Oregon Health Plan

Section 1115 Annual Report

July/01/2019 – June/30/2020

Demonstration Year (DY): 18

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I. Introduction

A. Letter from the State Medicaid Director

Oregon took many steps toward completing demonstration goals during this reporting period. Dual eligible members have been successfully transferred from the open card model into Coordinated Care Organizations. OHA successfully contracted with 15 CCOs for new 5-year contracts, and implemented many policy changes as a part of the CCO 2.0 process.

During the final months of this reporting period, OHA and CCOs began responding to the COVID-19 pandemic. OHA continues to work closely with CCOs to ensure members have access to quality care during the pandemic.

Lori Coyner, State Medicaid Director

B. Demonstration description

In July 2012, CMS approved an amendment and extension related to Oregon's 1115 Medicaid Demonstration waiver that transformed Oregon's health care delivery system to one of coordinated care. Sixteen Coordinated Care Organizations (CCOs) – which geographically cover the entire state – now deliver physical, oral and behavioral health services to approximately 90 percent of OHP members. During the previous five-year demonstration, which ended on June 30, 2017, Oregon sought to demonstrate the effectiveness of delivery system improvements under health system transformation.

In January 2017, CMS approved an extension to Oregon's 1115 Medicaid Demonstration waiver to continue and enhance Oregon's health system transformation initially approved in 2012. Moving forward, Oregon will continue to utilize community-driven, innovative practices aimed at promoting evidence-based, coordinated, and integrated care with the goal of improving the health of affected communities and populations, as well as an active commitment to data and measurement.

Under the demonstration, Oregon strives to promote the objectives of Title XIX by:

- Providing a basic benefit package;
- Insuring broad participation by health care providers;
- Implementing a clinical-effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Structuring benefits, using a prioritized list of health care conditions and treatments; and
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
    - Improving the individual experience of care;
    - Improving the health of populations; and
    - Reducing per capita costs of care for populations through such improvements.

The demonstration seeks to improve the coordinated care model to meet the following key goals:

1. Enhance Oregon's Medicaid delivery system transformation with a stronger focus on integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and continuing to bend the cost curve;
2. Increase the state's focus on encouraging CCOs to address the social determinants of health and improve health equity across all low-income, vulnerable Oregonians to improve population health outcomes;
3. Commit to ongoing sustainable rate of growth and adopt a payment methodology and contracting protocol for CCOs that promotes increased investments in health-related services and advances the use of value-based payments; and
4. Expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual-eligible members.

The extension of the demonstration also includes the following targeted changes:

- Conversion of the Tribal uncompensated care payments to a Medicaid benefit;
- Clarifying health-related services that meet the requirements as specified in the Code of Federal Regulations;
- Allowing passive enrollment of Medicare and Medicaid dually-eligible individuals into CCOs with the option for each individual to opt-out at any time;
- Specifying the demonstration will not impact American Indian and Alaska Natives rights to exemption from managed care, or the requirements to comply with the Medicaid Managed Care Regulations;
- Offering incentive payments to Patient-Centered Primary Care Homes and Comprehensive Primary Care Plus providers for enhanced fee-for-service delivery of care to Medicaid recipients; and
- Establishing minimum requirements for CCOs to collaborate and communicate in a timely and equitable manner with tribes and Indian Health Care providers.

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II. Title

Oregon Health Plan
Section 1115 Annual Report
Reporting period: July/01/2019 – June/30/2020
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III. Overview of the current year

A. Enrollment progress

1. Oregon Health Plan eligibility

Increases in Title XIX enrollees over the last several months of this reporting period are a direct result of Oregon adopting eligibility protections provided under H.R.6201 Families First Coronavirus Response Act as well as through 1115 Demonstration Waiver allowances related to the Public Health Emergency. Individuals who were receiving coverage on or after March 18, 2020 are maintaining continued coverage unless they die, are suspended while being an inmate of a public institution, cease to be a resident of the state, or voluntarily request closure. Oregon has experienced an increase in applications during the health emergency as household incomes have decreased or ceased. Concurrent to pandemic-related rule and system changes, Oregon has also been preparing to launch its new integrated eligibility system which has required staff engagement and training across the state for the past several months. The new business structure includes increasing the number of eligibility workers who can process applications for Medicaid and CHIP and has allowed for the elimination of

processing backlogs as it prepares to move non-MAGI Medicaid and other public assistance program eligibility into the shared system.

2. Coordinated care organization enrollment

The passive enrollment of Medicaid and Medicare dual-eligible members concluded during this reporting period. This reporting period represents the first quarter in which CCO enrollment figures will reflect that population remaining enrolled in their assigned CCOs. OHA continues to work with CCOs to ensure that members have access to quality care during the transition. No significant disruptions in the enrollment process have been reported.

Also during this reporting period, OHA prepared enrollment transitions for members who were enrolled in CCOs that are terminating at the end of 2019, as well as for members who will have a new CCO in their service are as of January 1, 2020.

B. Benefits

July, 2019 – September, 2019

The P&T Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: brexanolone and esketamine; patisiran and inotersen; dupilumab; atopic dermatitis and topical antipsoriatics; solriamfetol; modafinil/armodafinil; remove the PA requirement for preferred insulin pens; hepatitis C, direct-acting antivirals; tobacco smoking cessation; drugs for Duchenne muscular dystrophy; oral cystic fibrosis modulators; short-acting and long-acting opioids; drugs for transthyretin-mediated amyloidosis (ATTR); spinal muscular atrophy; bone metabolism agents; and Fabry disease treatments.

The committee also recommended changes to the preferred drug list (PDL): add the drugs for hATTR class to the PDL and to designate inotersen and patisiran non-preferred; make solriamfetol voluntary non-preferred; make sodium oxybate non-preferred; make methocarbamol tablets preferred; make valacyclovir tablets preferred; make insulin glulisine (pens and vials) and insulin regular, human U-500 pens preferred; make Humalog Mix 75/25 and 50/50 KwikPens preferred; make insulin detemir vials preferred; make Zepatier non-preferred; make Vyndaqel and Vyndamax non-preferred; add the spinal-muscular atrophy class to the PDL and make Zolgensma preferred and Spinraza non-preferred; and make Farbyzyme and Galafold non-preferred.

During 7/1/2019-9/30/2019, the 1/1/2019 Prioritized List remained in effect with no changes other than two errata. During this time, the Health Evidence Review Commission approved various changes for implementation 10/1/2019; these were published in the 10/1/2019 Notification of Interim Changes.

