Oregon Health Plan

Section 1115 Quarterly Report

10/1/2022 – 12/31/2022
Demonstration Year (DY): 21 (10/1/2022 – 9/30/2023)
Demonstration Quarter (DQ): 1
Federal Fiscal Quarter (FQ): 1/2023

Oregon Health Authority

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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. With the renewal and approval of new authorities in Oregon's 1115 Demonstration waiver occurring in the last quarter, partner education, engagement and implementation planning were a major focus of this period. Oregon's waiver team held *Waiver Days,* in English and Spanish*,* for partners and community members to learn more about what was approved, what changes occurred from application submission through the negotiations with the Centers for Medicare & Medicaid Services (CMS), and timelines and to ask questions.

In the latter half of this quarter, OHA leadership began briefing sessions with Governor-Elect Kotek's transition team, relayed proposed implementation timelines and responded to questions. Early in the next quarter, work will begin with the new administration to align policy priorities within the overall parameters of the approved waiver.

Dana Hittle, State Medicaid Director

B. Demonstration description

On September 28, 2022, CMS approved Oregon's renewed 1115 Demonstration waiver, which is effective from 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 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.

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II. Title

Oregon Health Plan Section 1115 Quarterly Report
Reporting period: 10/1/2022 – 12/31/2022
Demonstration Year 21—Quarter 1
Federal Fiscal Year 2023—Quarter 1

III. Executive Summary

This quarterly report summarizes OHA activities for Demonstration Year 21 Quarter 1 from October 1, 2022, through December 31, 2022. 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:

- Improved CCO financial performance
- Approval to expand Medicaid eligibility to YSHCN
- Submission of the required maintenance of effort (MOE) process and the Oregon Provider Payment Rate Increase Assessment to CMS, which will expand access to HRSN-related supports

A. Enrollment progress

1. OHP eligibility

Title XIX and Title XXI enrollment numbers have continued to steadily climb as eligibility protections related to the COVID-19 Public Health Emergency have remained in place.

Of note, Title XXI enrollment continues to increase at slightly higher-than-normal rates. This is partially because, as families with Title XIX children experience income increases that put children above the Title XIX income range, children are moved into Title XXI as the uppermost available program while their coverage remains active for the remainder of the Public Health Emergency period.

Additionally, the Federally Facilitated Marketplace (FFM) open enrollment period commenced, for which new Medicaid and Children's Health Insurance Program (CHIP) referrals were processed. For new FFM referrals, if Medicaid or CHIP is approved, coverage generally starts as of the referral month.

2. CCO enrollment

Total CCO enrollment for October 2022 – December 2022 grew by 2.5% across all plan levels (CCOA, CCOB, CCOE, CCOG). Specific CCO membership growth ranged between 1.5% and 3%, except for Trillium Community Health Plan in the Portland metro Tri-County area, which continued to experience greater enrollment growth at 12.3% as it continued to establish itself in this new market.

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

DY21 Q1 (Oct – Dec 2022) Member Growth Zone	**CCO Service Areas**
Greater than 5.001%	1
3.00% – 4.99%	1
2.00% – 2.99%	10
0.00% – 1.99%	4
Reduction in enrollment	0

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

DY19Q2 10/20 – 12/20	**DY19Q3 1/21 – 3/21**	**DY19Q4 4/21 – 6/21**	**DY20Q1 7/21 – 9/21**	**DY20Q2 10/21 – 12/21**	**DY20Q3 1/22 – 3/22**	**DY20Q4 4/22 – 6/22**	**DY20EP 7/22 – 9/22**	**DY21Q1 10/22 – 12/22**
3.9%	3.5%	2.4%	2.2%	2.4%	2.6%	1.4%	2.9%	2.5%

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 2022 (December 31, 2022).

Between October 2022 and December 2022, six CCOs required adjustments above their 2022 contract limit in 27 county service areas in order to sustain auto-enrollment algorithms. This was

mostly due to adding a significant number of members to the CCOs as these members transitioned from fee for service (FFS) to CCOF (dental services).

