The Behavioral Health Report (BHR) is intended to measure the quality of services and access to care. This first report will serve as a baseline and is focused on the following areas: 1) network adequacy and provider capacity information; 2) access to care as measured by timely prior authorizations; 3) specific behavioral health measures designed to assess the quality of behavioral health services provided to members; 4) assessment and comparison of CCO performance; 5) a discussion of plans for future reports.

Measures Reported by CCOs

Summary

This report describes the progress of Oregon's Coordinated Care Organizations (CCO) on behavioral health services. Measuring quality and access to care, and holding CCOs accountable to key metrics, is a cornerstone of Oregon's health system transformation.

Medicaid Waiver

State Medicaid programs (health coverage for people earning less than 138 % of the federal poverty level, and people who are aged, blind or experiencing disabilities) are administered by individual states but must follow certain federal requirements. States may obtain a 1115 Medicaid Demonstration waiver from the federal government, which grants them extra flexibility in how they use federal Medicaid funds and administer Medicaid programs in their state, with the goal of improving health care programs. Oregon has had an 1115 OHP Demonstration waiver since 1994. The 1115 OHP Demonstration waiver allows Oregon to deliver Medicaid services in unique ways, such as through the coordinated care model. Some of the key elements of Oregon's coordinated care model include using best practices to manage and coordinate care; transparency in price and quality; paying for better quality care and better health outcomes; shared responsibility for health; sustainable rate of growth; and measuring performance.

Coordinated Care

A coordinated care organization (CCO) is a network of health care providers (physical, behavioral, and oral health care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under OHP (Medicaid). CCOs were formed in Oregon in late 2012. In 2019, after an extensive procurement process, OHA signed new contracts with 15 CCOs to operate in communities across Oregon beginning on January 1, 2020. CCOs have the flexibility to support new models of care that are patient-centered, team-focused, and eliminate health inequities. CCOs can better coordinate services and focus on prevention, chronic illness management and person-centered care. They have flexibility within their budgets to provide services alongside today's OHP-covered benefits with the goal of meeting the triple aim of better health, better care and lower costs for the populations they serve. Before Oregon's CCOs were formed, physical, behavioral and oral health care were not integrated, making things more difficult for patients and providers and more expensive for the state.

Medicaid Expansion

Beginning in 2014, many more Oregonians were able to join the Oregon Health Plan because of federal health care reform law known as the Patient Protection and Affordable Care Act, which increased the income limit for Medicaid eligibility. The number of people covered by CCOs increased by 63%, from about 614,000 in 2013 to 1.2 million in 2021.

Behavioral Health Improvements

In 2017, Governor Kate Brown directed the Oregon Health Policy Board (OHPB) to provide recommendations to advance Oregon's healthcare transformation efforts, including to improve the behavioral health system and address barriers to integration of care. OHA worked in partnership with OHPB to develop policies for the 2020 CCO contracts. The policies aimed to make CCOs more accountable for developing a person-centered behavioral health system that members can count on, no matter who they are or where they live. Together, the policies aimed to remove barriers between behavioral, physical, and oral health. These policies were developed to help all members receive the right care, at the right time and in the right place. Policies required CCOs to:

- Be fully accountable for the behavioral health benefit.
- Assess capacity of comprehensive services.
- Address prior authorization and network adequacy issues that limit member choice and timely access to:
- Expand programs that integrate primary care into behavioral health.
- Support electronic health record adoption and access to electronic health information.
- Develop a diverse and culturally responsive workforce; and
- Ensure children have behavioral health needs met with access to appropriate services.

In October 2019, OHA signed contracts with 15 organizations[1] to serve as CCOs for the majority of OHP's approximately 1 million members. On Jan. 1, 2020, the 15 CCOs began service to OHP members across the state. The new contracts set new requirements for CCOs to improve care for OHP members and hold down cost increases in Oregon's Medicaid program. The contracts represent the largest procurement in state history, totaling more than $6 billion for the 2020 contract year.

Improving the behavioral health system is a priority for the next four years for CCOs. CCOs are required to administer behavioral health services, programs, and activities in the most integrated setting appropriate to the needs of members.

Measure Development

Measures in this report were designed to assess quality of services and access to behavioral health care. The CCO contract and relevant Oregon Administrative Rules were used as the foundational documents. All measures in this report were developed in partnership with the CCO Behavioral Health Directors via presentations and discussion at monthly meetings. Measures in this report were submitted by the CCOs or from OHA's Health Policy and Analytics division.

Impacts of the COVID-19 Pandemic

Because of the global pandemic that hit the United States in March 2020 and the declaration of a public health emergency (PHE), OHA evaluated and released sources of funding quickly to support CCOs as they prepared for a potential surge in patients needing care, including an anticipated surge in behavioral health needs. OHA sent explicit direction to all CCOs to cover synchronous video (or telephone-based service delivery if synchronous video was not possible) when medically or clinically appropriate to replace in-person visits. CCOs were asked to communicate to their members and provider networks about these options. CCOs were also permitted to use funds to purchase necessary equipment for members so they could participate in video or telephone-based services. These efforts were implemented to ensure continued access to care while containing the spread of the virus.

In response to the PHE, OHA briefly suspended some reporting requirements for Community Mental Health Programs (CMHPs) and CCOs to ensure community providers and CCOs could focus all efforts on addressing the needs of the community. The brief data suspension resulted in some data elements not being included in this report (Appendix A). Subsequent reports will include additional data as it becomes available. Appendix A has the full list of data elements the report will eventually include.

[1] In 2020, OHA approved updated application materials from Trillium Community Health Plan to expand its OHP service area to include Clackamas, Multnomah and Washington counties. Trillium started enrolling OHP members in those areas on September 1, 2020.

Report Highlights

As stated in the preamble to Exhibit M to the 2020 CCO contract, CCOs will administer behavioral health services designed to empower members to live, work, and thrive in their communities. One purpose of the annual Behavioral Health Report (BHR) described in Exhibit M, Section 20.a is to understand quality of care and access to behavioral health services throughout the state. This first report will serve as a baseline and is focused on the following areas: 1) network adequacy and provider capacity information; 2) access to care as measured by timely prior authorizations; 3) specific behavioral health measures designed to assess the quality of behavioral health services provided to members; 4) assessment and comparison of CCO performance; 5) a discussion of plans for future reports. Appendices contain tables and graphs visually comparing CCO performance.

This report provides each CCO with a view on how their performance compares to their peers on certain elements. This initial report will serve as a baseline for these measures and OHA will work with partners to develop attainable goals. In October 2020, OHA issued a guidance document to CCOs for submitting data for this report.

Data for each reporting area is compared to the requirements in the CCO contract. This report includes measures for the following:

- Cost and utilization of behavioral health services
- The timing of prior authorizations of four services: youth substance use disorder residential services, adult substance use disorder residential services, adult detoxification residential services, and youth mental health residential services.
- Wraparound: numbers and percentages enrolled in Wraparound services and data broken down by race, ethnicity, and language.
- Measures for adults with Serious and Persistent Mental Illness including Assertive Community Treatment, Supported Employment Services, warm handoffs, peer delivered services, and acute psychiatric hospitals and emergency department utilization.

Future Reports

Results from this initial reporting period will be used to establish a baseline for measures without established goals. OHA will develop future goals and measures in conjunction with CCOs. It will be a starting point to develop a standard process for measuring timely access to care and help inform network adequacy standards.

Measures Reported by CCOs

Cost and Utilization of Behavioral Health Services

Cost and utilization data are analyzed to improve health equity and access to services. This data will aid in analyzing and controlling costs, as well as help determine how resources are assigned.

Comments and Analysis

The following data was based on paid claims for all behavioral health services on the HERC prioritized list in 2020. This data should be considered preliminary as it was extracted from DSSURS in January 2021 and more claims will be processed over the next few months.

This section provides the following calculations:

- Estimated Prevalence counts and percentages based on the number of members with a primary, secondary, tertiary or detail diagnosis for a behavioral health disorder in claims.
- The percent served calculates the percent of persons in the prevalence estimate who received services for that disorder.
- The services per 1,000 member months is a count of encounters paid for services for behavioral health disorders per 1,000 member months.
- The estimated OHP cost per member per month is based on the total OHP costs reported for encounters. Note this estimate does *not* include sub-capitated payments by CCOs to providers. It should *not* be used as the total cost of behavioral health services.

There were 34 Behavioral Health conditions – each with a separate line - included in the 2020 HERC Prioritized List. The table below provides information on the top 10 behavioral health conditions based on estimated prevalence counts.