October, 2019 – December, 2019

The P&T Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: rifamycin; amikacin liposome inhalation suspension; targeted therapies for Gaucher disease; amifampridine; cholic acid; dupilumab; tricyclic antidepressant (TCA) therapy in children younger than the FDA-approved minimum age limit; and removed the PA requirement for all opioid use disorder (OUD) products, except for the dose limit of 24 mg buprenorphine per day for transmucosal products.

The committee also recommended changes to the preferred drug list (PDL): make rifamycin non-preferred; make amikacin liposome inhalation suspension non-preferred; add class for lysosomal storage disorder drugs

and make miglustat and eliglustat non-preferred; make taliglucerase alfa preferred and all other agents for Gaucher disease non-preferred; add class for Lambert-Eaton Myasthenic Syndrome (LEMS) agents and make Ruzurgi® preferred and Firdapse® non-preferred; make cholic acid non-preferred; and make buprenorphine injection (Sublocade™) preferred.

The Health Evidence Review Commission:

A new interim modification of the January 1, 2018 prioritized list went into effect on October 1, 2019 and remained in effect through December 31, 2019. Errata were published on 10/11/19, 11/18/2019 and 12/2/2019. These, along with interim modifications approved 11/14/2019 by the Health Evidence Review Commission, were reported in the Notification of Interim Changes for the January 1, 2020 Prioritized List.

January, 2020 – March, 2020

The P&T Committee:

Developed new or revised Prior Authorization (PA) criteria for the following drugs: insulin pens; biologics for autoimmune conditions; narcolepsy agents; orphan drugs; and short and long-acting opioids.

The committee also recommended changes to the preferred drug list (PDL): make azathioprine and tacrolimus preferred; make all forms of insulin lispro – except Admelog – preferred; add class for glucagon agents and make GlucaGen, Baqsimi and glucagon emergency kit preferred and Gvoke non-preferred; make lefamulin non-preferred; make secukinumab preferred; and to make armodafinil and modafinil preferred.

The Health Evidence Review Commission:

The January 1, 2020 prioritized list went into effect on January 1, 2020. Errata were published on 2/4/20 and 3/23/2020. These, along with interim modifications approved 3/12/2020 by the Health Evidence Review Commission, were reported in the Notification of Interim Changes for the March 13, 2020 Prioritized List.

April, 2020 – June, 2020

The P&T Committee developed new or revised Prior Authorization (PA) criteria for the following drugs: Acne Class; Sickle Cell Disease; Duchenne Muscular Dystrophy; Idiopathic Pulmonary Fibrosis; Cystic Fibrosis Modulators; Drugs for Constipation; Orphan Drugs; Oral Multiple Sclerosis Drugs; Oncology Agents; and Hepatitis C, Direct-Acting Antivirals.

The committee also recommended changes to the preferred drug list (PDL): make Altreno™ (tretinoin) and Arazlo™ (tazarotene) non-preferred and unassigned benzoyl peroxide products preferred; designate Xcopri® (cenobamate) non-preferred; make chlorthalidone and generic triamterene/hydrochlorothiazide preferred; create a PDL class for the Sickle Cell Disease (SCD) drugs and make a hydroxyurea formulation a preferred and designate Oxbryta™ (voxelotor) and Adakveo® (crizanlizumab-tmca) non-preferred; make generic hydroxyurea capsules preferred and Droxia®, Hydrea®, Siklos®, and Endari™ (L-glutamine) non-preferred; make Motegrity™ (prucalopride), Zelnorm® (tegaserod), and Ibsrela® (tenapanor) non-preferred; create a PDL class for the hemophagocytic lymphohistiocytosis (HLH) drugs and designate Gamifant® (emapalumab-lzsg) non-preferred.

The Health Evidence Review Commission:

Errata and urgent COVID-related changes to the March 13, 2020 Prioritized List were posted on 4/3/2020, 4/8/2020 and 4/15/2020. These, along with interim modifications approved 8/13/2020 by the Health Evidence Review Commission, have since been reported in the Notification of Interim Changes for the August 14, 2020 Prioritized List.

Topic of public review *May 21, 2020 Health Evidence Review Commission meeting testimony*

Topic: Review of the 2020 Agency for Healthcare Research and Quality (AHRQ) reports on non-pharmacologic treatments for pain, non-opioid pharmacologic treatments for pain, opioid treatments for pain; review of Washington Health Technology Assessment (HTA) report on lumbar surgery

The Health Evidence Review Commission submitted a benefit change approval request to CMS in August, 2019. The changes took effect in Oregon's Medicaid program as of January 1st, 2020.

C. Access to care (ANNUAL)

Relevant impacts on CCO and FFS populations and delivery systems

Federal and state regulations governing Medicaid services require each managed care contractor to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. Each contractor must submit documentation to the state Medicaid authority demonstrating the contractor's capacity to serve enrolled members in its service area in accordance with the state's standards for access to care. The Delivery System Network (DSN) report consist of two components: a Provider Narrative Report and a Provider Capacity Report that crosswalks to the network standards in the OHA 2020 Health Plan Services CCO 2.0 Contract Exhibit G (2)(a). OHA reduced the frequency of DSN Provider Narrative submissions to an annual basis and quarterly DSN Provider Capacity reports.

Most of the Managed Care Entities (MCEs) provide evidence of a sufficient network of appropriate providers, including preventive and specialty care, supported by written agreements. The MCEs prioritized member assignment to PCPCHs to support the objective of delivering coordinated and integrated care. To address the inherent challenges associated with the availability of services and rural networks, many MCEs utilized innovative strategies to ensure access to care, including contracting with mobile and telehealth providers, as well as enlisting the services of community health workers to accompany members to appointments.

Most MCEs were able to demonstrate how out-of-network data were monitored and used to inform network adequacy. While the majority of the CCOs used single-case agreements to ensure access to out-of-network providers, the DCOs as smaller MCEs with less need for out-of-network providers lacked any formal agreements with such providers. Monitoring access to care continued to be largely reactive, focusing on the review of access-related grievances and complaints, and capacity was less clear in that time and distance were not captured consistently and adequacy of provider to member ratios did not pertain to any specific guidelines across CCOs.

The MCEs have generally met the requirements specified in 42 CFR §438 and established standards for timely access to care and services, taking into account the urgency of members' need for services. The MCEs have policies, procedures, and programs that describe their coverage and authorization of service activities and support timely access to care by defining timeliness standards for delegates and providers. However, monitoring efforts for timely access to care continue to be deficient or poorly documented.