B. Benefits

The Pharmacy &Therapeutics (P&T) Committee:

The P&T Committee developed new or revised prior authorization (PA) criteria for the following: oncology agents; orphan drugs; targeted immune modulators; multiple sclerosis oral agents; calcitonin gene-related peptide (CGRP) inhibitors; hepatitis C, direct-acting antiviral (DAA); pulmonary arterial hypertension; Alzheimer's disease; topical antiparasitic agents; EPSDT; sedatives; growth hormones; long-acting beta-agonist/corticosteroid combination (LABA/ICS); long-acting muscarinic antagonist/long-acting beta-agonist (LAMA/LABA) and LAMA/LABA/inhaled corticosteroid (LAMA/LABA/ICS) combinations; retire the ICS/LABA specific PA; antivirals-influenza; and topical agents for inflammatory skin conditions.

The committee also recommended the following changes to the preferred drug list (PDL): designate Combivent® Respimat® and Incruse® Ellipta® preferred; Cosentyx® preferred; Aimovig® preferred and Emgality® non-preferred; branded Epclusa® non-preferred; donepezil, rivastigmine, memantine and Namzaric® preferred; Soolantral® and Vanalice™ non-preferred; Nutropin AQ® Nuspin non-preferred; Combivent® Respimat non-preferred and Spiriva® Respimat preferred; Zoryve™, Vtama® and tazarotene gel non-preferred.

Health Evidence Review Commission (HERC): For the October – December 2022 time period, the Notification of Interim Changes for the January 1, 2023, Prioritized List was published December 1, 2022. Errata to the prioritized list were published December 13 and December 19, 2022.

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 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 FFS data.

Trends

	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022	**New: Oct – Dec 2022**
Total complaints received	4,262	4,398	4,938	4,402
Total average enrollment	1,452,054	1,475,164	1,514,019	1,533,995
Rate per 1,000 members	2.94	2.98	3.26	2.87

Statewide Rolling 12-Month Complaint Totals

Complaint category	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022	**New: Oct – Dec 2022**
Access to care	1,559	1,618	1,990	1,676
Client billing issues	381	416	411	392
Consumer rights	344	436	386	314
Interaction with provider or plan	1,256	1,277	1,337	1,329
Quality of care	549	510	596	496
Quality of service	173	141	218	195
Other	0	0	0	0
Grand Total	4,262	4,398	4,938	4,402

Barriers

CCO data illustrate that the number of complaints reported for the October – December 2022 quarter shows a 10.9% decrease from the previous (July – September 2022) quarter. The access to care category continues to have the highest number of complaints, with a 15.8% decrease from the previous quarter. The interaction with provider or plan category remained relatively steady for the number of complaints compared with the previous quarter, with a 0.6% decrease. Quality of care continues to be the third-highest category of complaints, with a 16.8% decrease 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 number 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, providing more health navigators to assist members in making appointments and attending appointments, and taking 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 work to improve services to their members.

Under the FFS delivery system, 206 complaints were received from members during this quarter. An additional 597 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 150 complaints from members enrolled in dental care organizations (DCOs). Informational calls (9,178) were received asking for a variety of information, such as information about member coverage, CCO enrollment and how 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 specialty care and diagnostics. CCOs report that eligibility remains one of the most common reasons for denials. 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)	**Jan – Mar 2022**	**Apr – Jun 2022**	**Jul – Sep 2022**	**Oct – Dec 2022**

a) Denial or limited authorization of a requested service	26,862	28,669	26,379	25,077
b) Single pre-paid health plan (PHP) service area, denial to obtain services outside the PHP panel	835	680	658	709
c) Termination, suspension or reduction of previously authorized covered services	109	126	73	79
d) Failure to act within the time frames provided in Section 438.408(b)	9	9	12	19
e) Failure to provide services in a timely manner, as defined by the state	82	101	52	60
f) Denial of payment at the time of any action affecting the claim	54,606	52,775	56,727	57,162
g) Denial of a member's request to dispute a financial liability	0	0	0	0
Total	82,503	82,360	83,901	83,106
Number per 1,000 members	70.03	68.43	67.66	66.00

CCO Appeals

The table below shows the number of appeals the CCOs received during the October – December 2022 quarter. CCOs report that the highest number of appeals were for pharmacy services. Outpatient services was the next most common category of appeals, with specialty care the third most common category. CCOs review the 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	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022	Oct – Dec 2022

a) Denial or limited authorization of a requested service	1,072	1,193	1,159	1,016
b) Single PHP service area, denial to obtain services outside the PHP panel	34	22	34	16
c) Termination, suspension or reduction of previously authorized covered services	2	5	2	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	0	3
f) Denial of payment at the time of any action affecting the claim	244	331	433	396
g) Denial of a member's request to dispute a financial liability	0	0	0	0
Total	1,352	1,551	1,628	1,431
Number per 1,000 members	1.15	1.29	1.31	1.14
Number overturned at plan level	401	524	579	471
Appeal decisions pending	8	0	1	5
Overturn rate at plan level	29.7%	33.78%	35.57%	32.91%

CCO and FFS Contested Case Hearings

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

[1] In every quarter, there is an overlap between processed cases and those received. For instance, cases processed and resolved in October of 2022 may be cases OHA received as far back as July and August of 2022.