Top Ten Behavioral Health Conditions

Top 10 Disorders by Estimated Prevalence	Prevalence Count	Percent Served	Services/ 1,000 MM	Est OHP Cost PMPM
Line 414 OVERANXIOUS; GENERALIZED ANXIETY DISORDER	103,234	60.3%	21.4	$2.22
Line 7 MAJOR DEPRESSION	80,512	65.6%	23.1	$2.60
Line 5 TOBACCO DEPENDENCE	77,475	18.9%	1.6	$0.05
Line 4 SUBSTANCE USE DISORDER	66,194	69.0%	120.2	$7.45
Line 444 ADJUSTMENT DISORDERS	53,770	64.7%	18.5	$2.07
Line 173 POSTTRAUMATIC STRESS DISORDER	40,412	84.9%	28.5	$3.58
Line 121 ATTENTION DEFICIT/HYPERACTIVITY DISORDERS	32,137	80.7%	10.8	$1.04
Line 26 BIPOLAR DISORDERS	22,216	73.5%	10.6	$0.91
Line 203 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE	19,887	65.9%	5.5	$0.89
Line 22 SCHIZOPHRENIC DISORDERS	13,346	81.6%	14.4	$0.79

The following table provides information about all behavioral health conditions on the prioritized list for persons of all ages. This includes the percentage of members with a behavioral health diagnosis in any of the first three diagnoses or on the detailed diagnosis (estimated prevalence); the percentage of the prevalence population who received treatment services on the HERC list of CPT codes; the total encounters per 1,000 member months and the estimated OHP cost of services per member per month.

Please note: The services per 1,000 member months is a more accurate measure of the level of treatment services than the estimate cost per member per month. The cost estimate in this report is based solely on the amounts paid reported in the claim submissions in DSSURS. It does *not* include sub-capitation payments that CCOs pay to providers.

Behavioral Health Conditions on the Prioritized List (persons of all ages)				
Plan Name	Estimated Prevalence	Percent Served	Services/ 1,000 MM	Est OHP Cost PMPM
ADVANCED HEALTH	28.8%	63.3%	225.7	$11.93
ALLCARE CCO	24.5%	62.9%	216.3	$5.57
CASCADE HEALTH ALLIANCE	26.6%	68.0%	242.3	$28.42
COLUMBIA PACIFIC	29.6%	68.7%	259.7	$13.44
EASTERN OREGON CCO	25.2%	66.4%	177.4	$8.21
HEALTH SHARE OF OREGON	27.7%	71.7%	364.7	$30.41
INTERCOMMUNITY HEALTH NETWORK	29.4%	70.3%	274.0	$24.40
JACKSON CARE CONNECT	29.2%	72.6%	326.8	$34.19
OPEN-CARD	8.8%	52.8%	84.7	$15.61
PACIFICSOURCE CENTRAL	31.5%	72.5%	352.1	$39.53
PACIFICSOURCE GORGE	24.7%	72.2%	193.8	$18.40
PACIFICSOURCE LANE	32.4%	75.6%	368.1	$38.16
PACIFICSOURCE MARION POLK	25.6%	73.3%	347.1	$28.89
TRILLIUM COMMUNITY HEALTH	30.9%	74.6%	447.6	$42.76
UMPQUA HEALTH ALLIANCE	34.4%	66.5%	302.6	$14.82
YAMHILL COMMUNITY CARE	24.6%	71.9%	254.5	$10.58
Overall Figures	**26.3%**	**70.0%**	**280.9**	**$24.80**

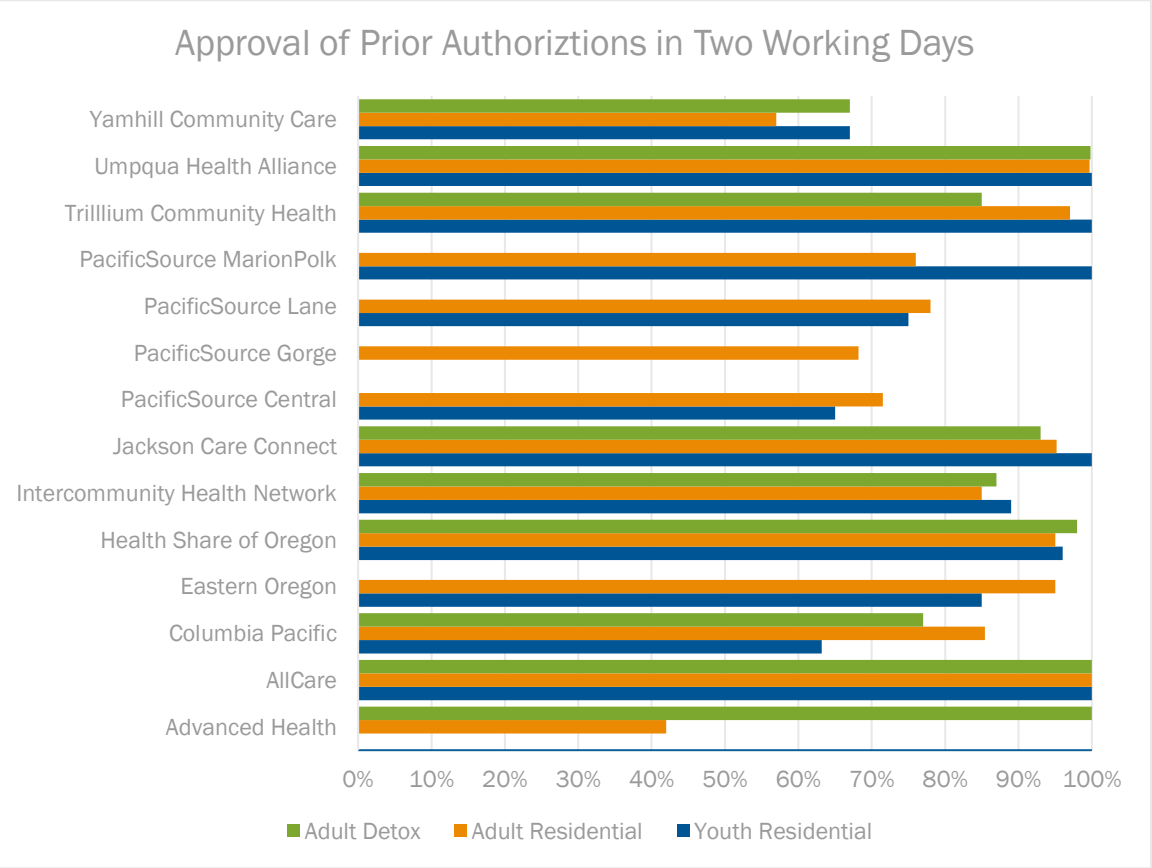
Prior Authorizations for Substance Use Disorder Services

CCOs reported information on prior authorizations pertaining to the following substance use disorder services: a) substance use disorder (SUD) residential treatment for youth, b) SUD residential treatment for adults and c) residential withdrawal management for adults. CCOs may elect to require prior authorization for certain services, per the CCO Contract. Cascade Health Alliance (CHA) does not require prior authorization for these services and is not included in the prior authorization measures.

The table below summarizes prior approval data for three types of services: youth substance use disorder residential treatment adult substance use disorder residential, residential withdrawal management for adults. The table shows reported percentages of prior authorizations that are approved within two working days.

- SUD residential treatment for youth: Of the 14 CCOs that require prior authorizations, six CCOs performed at 95-100%, with five of those CCOs achieving 100%. Six CCOs were in the 63.2%-89% range, and finally two CCOs reported 0 prior authorizations.
- SUD residential treatment for adults: Of the 14 CCOs that require prior authorizations, five CCOs performed at 95-100%. One CCO, AllCare, achieved 100%. Five CCOs achieved 76%-85.4% and four CCOs achieved below 71.5%, and Advanced Health reported only 42% of its prior authorizations were approved within three days.
- Residential withdrawal management for adults: of the 14 CCOs that require prior authorizations, four of the CCOs achieved 98%-100%, specifically Advanced Health, AllCare, HealthShare of Oregon and Umpqua Health Alliance. Three CCOs achieved 85%-93%. Six CCOs achieved 0-77%. All four Pacific Source CCOs reported zero prior authorizations; it is unclear if there were no prior authorizations for

withdrawal management or if no prior authorizations were performed within the mandated time frame. Eastern Oregon CCO did not submit data.