D. Quality of care (ANNUAL)

Federal regulations under 42 CFR §438.340 require each state Medicaid agency contracting with Managed Care Organizations to develop and implement a written quality strategy to assess and improve the quality of managed care services. OHA's current quality strategy was included as part of Oregon's 1115 Medicaid Demonstration Waiver and approved by CMS in June 2018. The quality strategy provides a framework to accomplish OHA's mission to improve the lifelong health of Oregonians, increase the quality, reliability, and availability of care for all Oregonians, and lower or contain cost of care so it is affordable to everyone. This framework for quality includes the following eight focus areas:

- Reduce preventable re-hospitalizations
- Address population health issues (i.e., diabetes, hypertension, and asthma) within a specific geographic area
- Deploy care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers
- Integration of health: physical health, oral health, and/or behavioral health
- Ensure appropriate care is delivered in appropriate settings
- Improve perinatal and maternity care
- Improve primary care for all populations through increased adoption of the patient-centered primary care home (PCPCH) model of care
- Social Determinants of Health

CCOs are required to submit their own Transformation and Quality Strategy (TQS) incorporating all components of the Quality Assessment and Performance Improvement (QAPI) program to ensure a robust quality program that supports the strategic goals of OHA. The TQS goals are to support the safe and high-quality care for all members under CCOs by ensuring the quality and transformation plan adequately covers federal requirements, pushes health transformation forward, and continues the path towards the triple aim (better care, better health, lower cost). These strategies, ongoing accountability and compliance reviews, and PIP activities are assessed and monitored by OHA for continuous improvement and incorporated in quality strategy updates.

Quality and Access Assessment

OHA works closely with its MCEs, partners, and stakeholders on improving quality of care for OHP members. This is primarily done through the engagement of internal and external committees to support quality and access monitoring, the requirement for MCEs to annually maintain a TQS to ensure robust and streamlined quality programs, and statewide and MCE-specific PIPs and focus studies.

The OHA contract requires each CCO to conduct three PIPs and one focus study designed to improve care in at least four of the eight QI focus areas noted above. The CCOs all participated in Oregon's statewide PIP on opioid safety and continue to implement their interventions for 46 CCO PIPs and focus study projects ranging from one PIP addressing OHA's focus area on reducing preventable re-hospitalizations, to 15 PIPs addressing the focus area on ensuring appropriate care is delivered in appropriate settings. Validation results for the statewide PIP demonstrated that the CCOs used methodologically sound and effective strategies for improving the safety of opioid prescribing and that there was a statistically significant statewide improvement (decrease) in the rate of high-dose opioid prescriptions from baseline to the final remeasurement. The CCO PIPs and focus

study projects include reducing ED utilization, ensuring oral health during pregnancy, screening for specific conditions (e.g., colorectal cancer, Hepatitis C, and SDOH), tobacco cessation, and contraceptive care.

For the March 2020 TQS submissions, OHA received a total of 156 TQS projects. The average score for CCOs was 28.84 (42 being the highest possible score). Individual CCO scores for 2020 TQS submissions are noted below.

CCO Name	Total score
Advanced Health	27.5
AllCare	33.2
Cascade Health Alliance	22.5
Columbia Pacific CCO	22.4
Eastern Oregon CCO	28.5
Health Share of Oregon	32
InterCommunity Health Network	31
Jackson Care Connect	32
PacificSource Community Solutions—Central Oregon	31.5
PacificSource Community Solutions—Columbia Gorge	31.5
PacificSource Community Solutions—Lane	32
PacificSource Community Solutions—Marion Polk	32
Trillium Community Health Plan	23
Umpqua Health Alliance	25.5
Yamhill CCO	22

Overall, the CCOs showed strong potential for improving member care and outcomes; addressing critical and exciting areas of transformation; improved use of SMART goals; and demonstrated increased partnerships across the delivery system. The CCOs submitted projects across the following component areas. As noted below, the CCOs have continued room for improvement across several areas.

Component	Average score*
Access: Cultural Considerations	1.75
Access: Quality and Adequacy	1.75
Access: Timely	1.80
Behavioral Health Integration	2.33
CLAS Standards	2.23
Grievances and Appeals	2.27
Health Equity: Cultural Responsiveness	2.03
Health Equity: Data	2.37
Oral Health Integration	1.90
PCPCH	2.23
Serious and Persistent Mental Illness	2.71
SDOH-E	1.69

Special Health Care Needs	1.85
Utilization Review	2.10

OHA has provided individual CCOs with written evaluations of the 2020 project submissions and recommendations for improvement for their 2021 TQS submissions. OHA will continue to work closely with CCOs to improve their 2021 submissions and improve overall scores.

All of the CCOs coordinate care at some level and most of them have dedicated care managers that work with members identified as needing intensive care coordination. Care coordination is generally tracked in care management systems that are sometimes linked to claims data, but many MCEs continue to lack formal care and treatment plans. The delegation of care coordination also continues to present a challenge for managing care coordination at the CCO level. Full integration continues to be a challenge for the CCOs but could greatly impact care coordination efforts if achieved.

E. Complaints, grievances, and hearings

CCO and FFS Complaints

The information provided in the charts below is a compilation of data from the current 15 coordinated care organizations (CCO) and fee-for-service (FFS) data. The annual reporting period covers July 1, 2019 through June 30, 2020.

Trends

	Jul – Sep 2019	Oct – Dec 2019	Jan – Mar 2020	Apr – Jun 2020
Total complaints received	6,776	5,954	4,233	2,503
Total average enrollment	1,203,531	1,183,310	1,050,851	1,046,476
Rate per 1,000 members	5.63	5.03	4.03	2.39

Barriers

The fourth quarter of this annual reporting period shows a decrease in complaints. The CCOs indicate the reduction in services during the pandemic crisis contributes to this decrease. Some CCOs also attribute the decrease to the use of telehealth visits. The Interaction with Provider/Plan category received the highest number of complaints however the data shows a decrease of 42.9% from the previous quarter and a 68% decrease over the past year. The Access to Care category shows a decrease of 57.4% this quarter and an overall decrease of 75.2% decrease over the past year. Over the previous quarter Quality of Care issues decreased slightly by 13.4%, with an overall decrease of 47.9% over the past year. FFS data shows the highest number of complaints are in the Quality of Service category, with Access to Care the next highest category.