FFS members[1] may be enrolled in a DCO for dental coverage.

During the first quarter (October 1, 2022 – December 31, 2022), the OHA received 186 hearing requests related to the denial of medical, dental and behavioral health services, including NEMT. Of those received, 162 were from CCO-enrolled members, and 24 were from FFS members.

Of the cases, 187[1] were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing.

OHA dismissed 94 cases that were determined to be not-hearable cases. Of the not-hearable cases, 70 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 93 cases that were determined to be hearable, 25 were approved prior to hearing. Members withdrew from 30 cases after an informal conference with an OHA hearing representative. Twenty-four cases went to hearing, where an administrative law judge upheld the OHA or CCO decision, and 12 cases were dismissed for the member's failure to appear. The administrative law judge reversed the decision stated in the denial notices in one case during this quarter 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	25	13%
Client withdrew request after pre-hearing conference	30	16%
Dismissed by OHA as not hearable	94	40%
Decision affirmed*	24	13%
Client failed to appear*	12	6%
Dismissed as non-timely	0	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	1	1%
Set aside*	1	1%
Total	187	

* Resolution after an administrative hearing.

Related Data

Reports are attached separately as an appendix.

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. CMS requires Oregon's capitation rates be actuarially sound and follow applicable Actuarial Standards of Practice, which are developed by the Actuarial Standards Board.

OHA has begun the planning of the HRSN billing and the fee schedule methodology for services related to HRSN.

OHA delivered the final CY23 CCO rate package to CMS, which included the Oregon CY23 rate certifications and contract rate sheets. OHA continues to monitor the COVID-19 pandemic closely and is working with CCOs in partnership to maintain our health care system.

4. Enrollment/Disenrollment

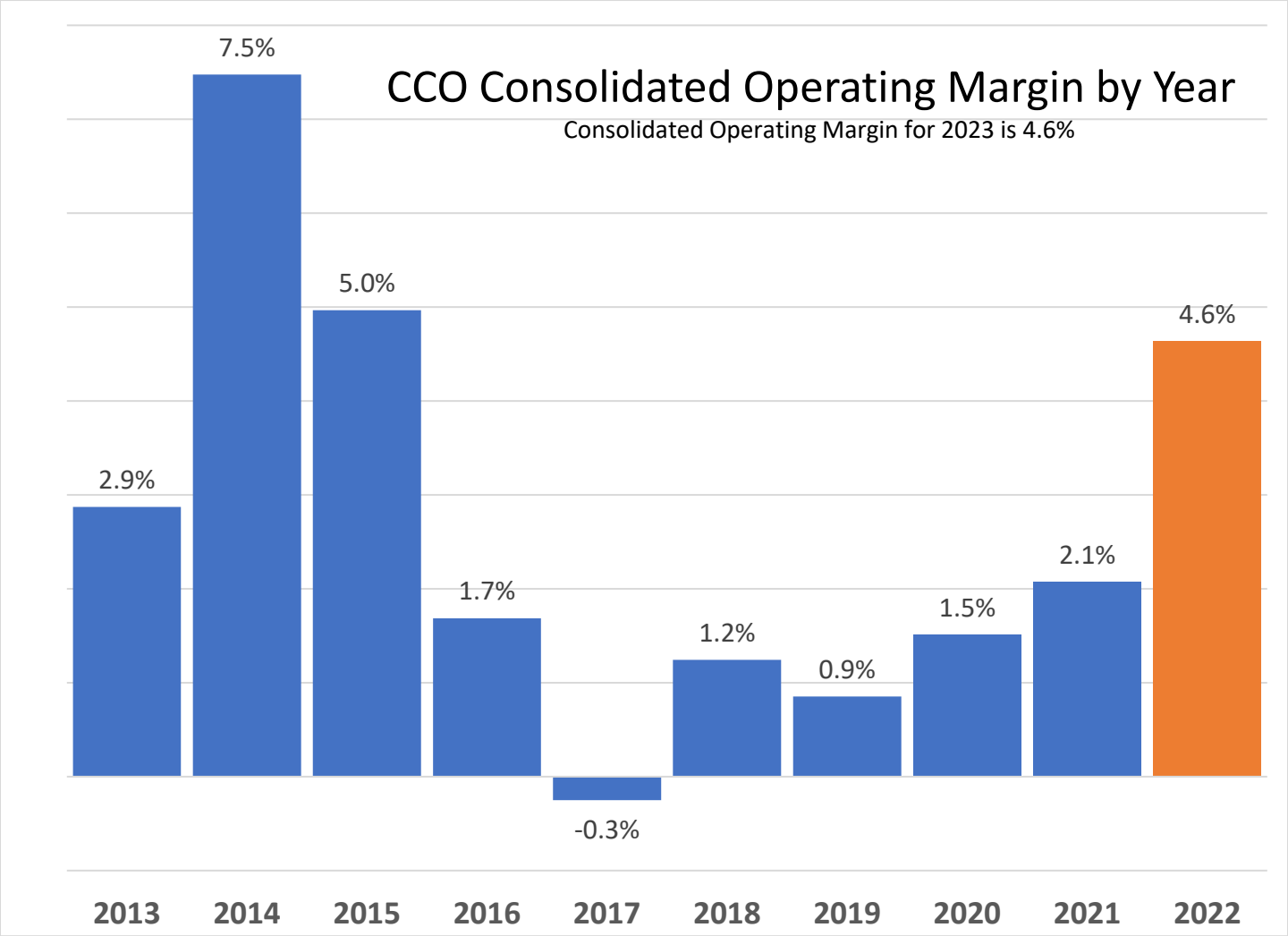
All significant enrollment and disenrollment trends are discussed in other sections of this report and in Appendix A.