Time frame 1/1/20 through 6/30/20. Data Source: 2020 CCO Behavioral Health Report Submission

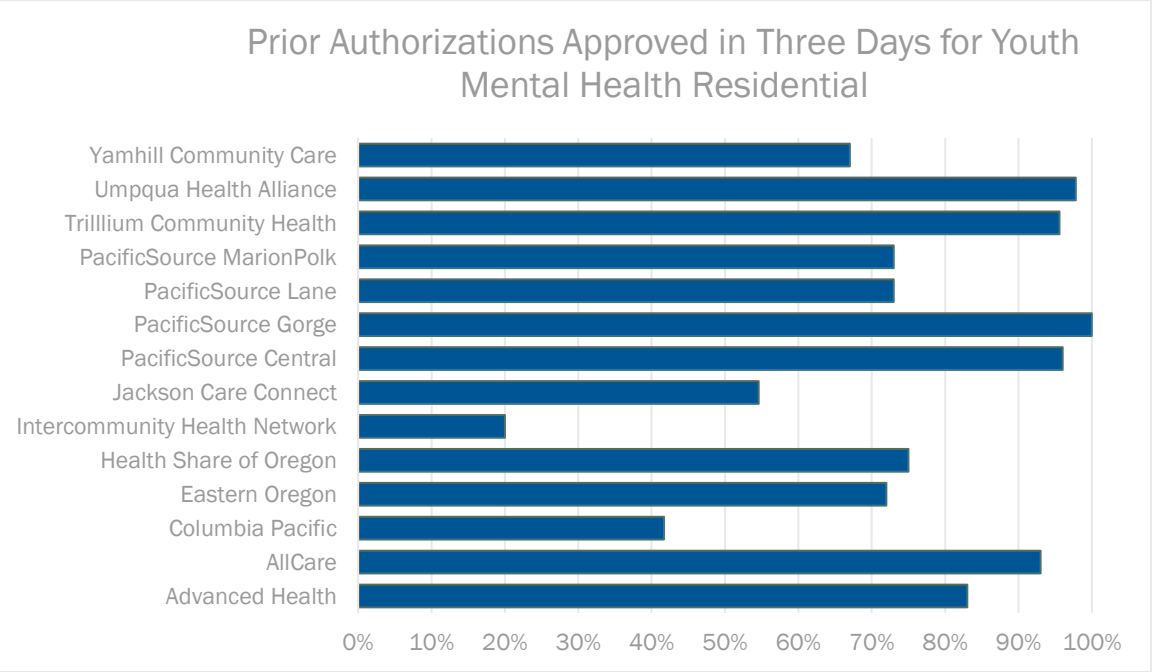
Comments and Analysis

Prior authorizations ensure timely access to care for members needing behavioral health services. These consumers are also among the most vulnerable needing appropriate services immediately. Delay in prior authorization can have unintended devastating effects. CCOs should identify any barriers in the prior authorization process within their service area to determine causes of delay: lack of workforce, care coordination, inadequate exchange of information due to lack of Health Information Exchange technology could all be reasons for delay. CCOs can consider one or more of the following to address improvement in prior authorization time: (1) using the newly established Behavioral Health Provider Directory by OHA to improve care coordination when providers are looking for residential level of care for their clients; (2) outreach and education to providers about care coordination and how CCO care coordinators can help expedite the process of prior authorization; and (3) working with local CMHPs to identify a plan in the CCO Comprehensive Behavioral Health Plan to address improvement in prior authorization process. OHA will work with underperforming CCOs to determine what barriers and issues are responsible and collaborate on solutions.

Prior Authorizations for Youth Mental Health Residential

Of the 14 CCOs that require prior authorization, six CCOs achieved 93%-100%, with Pacific Source Gorge achieving 100%. Five CCOs reported 72%-83%, four CCOs reported 20%-67%. This data will assist system partners in assessing the timeliness of processing prior authorizations and initiation of treatment. It will also inform of system gaps and weaknesses.

The table below summarizes prior approval data for youth mental health residential treatment, showing numbers and percentages of those who received prior authorizations in three calendar days.



Time Frame: 1/1/20 through 6/30/20 Data Source CCO submission, 2020 BH Report

Comments and Analysis

Delay in prior authorization for youth can have devastating consequences for children and their families, especially since a high proportion of youth who need residential services enter that level of care through the crisis system and emergency department. Low inventory of youth residential treatment facilities can be a challenge as well. However, these youth and their families are at highest risk of a repeat crisis event and/or self-harm. CCOs should work with local hospitals, CMHPs, and local crisis services to identify where improvements can be made. This includes identifying areas where OHA can help support CCOs by considering changes in policies, rules, and contracts. CCOs should work with the youth mental health residential providers in their service area to ensure there is consistent tracking and reporting of data in the Centralized Behavioral Health Provider Directory. This data will help CCOs develop a plan to address delay in prior authorization in coordination with other local partners. OHA will work with underperforming CCOs to determine what barriers and issues are responsible and collaborating on solutions.

Wraparound

Fidelity Wraparound is team-based planning process involving a member 0-17 years of age (or members who continue receiving Wraparound services from 18-25 years of age) and the member's Family that results

in a unique set of Community services, and services and supports individualized for that member and family to achieve a set of positive outcomes. Youth and families will work with a team of individuals trained to support youth and their families to create a plan of care, a crisis and safety plan that supports youth and family members moving toward their goals and vision for the future. Eligibility for Wraparound is children and youth ages 0-17 who experience complex mental health issues and are involved in mental health and one other system (e.g., foster care, special education, juvenile justice, intellectual/developmental disability programs). Once eligible for Wraparound, children and youth may receive services through age 25.

Wraparound Enrollment for Eligible Youth

CCOs are required to provide Wraparound services for all children and young adults who meet criteria. If a CCO lacks provider capacity to provide Wraparound, the CCO is to notify OHA and develop a plan to increase capacity. Lack of capacity may not be a basis for eligible members to be placed on a waitlist for Wraparound.

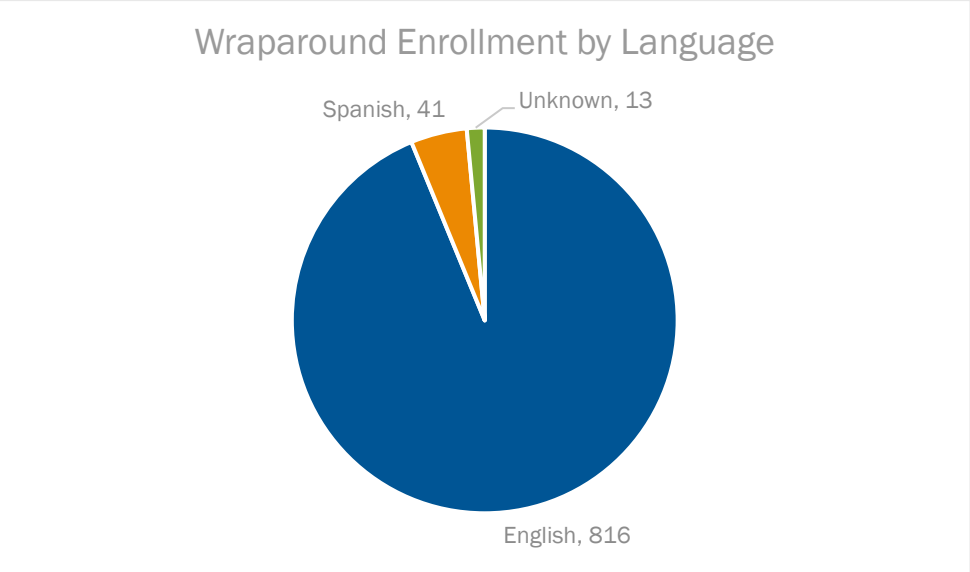
CCOs were to submit Wraparound enrollment numbers and percentages, defined as the number enrolled in wraparound services from among those determined to meet criteria, divided by the number who met criteria for Wraparound services. The time-period was determinations made from January 1, 2020 through June 30, 2020. This data includes total data, as well as data by race, ethnicity, and language.

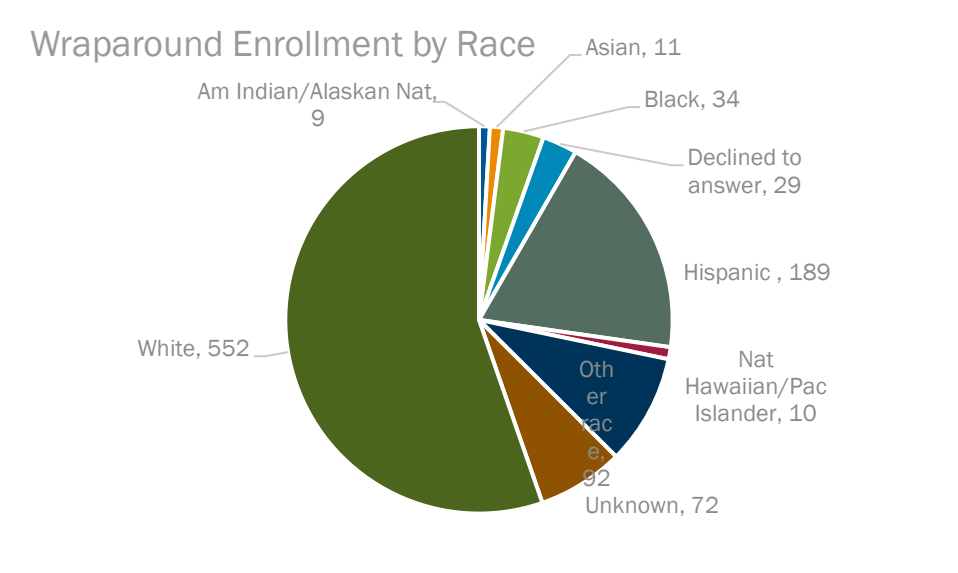
This measure shows how effectively CCOs enroll and engage individuals in Wraparound services by identifying the number of youth who enrolled in Wraparound services, as well as the percentage who enrolled from among those who were determined to meet the criteria for Wraparound services and what percent enrolled in Wraparound. Pacific Source Central Oregon achieved 100% enrollment for all individuals eligible for Wraparound services, and four other CCOs (27%) achieved enrollment over 90%. This data can be found in Appendix B.