Interventions

CCOs – some CCOs are reporting that the decrease in complaints in this last quarter may be attributed to more members choosing to use telehealth visits for non-emergent issues. CCOs continue to report they have established committees and taskforces specifically to address provider capacity within their networks. Some CCOs report they have increased care coordination and communication with providers, such as in-office visits with members, to ensure care coordination is open and on-going for members. CCOs report they are continuing to monitor on a regular basis any trends and working to reduce the numbers of issues related to members requesting to change providers. CCOs are continuing to report staff is being added internally as well as at sub-

contractor offices to focus on specific problem areas. Rural area CCOs are continuing to report issues with bringing on more providers, which has increased complaints in some areas. Some CCOs feel their efforts to reduce NEMT complaints is having an impact. The NEMT complaints, as with all complaints have decreased in the last two quarters.

Fee-For-Service –Client Services data shows an increase from the previous quarter for Fee for Service member complaints and complaints from members enrolled in a CCO. This is attributed to the shutdown of services during the first quarter of 2020 due to the pandemic crisis, and services beginning to reopen in the Apr – Jun quarter of this reporting period. The number of complaints from members who were on Fee for Service coverage during the Apr – Jun quarter was 245. An additional 442 records were identified as calls received from members enrolled in CCOs. These calls were referred to the appropriate CCO. There were 97 calls regarding complaints about Dental Care Organizations. There were 4832 informational calls received asking for a variety of information, such as information about their coverage, CCO enrollment, request ID cards, etc.

Statewide rolling 12-month Complaints totals

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

Complaint category	Jul – Sep 2019	Oct – Dec 2019	Jan – Mar 2020	Apr – Jun 2020
Access to care	2687	2370	1566	667
Client billing issues	586	604	293	446
Consumer rights	248	175	277	168
Interaction with provider or plan	2161	1863	1464	690
Quality of care	660	719	397	344
Quality of service	434	223	223	188
Other	0	0	13	0
Grand Total	6776	5954	4233	2503

Related data

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

CCO Notices of Adverse Benefit Determinations and Appeals

Notices of Adverse Benefit Determination (NOABD)

The following table lists the total number of notices of adverse benefit determinations (NOABD) issued by CCOs during each quarter. The NOABDs are listed by reason, as per 42 CFR 438.400(b) (1-7) and are the total number of NOABDs issued, regardless of whether or not an appeal was filed. For the Apr – Jun 2020 quarter CCOs report that the highest number of NOABDs issued were Pharmacy related denials. Specialty care related issues were the next highest and issues related to Behavioral Health were the third highest. CCOs report that eligibility remains one of the highest reasons for denials. Some CCOs are working to provide information about OHP members who are terminating to assist the provider in reducing confusion and the numbers of requests for services that end in denials. CCOs continue to monitor NOABDs to ensure written notices are sent to members in easily understood language and includes the appropriate citations. Tracking for timeliness, as well as reviewing for utilization and appropriateness of care are processes CCOs report they are doing to ensure NOABDs are issued appropriately and timely.

Notice of Adverse Benefit Determination (NOABD)	Jul – Sep 2019	Oct – Dec 2019	Jan – Mar 2020	Apr – Jun 2020
a) Denial or limited authorization of a requested service.	33,609	33,906	25,964	21,311
b) Single PHP service area, denial to obtain services outside the PHP panel	149	325	326	215
c) Termination, suspension, or reduction of previously authorized covered services	143	138	267	62
d) Failure to act within the timeframes provided in § 438.408(b)	26	8	47	11
e) Failure to provide services in a timely manner, as defined by the State	234	49	111	21
f) Denial of payment, at the time of any action affecting the claim.	19,823	19,581	41,912	40,779
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	53,984	54,007	68,627	62,399
Number per 1000 members	45	46	65	60

CCO Appeals

The table below shows the number of appeals the CCOs received over the past year. There has been a 38% decrease in the number of appeals over the past year with the steepest decreases in the last half of this reporting period. These decreases are attributed to the shutdown of services due to the pandemic. CCOs reported the highest number of appeals in the Apr – Jun quarter were related to Outpatient services. Appeals related to Specialty care were the next highest and Pharmacy was the third highest. CCOs report they review the overturn rates which leads to more in-depth discussions and reviews, monitoring and process changes. Some CCOs are reporting that Peer Reviews with Providers is resulting in improvements to services. CCOs report they are continuing to do activities such as staff education and monitoring for providers to improve understanding of the appeal process. CCOs also work with members to assist them in finding services they need or assist them with finding alternative covered options.

CCO Appeals	Jul – Sep 2019	Oct – Dec 2019	Jan – Mar 2020	Apr – Jun 2020
a) Denial or limited authorization of a requested service.	1,236	1,273	811	766
b) Single PHP service area, denial to obtain services outside the PHP panel.	17	3	4	7
c) Termination, suspension, or reduction of previously authorized covered services.	11	12	6	1
d) Failure to act within the timeframes provided in § 438.408(b).	1	3	4	0
e) Failure to provide services in a timely manner, as defined by the State.	0	0	0	0

f) Denial of payment, at the time of any action affecting the claim.	355	303	353	409
g) Denial of a member's request to dispute a financial liability.	0	0	0	0
Total	1,620	1,594	1,178	1,183
Number per 1000 members	1.35	1.35	1.1	1.13
Number overturned at plan level	495	537	379	308
Appeal decisions pending	8	8	9	12
Overturn rate at plan level	30.56%	33.69%	32.17%	26%

CCO and FFS Contested Case Hearings

The following information is a compilation of data from 15 coordinated care organizations (CCO), 5 dental care organizations (DCO) and fee-for-service (FFS).

The Oregon Health Authority (OHA) received 523 hearing requests related to the denial of medical, dental and behavioral health services, including Non-Emergent Medical Transportation (NEMT). Of those received, 465 were from CCO-enrolled members and 58 were from FFS members.

During the third quarter, 499* cases were processed and resolved. The table below shows the outcomes of these cases, some of which were decided after an administrative hearing. (In every quarter there is an overlap of processed cases with those received. For instance, cases processed and resolved in April of 2020 may be cases OHA received as far back as February and March of 2020.)

OHA dismissed 392 cases that were determined not hearable cases. Of the not-hearable cases, 356 were forwarded to the member's respective CCO to process as an appeal. Per Oregon Administrative Rule, Oregon Health Plan (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 107 cases that were determined to be hearable, 23 were approved prior to hearing. Members withdrew from 54 cases after an informal conference with an OHA hearing representative and 30 cases went to hearing, where an administrative law judge upheld the OHA or CCO decision in 16 cases and dismissed 12 cases for the members failure to appear. In two cases the administrative law judge reversed or set aside the decision stated in the denial notice.