5. Contract Compliance

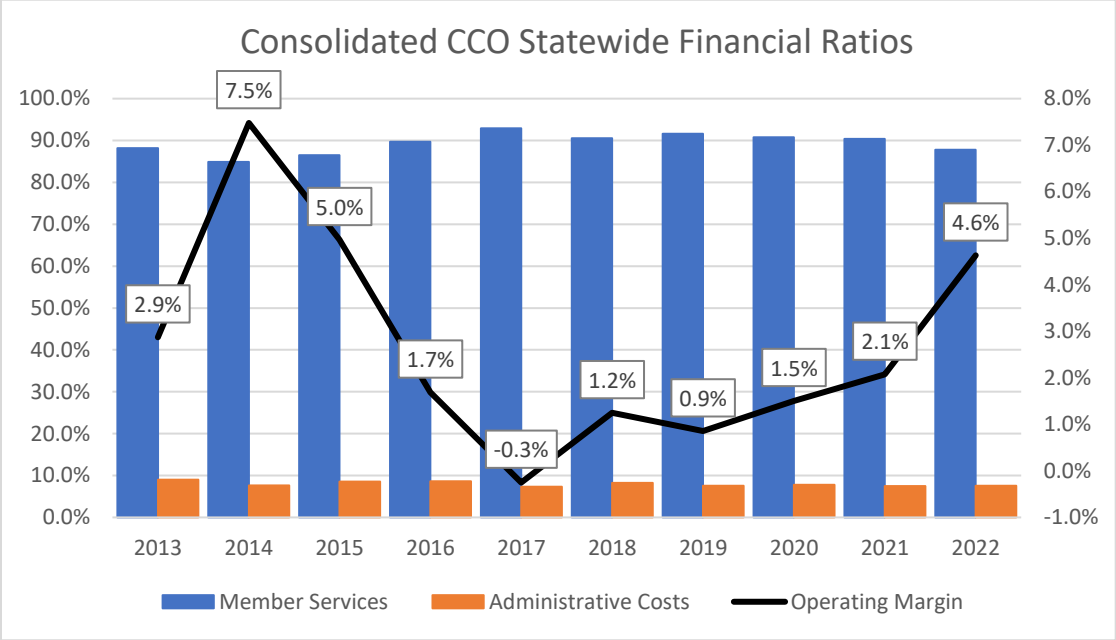
There are no additional issues with CCO contract compliance aside from those discussed in subsection 7 (CAPs) of this section.

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 Public Health Emergency.



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%.



In 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 April 14, 2020, which was later extended to October 31, 2020, and then re-extended to April 30, 2021. The current end date is when OHA determines the remaining area for improvement is "closed."

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.