Wraparound Race/Ethnicity and Language

Tracking the racial distribution of those served by the CCO can inform the CCO regarding diversity and health equity activities. Noting the primary language of those served can inform the CCO whether more diversity/bilingualism in personnel is required. The demographic analysis will help identify underserved populations and help inform efforts to increase access to treatment.

Below are high-level graphs to visually illustrate these demographics. More detailed charts can be found in Appendix B.





Time Frame: 1/1/20 through 6/30/20 Data. Source: CCO submission, 2020 BH Report

Comments and Analysis

Comparing this information to the racial demographics of individual CCO's coverage areas would give a more complete picture of how well the CCO serves diverse groups. CCOs should consider matching the diversity of their own staff and workforce to their service area. Additional information from the CCOs would be helpful, such as information about anyone not able to access services due to language barriers and about how many CCOs have bilingual staff and contractors. CCOs should consider engaging their community/communities of service to identify the barriers in Wraparound services. This is an opportunity to engage with CMHPs and community-based organizations in CCO service area/s to develop a plan of action to reach families who need Wraparound services but are not able to. In addition, consider equity of Wraparound service beyond race and ethnicity, such as equity for youth and families experiencing Intellectual and Developmental

Disabilities (I/DD), children with older adults as guardians/caregivers, children and families experiencing disability.

CCO Reporting Measures for Adults with Serious and Persistent Mental Illness (SPMI)

Assertive Community Treatment (ACT)

ACT is an evidence-based practice designed to provide comprehensive treatment and support services to adults diagnosed with SPMI. Services are to be provided in the most integrated community setting possible. The complete array of ACT services are provided by a multidisciplinary team. CCOs are required to assess members with SPMI to determine eligibility for ACT services. A provider or care coordinator then meets with the member to discuss ACT services and provide information to support the member in making an informed choice regarding participation. This information must include a description of ACT services, how to access ACT services, an explanation of the role of the ACT team, how supports can be individualized based on the member's self-identified need, and ways the ACT team can enhance a members care and support independent community living. Availability of ACT services can assist individuals in maintaining community tenure and can lead to reduced utilization of more restrictive levels of care, including involvement in the justice system. Not all individuals with SPMI want or need ACT services, but members who qualify for and desire ACT services shall be added to a wait list if no program is available in the member's service area. If a CCO lacks capacity to provide ACT, it is the responsibility of the CCO to notify OHA and develop a plan to increase capacity. Lack of capacity may not be a basis for eligible members to be denied ACT services. When a member is denied ACT services, it is the responsibility of the CCO to issue a Notice of Adverse Benefit Determination to the member, detailing steps for the member to file an appeal.

The table below identifies the number of members with SPMI per CCO, as well as the number and percentage of individuals enrolled in ACT services.

CCOs		ACT	
	SPMI	Individuals	Percent
ADVANCED HEALTH	1,936	44	2.3%
ALLCARE CCO	3,577	74	2.1%
CASCADE HEALTH ALLIANCE	1,834	79	4.3%
COLUMBIA PACIFIC	2,385	74	3.1%
EASTERN OREGON CCO	4,042	113	2.8%
HEALTH SHARE OF OREGON	30,690	396	1.3%
INTERCOMMUNITY HEALTH NETWORK	5,526	95	1.7%
JACKSON CARE CONNECT	4,177	51	1.2%
PACIFICSOURCE CENTRAL	4,978	34	0.7%
PACIFICSOURCE GORGE	972	13	1.3%
PACIFICSOURCE LANE	6,866	70	1.0%
PACIFICSOURCE MARION POLK	8,071	100	1.2%
TRILLIUM COMMUNITY HEALTH	5,677	111	2.0%
UMPQUA HEALTH ALLIANCE	2,860	32	1.1%
YAMHILL COMMUNITY CARE	2,172	37	1.7%
FFS	31,644	115	0.4%
Unduplicated total	100,090	1283	1.3%

Time Frame: 1/1/20 through 6/30/20 Data Source: MMIS

Comments and Analysis

Assertive Community Treatment is the highest level of community treatment available. As of 3/6/2020, the Oregon Center of Excellence for Assertive Community Treatment estimated the capacity of ACT to serve 1504 individuals statewide. The ACT enrollment statewide, including non-Medicaid funded individuals, was 1351 as of that same date, meaning that ACT had reached 90% of capacity. Oregon's goal for FY 2021-2022 is 1750 individuals in ACT.

Supported Employment Services

Supported Employment Services means individualized services that assist individuals to obtain and maintain integrated, paid, competitive employment. These services are provided in a manner that allows individuals to work the maximum number of hours consistent with their preferences, interests, and abilities and are individually planned, based on person-centered planning principles and evidence-based practices. Availability of supported employment services can assist individuals in maintaining community tenure and can lead to reduced utilization of more restrictive levels of care. CCOs are required to ensure access to supported employment services for all adult members eligible for these services.

The table below indicates the number of members with SPMI, per CCO, number and percentage of members receiving supported employment services.

CCOs		SE	
	SPMI	Individuals	Percent
ADVANCED HEALTH	1,936	85	4.4%
ALLCARE CCO	3,577	212	5.9%
CASCADE HEALTH ALLIANCE	1,834	35	1.9%
COLUMBIA PACIFIC	2,385	54	2.3%
EASTERN OREGON CCO	4,042	195	4.8%
HEALTH SHARE OF OREGON	30,690	472	1.5%
INTERCOMMUNITY HEALTH NETWORK	5,526	29	0.5%
JACKSON CARE CONNECT	4,177	188	4.5%
PACIFICSOURCE CENTRAL	4,978	49	1.0%
PACIFICSOURCE GORGE	972	35	3.6%
PACIFICSOURCE LANE	6,866	32	0.5%
PACIFICSOURCE MARION POLK	8,071	161	2.0%
TRILLIUM COMMUNITY HEALTH	5,677	44	0.8%
UMPQUA HEALTH ALLIANCE	2,860	51	1.8%
YAMHILL COMMUNITY CARE	2,172	112	5.2%
FFS	31,644	132	0.4%
Unduplicated total	100,090	1819	1.8%

Time Frame: 1/1/20 through 6/30/20. Data Source: MMIS

Comments and Analysis:

Oregon's Supported Employment program is well recognized nationally for having a robust program that offers high-fidelity employment services to the SPMI population. The Oregon Supported Employment program enjoys a strong collaboration with state Vocational Rehabilitation services to maximize the effectiveness of employment services provided to those who experience SPMI. Although data from 2020 was impacted by a COVID-19-related data collection pause, and by the impact of the pandemic on the availability of jobs, the existing data indicate that the employment rate for individuals accessing supported employment was

approximately 40%. Additionally, there was a significant increase of new job starts in the third quarter of 2020, from 216 job starts in quarter two, to 314 job starts in quarter four.

Peer Delivered Services

Availability of Peer Delivered Services (PDS) can assist individuals in maintaining community tenure and can lead to reduced utilization of more restrictive levels of care. CCOs are required to inform members and encourage utilization of PDS, including Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, Youth Support Specialist, or other Peer Specialist. CCOs are required to provide members with information, including a description of PDS and how to access it, a description of the types of PDS providers, an explanation of the role of the PDS provider and ways that PDS can enhance members' care.

The table below identifies the number of members with SPMI, per CCO, and the number and percentage of members receiving PDS.