Outcomes of Contested Case Hearing Requests Processed

Outcome Reasons	Count	% of Total
Decision overturned prior to contested case hearing	23	4%
Client withdrew request after pre-hearing conference	54	10%
Dismissed by OHA as not hearable	392	78%
Decision affirmed*	16	3%
Client failed to appear*	12	2%
Dismissed as non-timely	0	0%
Dismissed because of non-jurisdiction	0	0%
Decision reversed*	1	0%
Set Aside	1	0%
Total	499	

* Resolution after an administrative hearing.

F. CCO activities

1. New plans

After an extensive RFA process, OHA signed contracts with 15 CCOs in October 2019. One entity previously operating as a CCO in Josephine and Jackson Counties was not awarded a contract. Another entity previously serving the Marion and Polk regions applied as a new entity but were ultimately denied a contract. The provider networks in these regions were absorbed by the remaining CCOs in the regions. There were no adverse impacts in access to care for OHP members resulting from the CCO contract awards. OHA implemented transition of care rules to support members and provide continuity of care for OHP members moving between CCOs.

2. Provider networks

There were no other substantive impacts to provider networks impacting access to physical, behavioral, and oral health networks.

3. Rate certifications

July – September 2019:

The Oregon Health Authority (OHA) contracts with Coordinated Care Organizations (CCOs) to manage and deliver integrated services that include Physical Health, Behavioral Health, and Dental Services to the majority of Oregon's Medicaid population. OHA pays CCOs with Actuarially Sound capitation rates that are developed on an annual basis. Capitation rates pay an amount per month depending on the individual's age and OHP eligibility category. In addition to CCOs, OHA also retains seven Dental Only (DCO) contracts and a Mental Health Only (MHO) contract where capitation rates are developed separately.

In July 2019, OHA awarded the CCO 2.0 contracts. Once contracts were awarded OHA met with CCOs at an August 8 Rates Workgroup meeting to discuss program changes, trend, and non-medical load, as well as to discuss the impact of member reallocation in areas with multiple CCOs and walk through the cost attribution methodology.

In addition, OHA held an August 28 Rates Workgroup meeting to discuss area factors and risk factors that inform individual CCO rates. OHA delivered the CY2020 rates to individual CCOs during August 28-30, 2019.

Each CCO had until September 13, 2019 to review and ask questions in the 2020 contract year. OHA delivered FINAL 2020 rates on September 27, 2019 to ensure final CCO 2.0 contract signing.

OHA submitted final rates to CMS on October 2, 2019, which allows for a 90-day review window, per CMS rule.

October – December 2019:

The Oregon Health Authority (OHA) contracts with Coordinated Care Organizations (CCOs) to manage and deliver integrated services that include Physical Health, Behavioral Health, and Dental Services to the majority of Oregon's Medicaid population. OHA pays CCOs with Actuarially Sound capitation rates that are developed on an annual basis. Capitation rates pay an amount per month depending on the individual's age and OHP eligibility category. In addition to CCOs, OHA also retains seven Dental Only (DCO) contracts and a Mental Health Only (MHO) contract where capitation rates are developed separately.

In October 2019, OHA submitted the final CY2020 CCO Rates Certifications CMS which effective as of January 1st, 2020 through December 31st, 2020. However, a rate amendment was submitted to CMS on January 28, 2020. This amendment reflects an update to the qualified directed payment amounts (QDP), provider contracting, and new information that was added on by the CCOs regarding rate add-ons.

OHA has also submitted the CCO CY2020 Expenditure Report and the Contract Rate Sheet by Plan and by CCO to accompany the amendment.

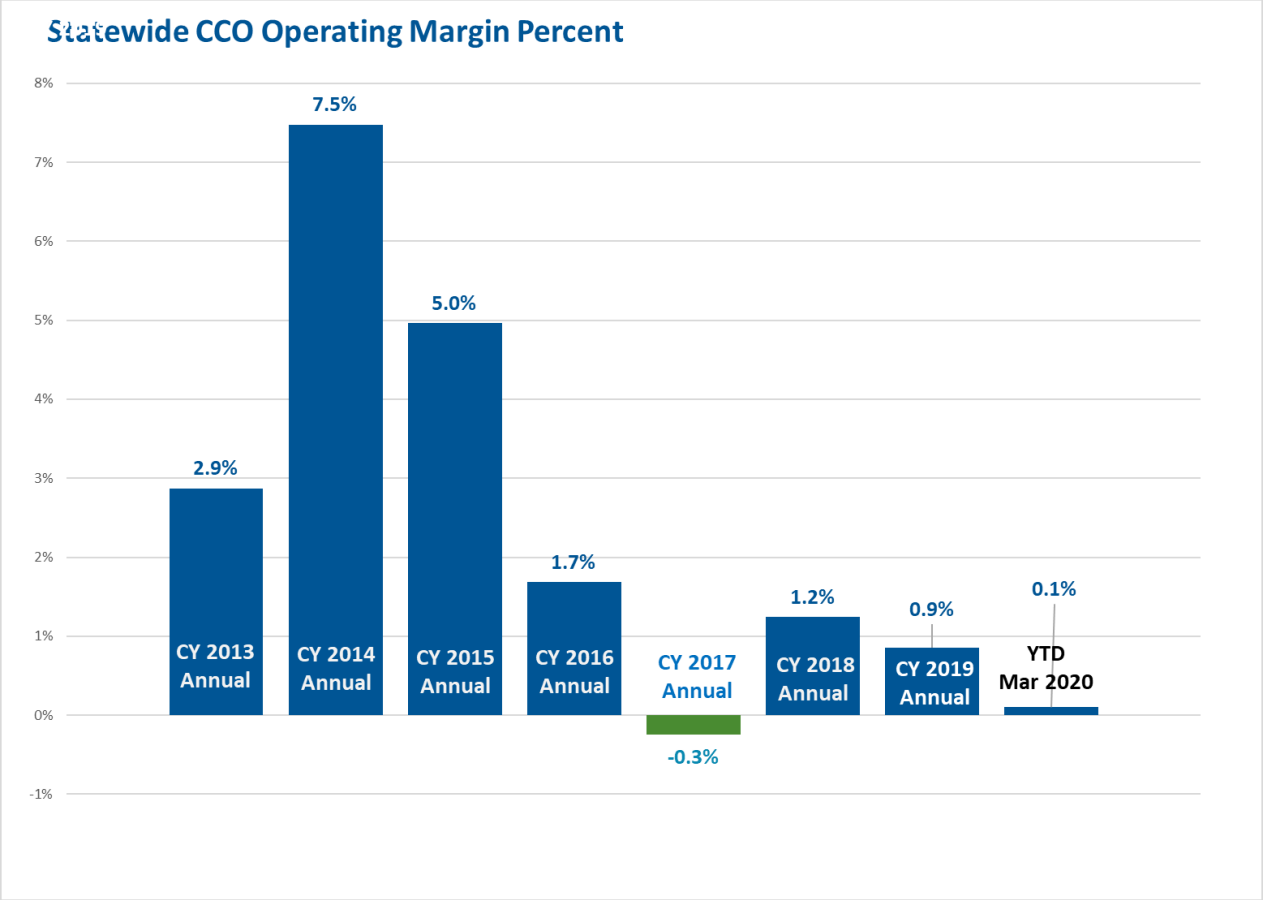
January – March 2020:

The Oregon Health Authority (OHA) contracts with Coordinated Care Organizations (CCOs) to manage and deliver integrated services that include Physical Health, Behavioral Health, and Dental Services to the majority of Oregon's Medicaid population. OHA pays CCOs with Actuarially Sound capitation rates that are developed on an annual basis. Capitation rates pay an amount per month depending on the individual's age and OHP eligibility category. In addition to CCOs, OHA also retains six Dental Only (DCO) contracts where capitation rates are developed separately.

Starting January 1, 2020, OHA entered a new five-year contracting cycle with CCOs. The start of the contract included a member transition period, and it was expected that risk would shift in the program. Because the shifts in risk were not reasonably predictable prior to the original publication of 2020 capitation rates, state law allows for and OHA will prepare a retroactive rate adjustment covering all of 2020. OHA is working closely with CCOs on the retroactive rate process to adjust for risk changes due to membership. OHA is also monitoring the COVID-19 pandemic closely and working with CCOs in a partnership in preparing and maintaining our healthcare system.

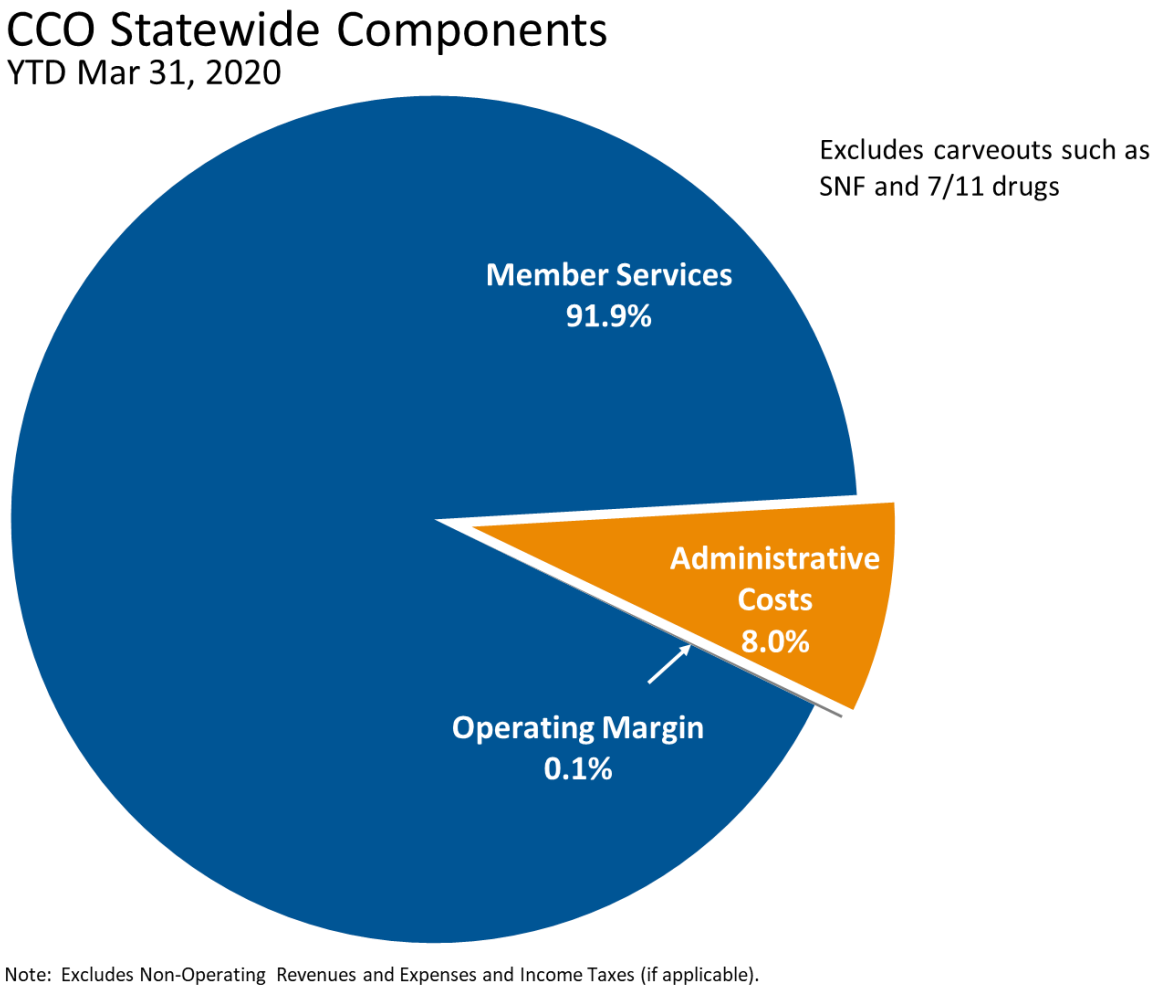
OHA meets with CCOs regularly to review financial and rate-related matters. During Quarter 1 2020, OHA met with the CCOs to discuss; 1) the transition to a new financial reporting standard and NAIC submission, 2) the CY2021 rate development process, and 3) the CY2020 retroactive rates.

For the three-months ended March 31, 2020, the statewide CCO operating margin was at 0.1% compared to 0.9% for the year ended December 31, 2019. For reference, the capitation rates include a 1% profit margin. CCO operating margins returned to a slightly profitable status after trending downward during 2015-2017 period.