The areas for improvement identified in the CAP are provider (driver) no-shows, on-time (pick-up) performance, call wait times, call abandonment and member grievances. In a letter dated January 29, 2021, OHA formally notified the HSO of its satisfaction with the improvements made in four of the five areas. The CAP is considered closed for those areas. The HSO is required to continue submitting monthly progress reports for the area of member grievances as well as documentation relating to specific NEMT concerns identified through member grievances. During the current quarter, the HSO submitted monthly progress reports demonstrating continued improvement for the five areas requiring

ongoing monitoring. OHA has determined the monthly reporting shows significant improvement and indicates the compliance breaches are remedied. OHA will seek to close the CAP in the upcoming quarter.

8. One-Percent Withhold

OHA analyzed encounter data received for completeness and accuracy for the subject months finalized for March 2022 through May 2022.

The Health Systems Division within OHA analyzed encounter data received for completeness and accuracy for the subject months of March 2022 through May 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 AP standard for the subject months of March 2022 through May 2022. No withhold was taken, as the CCO put remediation in place to ensure ongoing compliance. OHA leadership determined that due to the current 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

Nothing to report for this quarter.

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

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. Given the upcoming governor's office leadership transition and uncertainty regarding specific agency leadership details, the briefings that occurred in the October to December 2022 time frame were very general and intended to educate audiences on the basics of the CMS-approved waiver, as well as those items that are still pending approval. The following list of meetings included the 1115 waiver as an agenda item; please note that this list is not exhaustive:

- Waiver Days:10/25/2022 and 11/21/2022
    - 1115 Medicaid Waiver approval summary for partners and community members: Lori Coyner, Senior Medicaid Policy Advisor, OHA, provided an overview of the new authorities received and ongoing negotiations with CMS.
- HERC & Value-based Benefits Subcommittee:10/6/2022
- HERC & Value-based Benefits Subcommittee: 11/17/2022
- Medicaid Advisory Committee (MAC): 12/7/2022
    - 1115 Medicaid Waiver Summary: Lori Coyner, Senior Medicaid Policy Advisor, OHA, updated the MAC on the changes to the 1115 Medicaid Waiver as they continue negotiations with CMS. Lori focused on what has changed and what to expect going forward. MAC members asked questions about the following topics:
        - Housing supports for outpatient substance use disorders (SUDs) for people transferring from Medicaid to Medicare
        - Accessing climate assistance in 2024
- Health Equity Committee (HEC): 11/10/2022
    - 1115 Medicaid Waiver Summary: Lori Coyner, Senior Medicaid Policy Advisor, OHA, gave an overview of the 1115 Medicaid Waiver to the HEC. Lori presented an overview of the waiver and its relation to the OHA goal of advancing health equity.
    - Specific topics were the following:
        - An overview of the populations that will be receiving HRSN benefits
        - Explanation of the housing, food and climate benefits
        - Comprehensive investments in children's health to advance health equity
        - What is not included in the waiver
    - HEC members asked questions about the following:
        - Long-term funding for the HRSN benefits
        - Informational awareness campaigns related to the HRSN benefits

IV. Progress Toward Demonstration Goals

CE for Adults and Children

Oregon received CMS approval via the 1115 Demonstration waiver to expand CE in October 2022:

- 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.

Oregon implemented Healthier Oregon coverage in July of 2022, and much of the analysis during this time was to determine how Healthier Oregon and new CE provisions would interact.

Analysis was also performed to assess potential enrollment impact, including reviewing statistics related to prior years' eligibility terminations for reasons that would allow coverage to continue with CE in place.

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.

Eligible populations will include those aged 19 to 26 who meet one or more of the following criteria:

1. Have one or more serious chronic conditions as represented by the Pediatric Medical Complexity Algorithm's (PCMA) list of complex chronic conditions;
2. Have a serious emotional disturbance or serious mental health issue;
3. Have a diagnosed intellectual or developmental disability through Oregon's Office of Developmental Disabilities Services;
4. Have an "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener; or
5. Starting no earlier than January 1, 2026, have two or more chronic conditions as represented by a subset of the PMCA's noncomplex chronic conditions as described in the New Initiatives Implementation Plan (see State Terms and Condition (STC) 11.4).

During this quarter, Oregon began developing a strategic work plan to implement this new eligibility category, identified additional supporting staff, and set up a policy oversight and governance structure for implementation.