CCOs		PEER	
	SPMI	Numbers	Percent
ADVANCED HEALTH	1,936	81	4.2%
ALLCARE CCO	3,577	180	5.0%
CASCADE HEALTH ALLIANCE	1,834	144	7.9%
COLUMBIA PACIFIC	2,385	88	3.7%
EASTERN OREGON CCO	4,042	243	6.0%
HEALTH SHARE OF OREGON	30,690	1,988	6.5%
INTERCOMMUNITY HEALTH NETWORK	5,526	151	2.7%
JACKSON CARE CONNECT	4,177	199	4.8%
PACIFICSOURCE CENTRAL	4,978	585	11.8%
PACIFICSOURCE GORGE	972	80	8.2%
PACIFICSOURCE LANE	6,866	383	5.6%
PACIFICSOURCE MARION POLK	8,071	437	5.4%
TRILLIUM COMMUNITY HEALTH	5,677	393	6.9%
UMPQUA HEALTH ALLIANCE	2,860	74	2.6%
YAMHILL COMMUNITY CARE	2,172	167	7.7%
FFS	31,644	751	2.4%
Unduplicated total	100,090	5595	5.6%

Time Frame: 1/1/20 through 6/30/20. Data Source: MMIS

Comments and Analysis

This data reflects the Medicaid billing codes for PDS, without differentiating what specific service has been provided. There are national measures regarding specific peer delivered services. OHA will investigate possible ways to compare the current data with national data.

Although this data reflects utilization of PDS Medicaid Billing Codes, Oregon has a robust system of Peer Delivered Services working outside of Medicaid Billing. This system operates in coordination with CCOs in community settings across the entire continuum of behavioral health care, from intervention to aftercare and long-term recovery. CCOs should consider using peers in as many settings as possible, including outreach into the community. In addition, OHA urges CCOs to use peer-led programs in the state. CCOs should aim for connecting consumers with a peer as soon as service delivery begins and ensure consumers are able to contact their assigned peers even at times when they cannot reach their behavioral health

provider. OHA is working with CCOs, counties and Oregon's PDS network to integrate and incentivize the coordination of peer-delivered services. The OHA Health Systems Division (HSD) recognizes the value of peer-delivered services in transforming a behavioral health system of care based on recovery. HSD works with consumers, survivors, stakeholders and Oregon's peer network to:

- Develop strategies to increase the use and availability of peer-delivered services (PDS) in collaboration with local CMHP, local mental health authority (LMHA), harm reduction programs, and hospitals.
- Identify ways to establish value-based payment methodology for programs that use peers for outreach and engagement.
- Influence health policy and improve enrollment and use of peers in expanded insurance options and integrated health care programs.
- Promote the development of PDS training programs and certified peers representing Oregon's diverse population, including those with military experience and young adults, and
- Incorporate training among contracted providers and their staff on how to work in partnership with peers while delivering services.

OHA has implemented multi-dimensional projects toward the above goals across the state. This includes internal support and development as well as facilitation of community partnerships to include the breadth and depth of expertise within the field of PDS across Oregon. OHA will be coordinating with CCOs' Traditional Health Worker Liaisons, a new contract requirement in 2020, to meet the above goals, track data of PDS, and coordinate care between CCO and community based, RCO (Recovery Community Organizations) and PRO (Peer Run Organizations), settings.

Acute Care Psychiatric Hospital

CCOs are required to provide acute inpatient hospital psychiatric care for members who do not meet the criteria for long-term psychiatric care and for whom it is medically appropriate. This measure can inform system partners about patterns of Acute Care Psychiatric Hospital (ACPH) utilization among different CCOs and can inform regarding gaps in outpatient services. CCOs were told to report the number of CCO members admitted to ACPHs for a mental health diagnosis, and to provide the percentage of such persons among adult CCO members with an SPMI.

The table below identifies the number of members with SPMI, per CCO, and the number and percentage of members admitted to ACPHs for a mental health diagnosis.

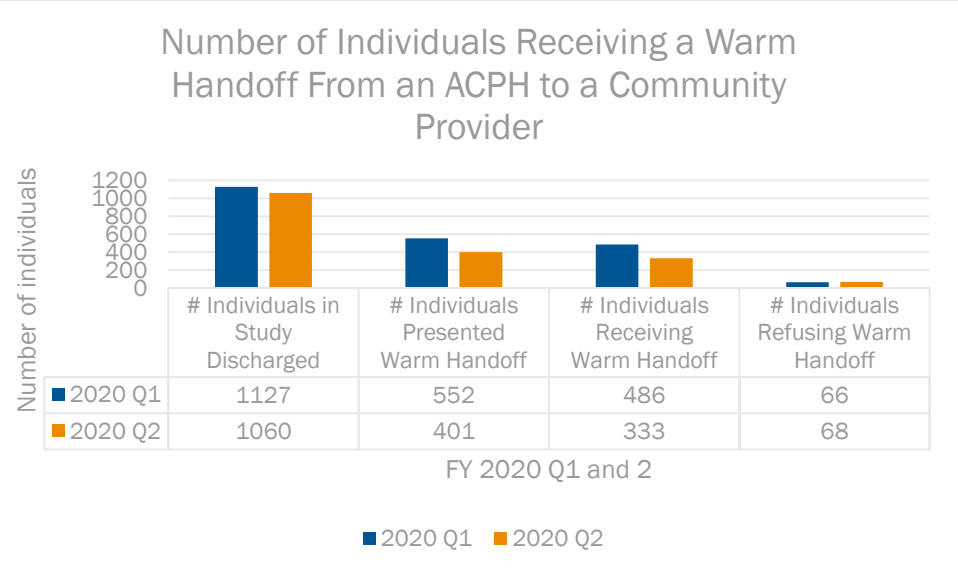
Comments and Analysis

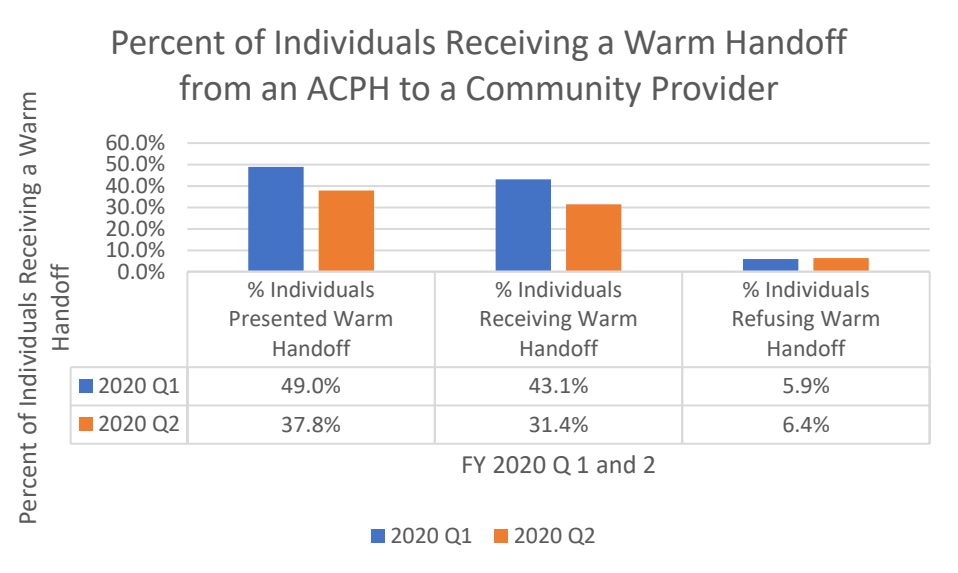
Cascade Health Alliance (CHA) has the lowest utilization of ACPHs at 0.4%, and Health Share of Oregon the highest, at 4.5%. It is unclear from the data submitted whether more rural CCOs, such as CHA, have less demand per capita than larger CCOs, or if lack of inpatient resources requires utilization of alternative strategies. More information is needed from CCOs to understand whether individuals who are not going into acute psychiatric care facilities are receiving alternative care elsewhere or not receiving care at all. For those CCOs who are successfully diverting individuals from acute psychiatric care, they can highlight their successful strategies in their Comprehensive Behavioral Health Plan. In addition, information around how CCOs are working with local crisis hotlines and services overseen by CMHPs to reduce burden on acute care for mental health crisis.

CCO Names	SPMI	ADMISSIONS	
		Individuals	Percent
ADVANCED HEALTH	1,936	63	3.3%
ALLCARE CCO	3,577	50	1.4%
CASCADE HEALTH ALLIANCE	1,834	7	0.4%
COLUMBIA PACIFIC	2,385	79	3.3%
EASTERN OREGON CCO	4,042	39	1.0%
HEALTH SHARE OF OREGON	30,690	1396	4.5%
INTERCOMMUNITY HEALTH NETWORK	5,526	122	2.2%
JACKSON CARE CONNECT	4,177	106	2.5%
PACIFICSOURCE CENTRAL	4,978	155	3.1%
PACIFICSOURCE GORGE	972	13	1.3%
PACIFICSOURCE LANE	6,866	184	2.7%
PACIFICSOURCE MARION POLK	8,071	188	2.3%
TRILLIUM COMMUNITY HEALTH	5,677	195	3.4%
UMPQUA HEALTH ALLIANCE	2,860	45	1.6%
YAMHILL COMMUNITY CARE	2,172	67	3.1%
FFS	31,644	642	2.0%
Duplicated total	117,407	3,351	na
Unduplicated total	100,090	3253	3.3%

Warm Handoffs from Acute Care Psychiatric Hospital

CCOs are required to provide every patient discharged from an ACPH with a warm handoff to a community case manager, peer, or other community provider prior to discharge. CCOs were told to report the number of CCO members discharged from ACPHs with documentation of warm handoffs, and the percentage of those persons among adult CCO members with an SPMI. This measure can inform system partners about how well CCOs and community partners coordinate continuing care after discharge from an ACPH.