CCO member services ratio (MSR) is a key financial metric that calculates the cost of services a CCO provides to its members (this includes medical, behavioral, dental and health-related services, reinsurance premiums and recoveries, and other adjustments) as a percentage of total revenue. For the 3-months ended March 31, 2020, the MSR for all CCOs in aggregate was 91.9%. Administrative Services accounted for 8% of total CCO revenue, leaving 0.1% as operating margin.

For the 3-months ended March 31, 2020, all of the 15 CCOs met or exceeded the 85% target for MSR, a key indicator for MLR (14 of the CCOs had MSRs above 90%).



Note: Excludes Non-Operating Revenues and Expenses and Income Taxes (if applicable).

At end of March 31, 2020, net Assets of the CCOs ranged from a low of $199 per member (Health Share of Oregon) to a high of $1,430 per member (Trillium Comm. Health Plan), averaging $439 per member for the state.

April – June 2020:

The Oregon Health Authority (OHA) contracts with Coordinated Care Organizations (CCOs) to manage and deliver integrated services that include Physical Health, Behavioral Health, and Dental Services to the majority of Oregon's Medicaid population. OHA pays CCOs with Actuarially Sound capitation rates that are developed on an annual basis. Capitation rates pay an amount per month depending on the individual's age and OHP eligibility category. In addition to CCOs, OHA also retains six Dental Only (DCO) contracts where capitation rates are developed separately.

In April 2020, CCOs submitted their completed Exhibit L's to OHA to begin the CY 2021 rate development and data validation process. Simultaneously, the CY2020 Retroactive Rates were also developed and began in April 2020 to account for member health status changes in the program due to the start of a new contract cycle for CCOs.

In May 2020, OHA met with each individual CCO to discuss the triangulation process of the CCOs' financial data for their CY2021 rates. The purpose of the triangulation meetings was to discuss the CCOs' financial data, the rate setting data, and the encounter data to cross-compare and ensure there is a consensus on the starting point of the base data. The discussions centered around encounter data validation and CY2019 financials.

In June 2020, OHA met with CCOs to continue discussions related to the CY2020 Retroactive Rate adjustments and factors and CY2021 base data. On July 6, 2020 OHA delivered the CY2020 Retroactive Rates to CCOs for their review and feedback. The CY2021 rates are expected to be delivered in August 2020.

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

4. Enrollment/disenrollment

No significant enrollment activities have occurred other than those noted in the enrollment section above.

5. Contract compliance

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

6. Relevant financial performance

The Oregon Health Authority (OHA) contracts with Coordinated Care Organizations (CCOs) to manage and deliver integrated services that include Physical Health, Behavioral Health, and Dental Services to the majority of Oregon's Medicaid population. OHA pays CCOs with Actuarially Sound capitation rates that are developed on an annual basis. Capitation rates pay an amount per month depending on the individual's age and OHP eligibility category. In addition to CCOs, OHA also retains six Dental Only (DCO) contracts where capitation rates are developed separately.

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

Also refer to reporting on Lever 2.

7. Corrective action plans

One CCO successfully completed its Corrective Action Plan (CAP), and a different CCO was placed on a CAP scheduled to continue through October 2020.

COMPLETED CAP

• *Entity name:* Cascade Health Alliance (CHA)

• *Purpose and type of CAP:* Non-compliance with CCO contract and Hepatitis C Risk Corridor, OAR and CFR. CCO was not timely responding to authorization requests, not determining approvals and denials timely or appropriately, not providing notice to members and providers, and not providing authorized medication timely or at all to members who qualified for treatment for Hepatitis C.

• *Start date of CAP:* May 20, 2019

• *End date of CAP:* May 20, 2020; updated to December 31, 2019

• *Action sought:* Immediate correction of non-compliance; development and implementation of a plan for correcting the issues identify by OHA; submission of quarterly reports to OHA for a period of at least one (1) year.

• *Progress during year:* The CAP was competed at the end of the October-December 2019 quarter. CHA is compliant with the requirements. Its quarterly reports for July-September and October December 2019 indicate that: all authorization requests were decided within the required timeframe; members and providers were notified about the decisions; and authorized medications were provided timely. No requests were denied. OHA agreed to close the CAP early.

CONTINUING CAP

• *Entity name:* Health Share of Oregon (HSO)

• *Purpose and type of CAP:* Non-compliance with CCO contract and Oregon Administrative Rule. CCO was not providing reliable non-emergency medical transportation (NEMT) services to covered appointments, resulting in disruption to members' access to care.

• *Start date of CAP:* October 14, 2019

• *End date of CAP:* April 14, 2020. Given changes in the CCO's NEMT vendors during the January-March 2020 quarter, OHA is continuing the CAP through October 2020.

• *Action sought:* Development and implementation of a plan for correcting the issues identified by OHA; submission of weekly reports to OHA for a period of at least six (6) months.

• *Progress during year:* 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. The overall performance in each area over the course of the CAP is as follows:

- Provider (driver) no-shows: Slightly worse than when the CAP began, except for one month in which the performance target was nearly met.
- On-time (pick-up) performance: Slightly worse than when the CAP began, except for the last month of the report period where there was a marked improvement in performance over the preceding two months.
- Call wait times & call abandonment: Both are significantly better than when the CAP began, although HSO acknowledges that this improvement is the result of lower call volume due to members receiving fewer face-to-face healthcare services because of the COVID-19 Emergency and thus making fewer

calls to arrange for NEMT services. The performance target for each area was met for the last 3 months of the report period.

- Member grievances: Significantly better than when the CAP began. The performance target was met for each month of the report period except for the first month.

Several factors have affected HSO's performance over the CAP: (1) On February 1, HSO entered into a contract with a new vendor for NEMT services; (2) on March 1, HSO deployed new ride management software for its NEMT provider network; and (3) starting in March, HSO's members and NEMT provider network began to experience the effects of the COVID-19 Emergency.

8. One-percent withhold

Health Systems analyzed encounter data received for completeness and accuracy for the subject months of January 2019 through December 2019. All CCOs except for two met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred.

One CCO did not meet the Administrative Performance (AP) standard for the months of May, June, July, August, September, October and November 2019 subject months no 1% withhold was taken as the CCO put remediation in place to ensure ongoing compliance and a decision was made by OHA leadership that due to the current pandemic affecting recent submissions, no withhold would be applied.

One CCO did not meet the Administrative Performance (AP) standard for the months of August and September 2019 subject months no 1% withhold was taken as the CCO put remediation in place to ensure ongoing compliance and a decision was made by OHA leadership that due to the current pandemic affecting recent submissions, no withhold would be applied.