Further, Oregon identified two key policy tasks that will inform necessary systems changes and operationalization: 1) finalizing specific criteria for YSHCN eligibility, and 2) finalizing eligibility pathways for each criterion that centers equity (e.g., a culturally and linguistically responsive screening pathway).

EPSDT

Oregon did not seek to renew its long-standing waiver regarding EPSDT. As of January 1, 2023, Oregon will have fully implemented the complete EPSDT program, benefits and services to OHP

members aged birth to 21. In Q4 of 2022, OHA collaborated with the managed care entities (MCEs) as well as the FFS program to ensure coverage of all EPSDT services for both our MCE-enrolled and FFS populations. EPSDT in Oregon is now a Medicaid program in alignment with other states' EPSDT programs and CMS requirements.

Expand Access to Supports That Address HRSN

The recently approved waiver includes authority to establish a series of time-limited services to help address eligible members' HRSN, 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.

Because these are, to a great extent, new services within the OHP Medicaid benefit, capacity must be built to ensure successful and timely implementation.

This first demonstration quarter was used, in large part, to establish initial organizational structure and processes for detailed implementation planning. A timeline including CMS deliverables and implementation milestones was created and shared with staff of partnering state agencies, as well as Tribal leaders and various community and system partners.

OHA's ability to implement the waiver will require additional policy and operational staff. Prior to CMS' waiver approval, more than 100 full-time positions were included in OHA's biennial budget request to support implementation; this request will be reviewed and potentially modified when the incoming Kotek Administration takes office. (Note that Governor-Elect Tina Kotek took office in January 2023.)

In the latter half of this quarter, OHA leadership began briefing sessions with Governor-Elect Kotek's transition team and responded to questions. OHA recognized that, within the overall parameters of the approved waiver, specific policies and processes might be modified to reflect the new governor's process preferences and/or policy priorities early in 2023. In this quarter, the required MOE process and the Oregon Provider Payment Rate Increase Assessment were developed and submitted to CMS.

Designated State Health Programs

To date, Oregon has received approval for 15 programs to claim federal financial participation as Designated State Health Programs (DSHP).

In this quarter, OHA worked to gather information on 32 programs to submit for approval in the first quarter of 2023.

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 to communicate 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.

V. Appendices

A. Quarterly enrollment reports

1. Statistical Enrollment Data System (SEDS) reports

Attached separately.

2. State-reported enrollment table

Enrollment	October 2022	November 2022	December 2022
Title XIX-funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,270,274	1,277,445	1,283,795
Title XXI-funded State Plan	137,784	140,795	143,182
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
Designated State Health-funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A

3. Actual and unduplicated enrollment

Ever-enrolled report

POPULATION			Total Number of Clients	Member Months	% Change from Previous Quarter	% Change from Previous Year
Expansion	**Title XIX**	PLM children FPL > 170%	N/A	N/A	N/A	N/A
		Pregnant women FPL > 170%	N/A	N/A	N/A	N/A

	Title XXI	SCHIP FPL > 170%	62,594	169,141	0.50%	-19.28%
Optional	**Title XIX**	PLM women FPL 133% – 170%	N/A	N/A	N/A	N/A
	Title XXI	SCHIP FPL < 170%	141,276	379,126	2.19%	5.65%
Mandatory	**Title XIX**	Other OHP Plus	220,303	633,104	2.77%	16.54%
		MAGI adults/children	997,919	2,845,790	2.13%	5.69%
		MAGI pregnant women	20,848	52,653	10.81%	46.11%
		QUARTER TOTALS	1,442,940			

** 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**
October	1,328,500	1,244,538	1,727	183	12,285	71,194	N/A
November	1,337,129	1,253,068	1,936	179	12,401	71,798	N/A
December	1,346,435	1,262,077	1,106	129	12,441	71,742	N/A
Quarter average	1,337,355	1,253,228	1,590	164	12,376	71,578	N/A

** Total OHP eligibles include Temporary Assistance for Needy Families (TANF), General Assistance (GA), Poverty Level Medical (PLM)-Adults, PLM-Children, MAGI Adults/Children, MAGI Pregnant Women, OAA, Aged blind and disabled (ABAD), CHIP, FC and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.*

*** CCOA: Physical, dental and mental health; CCOB: Physical and mental health; CCOE: Mental health only; and CCOG: Mental and dental health*

B. Complaints and grievances

Please see appendices.

C. CCO appeals and hearings

Please see appendices.

D. Neutrality reports

Budget monitoring spreadsheets are attached separately.