Time Frame: 1/1/20 through 6/30/20 Data Source: Healthinsight Assure

Comments and Analysis

This data is aggregated for the data collection period. OHA is working with its contractor to sort this information by CCO in subsequent reports. Data is collected by the hospital and provides an overall rate for warm handoffs from an ACPH to a community provider. In the first quarter of 2020, warm handoffs were offered 49% of the time and accepted 43.1% of the time. The second quarter saw fewer reported warm handoffs, likely due to the impact of pandemic restrictions. In the second quarter, warm handoffs were offered to only 37.8%, and accepted by 31.4%. The percentages were very close to those in the first quarter. CCOs received technical assistance from OHA on what are some ways CCOs can coordinate with community providers, CMHPs, and peers to ensure warm handoff. CCOs should work with their local partners to identify where in the process there have been gaps that led to lower warm handoff rates. Low warm handoff rates can be a critical driver of higher ED utilization, and repeat incidents of MH crisis including self-harm and suicide. CCOs should utilize every possible tool including virtual interaction with providers to ensure warm handoff from acute care settings.

Follow-up Visits

CCOs are required to ensure that members receive a follow-up visit with a CMHP within seven days of discharge from an ACPH.

This measure is a long-standing Healthcare Effectiveness and Data Information Set (HEDIS) measure to assess how comprehensively post discharge engagement occurs across CCOs. The table below identifies CCO members discharged from ACPHs who received a follow-up visit within seven days.

Individuals Receiving 7 Day Follow-Up After Hospitalization for Mental Illness

	Individuals		
CCO	Members discharged from ACPFs	visit 7d	rate 7d
ADVANCED HEALTH	75	50	66.7%
ALLCARE HEALTH PLAN	54	47	87.0%
CASCADE HEALTH ALLIANCE	12	11	91.7%
COLUMBIA PACIFIC	88	67	76.1%
EASTERN_OREGON	53	35	66.0%
HEALTHSHARE OF OREGON	1450	1010	69.7%
INTERCOMMUNITY HEALTH NETWORK	124	102	82.3%
JACKSON CARE CONNECT	115	92	80.0%
PACIFICSOURCE CENTRAL	140	119	85.0%
PACIFICSOURCE LANE	166	142	85.5%
PACIFICSOURCE MARIONPOLK	190	125	65.8%
PACIFIC SOURCE COLUMBIA GORGE REGION	17	13	76.5%
TRILLIUM	193	160	82.9%
UMPQUA HEALTH ALLIANCE	41	34	82.9%
YAMHILL COMMUNITY CARE	76	56	73.7%
Total of CCOs	2794	2063	73.8%
FFS	242	119	49.2%
Total of CCO and FFS	3036	2182	71.9%

Time Period: 1/1/20 through 6/30/20. Data Source: MMIS

Comments and Analysis

The statewide cumulative average for this measure is 71.9%. Cascade Health Alliance had the highest percentage of 7 day follow up at 91.7%, but also had the smallest number of individuals hospitalized. OHA, CCOs, CMHPs, and LMHAs should continue to work towards establishing how follow up services within seven days after discharge can be improved.

Housing Services

CCOs are required to coordinate with community partners to ensure members who are homeless and who have had two or more readmissions to an ACPH in a six-month period are connected to a housing agency or behavioral health agency to ensure these members are linked to housing in an integrated setting, consistent with the member's treatment goals, clinical needs and informed choice. The CCO is required to work with OHA and the CMHPs to ensure that members who are discharged from an ACPH are discharged to housing that meets the individuals' immediate need for housing. CCOs are required to work with ACPHs in the development of each individual's housing assessment. The housing assessment will be documented in a plan for integrated housing that is part of the individual's discharge plan, and will be based on the member's

treatment goals, clinical needs, and informed choice. The CCO is required to notify, or require the ACPH to notify, the community provider to facilitate the implementation of the plan for housing.

This measure gauges how effectively the CCOs and other system partners address social determinants of health, specifically housing. This measure identifies the number of members discharged from ACPHs who are homeless, that are connected to a housing provider with an appropriate documented housing assessment, as well as the percentage of such persons among CCO members discharged from ACPHs. For FY 2020, 9,231 individuals, or 89.2% of those discharged had a housing plan upon discharge.

Comments and Analysis

Currently housing status is not routinely and uniformly collected across CCOs, making it difficult to report on the percent of homeless members across the state. However, when homelessness or housing insecurity is noted in the treatment, housing plans are noted upon discharge for individuals. In order to have a clearer sense of housing status and compelling need to address housing supports, CCOs will need to track risk for homelessness overall. Efforts to do so are currently underway, as a Social Determinant of Health Quality Metric, to explore uniform data collection around this information.

Even with robust data collection and discharge planning, however, we anticipate barriers, given the extreme shortage of housing and residential facilities across the state. OHA continued to explore collaborative efforts with Oregon Housing and Community Service to pursue these needs. OHA continues to collaborate with CCOs to develop ongoing guidance information. CCOs should analyze gaps in services and implement mitigation strategies.

Acute Care Psychiatric Hospital Readmissions

CCOs were told to report the number of members discharged from ACPHs who are readmitted in 30 days and 180 days, as well as the percentage of those members among CCO members discharged from ACPHs. Duplicated totals mean individuals had more than one event. 180-day numbers are not available due to data lag and are blacked out.

CCO Names	SPMI	ADMISSIONS		DISCHARGES		Readmits within 30 days	
ADVANCED HEALTH	1,936	63	3.3%	63	3.3%	6	9.5%
ALLCARE CCO	3,577	50	1.4%	50	1.4%	9	18.0%
CASCADE HEALTH ALLIANCE	1,834	7	0.4%	7	0.4%	1	14.3%
COLUMBIA PACIFIC	2,385	79	3.3%	77	3.2%	8	10.4%
EASTERN OREGON CCO	4,042	39	1.0%	39	1.0%	4	10.3%
HEALTH SHARE OF OREGON	30,690	1396	4.5%	1387	4.5%	202	14.6%
INTERCOMMUNITY HEALTH NETWORK	5,526	122	2.2%	122	2.2%	19	15.6%
JACKSON CARE CONNECT	4,177	106	2.5%	106	2.5%	10	9.4%
PACIFICSOURCE CENTRAL	4,978	155	3.1%	150	3.0%	34	22.7%

PACIFICSOURCE GORGE	972	13	1.3%	13	1.3%	1	7.7%
PACIFICSOURCE LANE	6,866	184	2.7%	179	2.6%	29	16.2%
PACIFICSOURCE MARION POLK	8,071	188	2.3%	185	2.3%	24	13.0%
TRILLIUM COMMUNITY HEALTH	5,677	195	3.4%	193	3.4%	19	9.8%
UMPQUA HEALTH ALLIANCE	2,860	45	1.6%	45	1.6%	4	8.9%
YAMHILL COMMUNITY CARE	2,172	67	3.1%	67	3.1%	6	9.0%
FFS	31,644	642	2.0%	628	2.0%	43	6.8%
Unduplicated total	100,090	3253	3.3%	3217	3.2%	417	13.0%

Note: The readmits within 180 days cannot be calculated because there was insufficient follow up period. Time Frame: 1/1/20 through 6/30/20. Data Source: MMIS

Comments and Analysis:

The statewide rate for readmission to an ACPH at 30 days is 13%. 180-day readmission rates are unavailable due to data lag. For the 30-day measure, re-admission rates to ACPHs for CCO members ranged from 7.7% (PacificSource Columbia Gorge) to 22.7% (PacificSource Central Oregon). The lowest re-admission rates overall, at 6.8%, were for individuals who are Fee for Service (FFS) and not followed by a managed care entity.

Readmissions to ACPHs for adults with SPMI can be an indicator of inadequate care in community settings. Readmissions can result from barriers to access, lack of services, inadequate case management, or inadequate engagement on the part of community providers. Improving community services is a good way to lower readmission rates to ACPHs. Readmission to acute care can be an indication of gaps in care coordination, gaps in warm handoffs where needed, or a lack of connection of individuals to social services workers/community resources/community providers such as primary care providers. This data shows that there is room for growth in collaborative relationship between the CCO, hospitals, CMHPs including the crisis system, and peer-delivered Services. CCOs should identify if delays or gaps in follow-up are due to lack of adequate health information technology. OHA will work with CCOs to understand challenges and issues affecting readmission rates.

Emergency Departments

CCO's behavioral health services are required to address the following key areas: reduce visits to emergency departments (ED), reduce repeat visits to EDs, reduce the length of time members spend in the ED, ensure members are contacted and offered services to prevent utilization of the ED, and ensure members with SPMI have appropriate connection to community-based services after leaving ED with follow-up visits from an intensive care coordinator within three days. CCOs are required to work with hospitals on strategies to reduce ED utilization and to work with CMHPs and OHA to develop and implement plans to better meet the needs of members in less institutional community settings and to reduce recidivism to the ED for behavioral health reasons. When an adult with SPMI visits the ED, this is sometimes an indication that the individual was not receiving, or not benefiting from, community services and supports. Community services and supports may prevent crises or allow for earlier intervention and potential avoidance or mitigation of a crisis. A decreased rate of emergency department visits can be an indicator that individuals are having their mental health treatment needs met in the community.

The table below shows the number of CCO members admitted to the ED for a mental health diagnosis, as well as the percentage of those members among adult CCO members with an SPMI.

DOJ MEASURE 41: Rate of ED Visits for Psychiatric Reasons BY CCO: 1 Jul 2019 THROUGH 30 Jun 2020				
NAME	Individuals with SPMI	total member months	ED Visits	Rate
ADVANCED HEALTH	165	163,162	252	1.54
ALLCARE CCO	243	375,139	334	0.89
CASCADE HEALTH ALLIANCE	74	138,587	125	0.90
COLUMBIA PACIFIC	153	192,455	214	1.11
EASTERN OREGON CCO	223	339,507	306	0.90
FEE-FOR-SERVICE (FFS)	1683	114,9483	2594	2.26
HEALTH SHARE OF OREGON	2642	2,381,036	5056	2.12
INTERCOMMUNITY HEALTH NETWORK	303	419,322	463	1.10
JACKSON CARE CONNECT	205	277,378	337	1.21
PACIFICSOURCE CENTRAL	349	354,325	508	1.43
PACIFICSOURCE GORGE	55	78,456	67	0.85
PACIFICSOURCE LANE	209	200,424	277	1.38
PACIFICSOURCE MARION POLK *	278	319,331	393	1.23
PRIMARYHEALTH JOSEPHINE CO CCO **	22	41,476	29	0.70
TRILLIUM COMMUNITY HEALTH	682	513,482	1054	2.05
UMPQUA HEALTH ALLIANCE	256	215,289	420	1.95
WILLAMETTE VALLEY COMM. HEALTH **	315	315,699	439	1.39
YAMHILL COMMUNITY CARE	188	174,613	290	1.66
Totals		7,649,171	13158	1.72
Data extracted from the Oregon MMIS/DSS Warehouse 5 Feb 2021				
based on ED claims found in OR0134309.T_UTIL_ER_CLMS_NS2 run on 5 Feb 2021 * Did not hold a contract in 2019 ** Did not hold a contract in 2020				

Comments and Analysis

Currently the overall average rate is 1.72 ED visits per 1,000 member months. The CCO with the lowest ED utilization rate for the period was Primary Health of Josephine County with 0.7 visits per 1,000 member months. For CCOs, HealthShare of Oregon had the highest utilization for its members at 2.12 visits per 1,000 member months. The Fee for Service (FFS) group had the highest utilization at 2.26 visits per 1,000 member months. This group is not served by any managed care entity. This could indicate that being a CCO member reduces utilization of higher levels of care by providing more community-based supports. CCOs should use methods such as environmental scan to identify community-based resources and social determinants of health that lead to lower utilization of ED. This is an area where CCOs should also leverage the expertise of Peers for outreach and to be part of first line of contact for members with SPMI. Crisis stabilization centers are also a proven method of diverting individuals form ED. CCOs should engage in planning with OHA about how the 988 system can be leveraged to reduce ED visits.

Summary

The emergency measures undertaken to address COVID-19, as well as the impact of massive wildfires statewide in the Summer of 2020 produced a severe strain on Oregon's social services and physical and behavioral health services. Behavioral health services were especially affected. Staff and financial resources were diverted to provide needed care for COVID-19 patients.

In order to support Community Mental Health Programs (CMHP), providers, and contractors in meeting their community's needs, OHA waived certain data collection and reporting requirements so their personnel could provide needed emergency services. As such, certain data points are missing from this report. OHA is working on solutions to these issues and hopes to have processes in place by next year's report. OHA will issue revised guidance utilizing information obtained in this report to improve the usefulness of information obtained in subsequent reports.

OHA will meet with CCO Behavioral Health Directors to review the baseline data in this report and develop goals to improve behavioral health. OHA will continue to work with CCO Behavioral Health Directors to determine if these measures are adequately assessing access and quality of services.

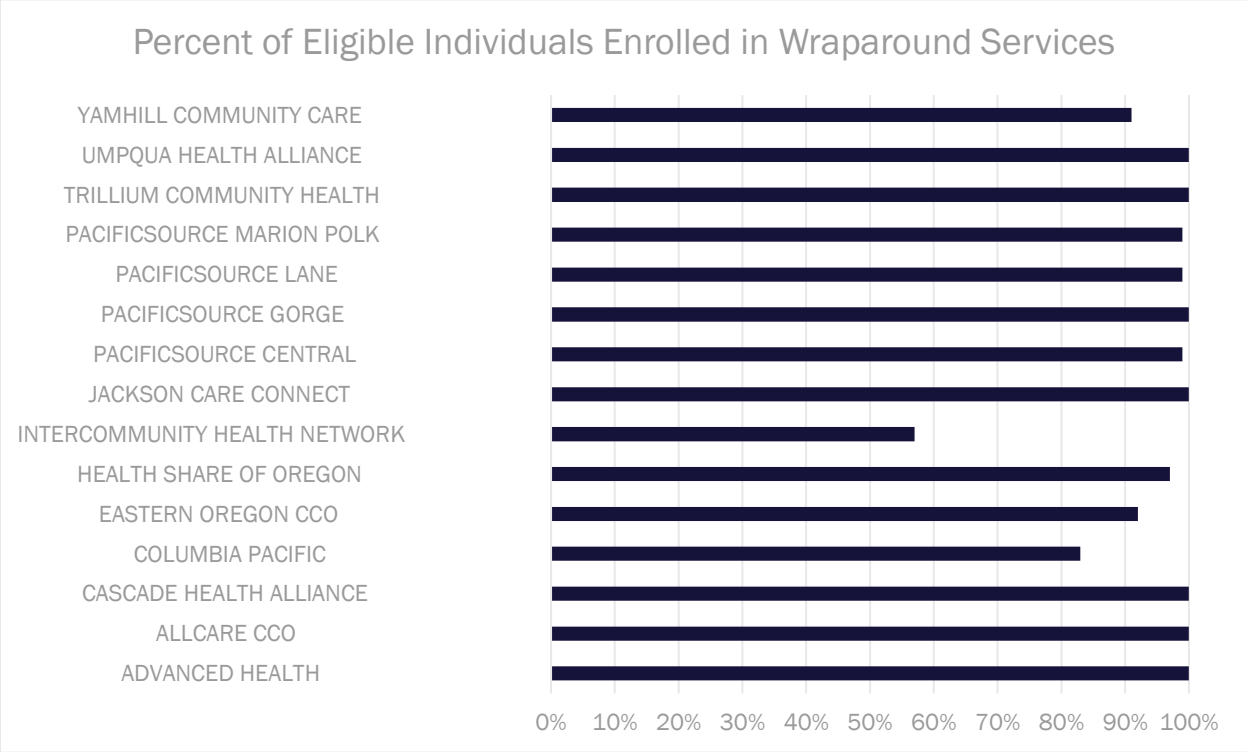
Appendices

Appendix A

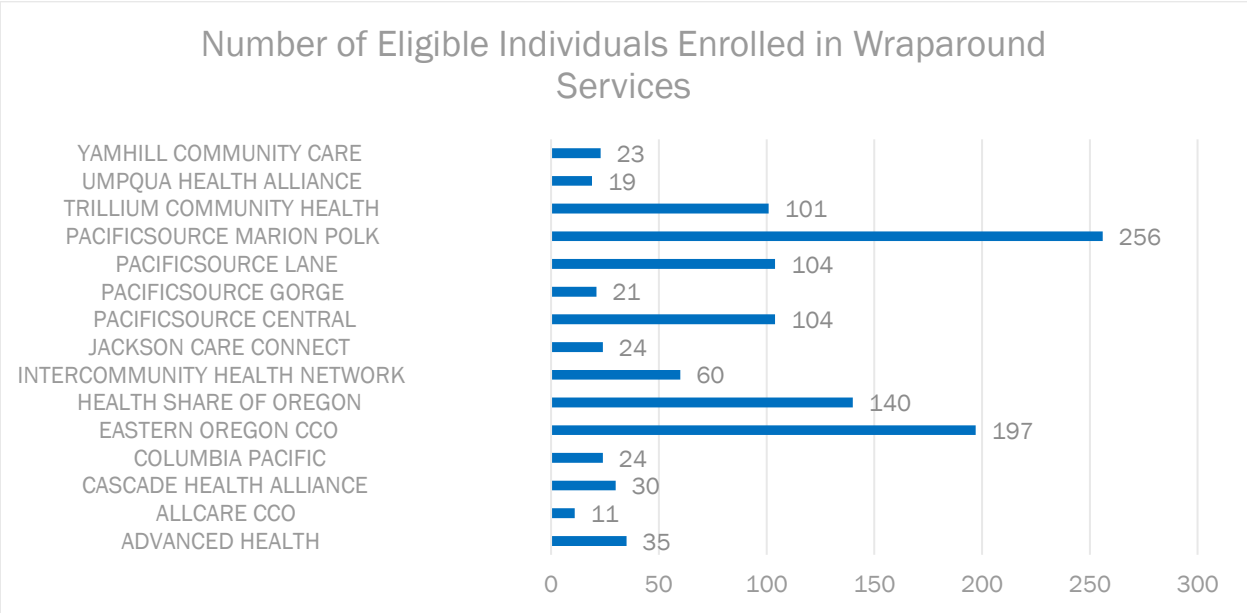
Community Mental Health Programs and behavioral health providers were essential service providers during the COVID-19 emergency. In collaboration with the CMHPs, OHA temporarily suspended some data collection. Some of the data elements are not included in this report, as some of the data collection methodologies were not completed as resources were focused on the emergency response. Missing data elements in this report are:

- Network adequacy and provider capacity information
- The following behavioral health measures:
    - Number and percentage of CCO members who, once determined Ready to Transition (RTT) by Oregon State Hospital (OSH), receive care coordination from CCO (for Assertive Community Treatment (ACT))
    - Number and percentage of CCO members referred to ACT and meeting criteria for ACT
    - Number and percentage of CCO members meeting criteria and accepted into ACT
    - Number and percentage of CCO members accepted and admitted into ACT
    - Number and percentage of denials to ACT
    - Number and percentage of program denials reviewed for appropriateness by CCO
    - Number and percentage of Notice of Action for Adverse Benefit Determination (NOABD) issued
    - Number and percentage of members discharged from ACPFs with documentation of linkages to appropriate behavioral and primary health care prior to discharge
- Data not currently captured by CCO for the following metrics:
    - Number and percentage discharged from Oregon State Hospital (OSH) to Secure Residential Treatment Facilities (SRTF) and Acute Care Psychiatric Facilities (ACPF)
    - Number and percentage of members admitted to Acute Care Psychiatric Facility (ACPF) within thirty (30) days and one hundred and eighty (180) days of discharge from OSH.
    - Number and percentage of members receiving Secure Residential Treatment Services
    - Number and percentage of members receiving Residential Treatment Services (non-Secure)

Appendix B



Time Frame: 1/1/20 through 6/30/20 Data Source CCO submission, 2020 BH Report



Time Frame: 1/1/20 through 6/30/20 Data Source CCO submission, 2020 BH Report

	Wraparound enrollment race
ADVANCED HEALTH	Unknown 31% Caucasian 59% Native American 3% Hispanic 3% Black 3%
ALLCARE CCO	White 90% Native American/Alaska Native 10%
CASCADE HEALTH ALLIANCE	Unknown 83% Other White 13% Slavic 3%
COLUMBIA PACIFIC	America Indian/Alaska Native 5% Black or African American 5% Other White 70% Other Hispanic or Latino 15% Tongan 5%
EASTERN OREGON CCO	White 93% Native American 3% Asian .05% Black 1% Other/multiple races 2%
HEALTH SHARE OF OREGON	Declined to answer 11% Other Asian 7% Black or African American 11% Other White 14% Other race 14% Other Hispanic/Latino 7% Hispanic/Latino Mexican 3% American Indian/Alaska native 3% Alaska Native 3% Other American Indian/Alaska native 7% American Indian 7% Other Pacific Islander 3% Blank 11%

INTERCOMMUNITY HEALTH NETWORK	Alaska Native 3% Unknown 15% White 78% Hispanic/Latino Mexican 3%
JACKSON CARE CONNECT	Declined to answer 4% Other White 66% Other race 4% Other Hispanic/Latino 12% Other American Indian/Alaska Native 12%
PACIFICSOURCE CENTRAL	American Indian/Alaska Native 1% Black 6% Hispanic 13% White 46% Other 2% Unknown 31%
PACIFICSOURCE GORGE	White 76% Other 19% Hispanic 4%
PACIFICSOURCE LANE	American Indian/Alaska Native 1% Black 6% Hispanic 13% White 46% Other 2% Unknown 31%
PACIFICSOURCE MARION POLK	American Indian/Alaska Native 2% Asian .08% Black 2% White 73% Other 18% Unknown 3%

TRILLIUM COMMUNITY HEALTH	Caucasian 49% Unknown 33% Hispanic 12% Hispanic/Latino Central America 1% Black 2% Other 1% Asian 1% American Indian/Alaska Native 1%
UMPQUA HEALTH ALLIANCE	White 84% Black 5% Native American 5% American Indian 5%
YAMHILL COMMUNITY CARE	Alaskan Indian 4% Asian 4% Unknown 9% White 81%
1.1.2020 through 6.30.2020 Data Source CCOs	

Time Frame: 1/1/20 through 6/30/20 Data Source CCO submission for 2020 Behavioral Health Report

	Wraparound enrollment ethnicity
ADVANCED HEALTH	Unknown 38% Not Hispanic 69% Hispanic/Latino Mexican 3%
ALLCARE CCO	Not Hispanic 64% Hispanic 27% Unknown 9%
CASCADE HEALTH ALLIANCE	White 16% Blank 73% Unknown 10%
COLUMBIA PACIFIC	Unknown 85% Hispanic 15%
EASTERN OREGON CCO	Not Hispanic 80% Hispanic 19% Unknown 1%

HEALTH SHARE OF OREGON	Other 4% Unknown 11% Hispanic 23% Not Hispanic 61%
INTERCOMMUNITY HEALTH NETWORK	Hispanic 8% Unknown 12% Hispanic 8% Declined 4%
JACKSON CARE CONNECT	Not Hispanic 54% Unknown 33% Hispanic 8% Declined 4%
PACIFICSOURCE CENTRAL	Other 92% Hispanic 8%
PACIFICSOURCE GORGE	Other 95% Hispanic 5%
PACIFICSOURCE LANE	Other 80% Hispanic 20%
PACIFICSOURCE MARION POLK	Other 71% Hispanic 29%
TRILLIUM COMMUNITY HEALTH	Unknown 34% Hispanic 13% Not Hispanic 53%
UMPQUA HEALTH ALLIANCE	Not Hispanic 89% Unknown 11%
YAMHILL COMMUNITY CARE	Not Hispanic 66% Unknown 19% Mexican 10% Hispanic 4%
1.1.2020 through 6.30.2020 Data Source CCOs	

Time Frame: 1/1/20 through 6/30/20 Data Source CCO submission for 2020 Behavioral Health Report

	Wraparound enrollment language
ADVANCED HEALTH	English 24% Blank 19% Spanish 6%
ALLCARE CCO	English 100%

CASCADE HEALTH ALLIANCE	Unknown 3% English 97%
COLUMBIA PACIFIC	English 100%
EASTERN OREGON CCO	English 98% Spanish 2%
HEALTH SHARE OF OREGON	English 90% Blank 1% Unknown 2% Spanish 3% French Creole 1%
INTERCOMMUNITY HEALTH NETWORK	English 91% Unknown 9%
JACKSON CARE CONNECT	English 92% Spanish 4% Undetermined 4%
PACIFICSOURCE CENTRAL	English 96% Spanish 4%
PACIFICSOURCE GORGE	English 100%
PACIFICSOURCE LANE	English 91% Spanish 9%
PACIFICSOURCE MARION POLK	English 92% Spanish 8%
TRILLIUM COMMUNITY HEALTH	English 87% Spanish 3% Undetermined 10%
UMPQUA HEALTH ALLIANCE	English 100%
YAMHILL COMMUNITY CARE	English 95% Undetermined 5%
1.1.2020 through 6.30.2020 Data Source CCOs	

Time Frame: 1/1/20 through 6/30/20 Data Source CCO submission for 2020 Behavioral Health Report

HEALTH SYSTEMS DIVISION
Office of Behavioral Health