9. Other significant activities

OHA developed new guidance and additional channels of communications with CCOs to respond to the COVID-19 pandemic. These include guidance for safety of patients and providers, as well as how to access additional resources. OHA will continue to work closely with CCOs to ensure members needs are met, and that CCO provider networks remain viable during the pandemic.

G. Health Information Technology

Medicaid Electronic Health Record (EHR) Incentive Program

Through the Medicaid EHR Incentive Programs (also known as the Promoting Interoperability Programs), eligible Oregon providers and hospitals can receive federally funded financial incentives for adopting, implementing, upgrading, or meaningfully using certified electronic health records technology (CEHRT). Since the Medicaid EHR Incentive Program's inception in 2011, 3,845 Oregon providers and 60 hospitals have received over $208 million in federal incentive payments (as of June 30, 2020). Between April and June 2020, 18 providers received $144,000 in incentive payments, and between July 2019 and June 2020, 706 Oregon providers received $5.9 million in Medicaid EHR incentive payments. The program sunsets at the end of 2021.

HIT Commons

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

The HIT Commons Governance Board meets bi-monthly and supports two ongoing initiatives, Emergency Department Information Exchange (EDie) and Prescription Drug Monitoring Program (PDMP) Integration. In 2020, HIT Commons has also engaged in adoption and spread activities in support of the Oregon Provider Directory, exploration and conceptual development of a statewide social determinants of health (SDOH) "Community Information Exchange" effort (see below for more information), and networking/technical assistance activities around health IT adoption and use for COVID-19.

EDie/Collective Platform

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

Collective Platform (formerly known as PreManage) is a web-based version of EDie. Collective Platform brings the same real-time hospital event notifications (ED and Inpatient Admit, Discharge, and Transfer [ADT] data) to those outside of the hospital system, such as health plans, CCOs, providers, and care coordinators. EDie and Collective Platform are in use statewide and adoption for Collective Platform continues to grow.

Oregon continues to work towards improving and enhancing EDie/Collective Platform for users. Highlights included:

- A 2020 Technical Assistance with three out of four series held. The series supported basic, intermediate, and advanced use of the platform for primary care, behavioral health clinic use and workflows, and technical workflows.
- 66% of Oregon's hospitals are receiving PDMP data (see below) within their EDie alert.
- Physician Orders for Lifesaving Treatment (POLST) forms are available to view for clinics, Skilled Nursing Facilities (SNFs), payers, and hospitals who receive EDie alerts through paper/fax.
- Collective Platform began to roll out to SNFs across Oregon in 2019. More than half of Oregon's SNFs are live. SNFs are also now contributing admission and discharge encounter information into the platform to further support transitions of care and care coordination. Marquis Company, a SNF, reports within 5 months of implementing Collective Platform, it has reduced its hospital readmissions rates by 60%.
- Oregon created specific cohorts and informationals for Collective users in support of COVID-19 response and is leveraging Providence and Reliance eHealth Collaborative feeds to share positive COVID19 lab results with providers to improve care coordination.
- HIT Commons and OHA formed a small working team comprised of three CCOs, two large health systems, one Health Information Exchange (HIE) and Collective. This group met weekly through August and now meets monthly and is organizing COVID-19 response efforts for those using the platform.
    - Housing Management Information System (HMIS) data is populating data for a pilot to identify homeless individuals who need additional supports during the pandemic.

Oregon Prescription Drug Monitoring Program (PDMP) Integration Initiative

Oregon's Prescription Drug Monitoring Program (PDMP) Integration initiative connects EDie, HIEs, EHRs, and pharmacy management systems to Oregon's PDMP, which includes prescription fill information on controlled substances, and is administered by OHA's Public Health Division. HIT Commons oversees the PDMP Integration work with guidance from the Oregon PDMP Integration Steering Committee and in coordination with OHA's Public Health PDMP program.

PDMP Integration capabilities went live in summer of 2017 and the statewide subscription funding officially launched through the HIT Commons in Spring 2018.

- As of 2nd quarter (Q2) 2020, integrated queries are up overall by 112.5% over Q2 2019. Within pharmacists, integrated queries are up by 415.6% over last year.
- As of 8/12/2020, 20,585 (this number cannot be deduplicated and may reflect duplicate prescriber counts) prescribers across 174 organizations have integrated access to Oregon's PDMP data– either through their EDie alerts, or through one-click access at the point of care (EHR or HIE), seven7 retail pharmacy chains (across 368 sites) and one rural pharmacy are also live.
- Interstate data sharing is established with PDMPs in Idaho, Kansas, Nevada, Texas, North Dakota, and Washington (WA for web portal only). Alaska, Wyoming and California are in progress.

Community Information Exchange

Community Information Exchange (CIE) includes a data repository of shared community resources that connects health care, human and social services partners to improve the health and well-being of communities. A technology platform supporting a CIE could provide many functions, including statewide social services directory, shared SDOH assessments, real-time closed loop referral management, collaborative care plans and standardized outcomes and data analysis. CIE adoption and spread has continued organically in Oregon during the pandemic, with CIE efforts launched or planned in 23 counties. Aunt Bertha is now live in four Oregon counties and Unite Us is now live in 10 Oregon counties. OHA has two parallel bodies of work which is supports/is engaged with:

HIT Commons activities: HIT Commons supported work (funded by OHA) around CIE include:

- An environmental scan of CIE efforts in Oregon was completed in fall 2019 and included 20 meetings/interviews.
- A mapping of CIE activities in Oregon was developed.
- An Oregon CIE Advisory Group was chartered to engage stakeholders statewide to discuss components of an effective CIE, assess opportunities for alignment of regional CIE efforts, and to develop a CIE Roadmap for Oregon by the end of 2020. The Advisory Group met in December 2019, and January, February, and March of 2020. It was put on pause due to COVID-19 and re-engaged in September 2020. COVID-19 has been an accelerator in Oregon for health care organizations to lean into contracting discussions with CIE vendors on an expedited timeline. Because of that, and the CIE efforts unfolding in real-time, the Oregon Advisory Group is considering rescoping and determining the critical areas of focus where there may be value for statewide alignment/work.

OHA/DHS activities: In the fall of 2019 OHA began exploring the concept of how CIE may be needed within OHA and the Department of Human Services (DHS). An internal OHA/DHS CIE Workgroup met twice at the beginning of 2020. Due to COVID, that work was paused. In spring 2020, OHA submitted a request to the

legislature for funding in the 2021-2023 biennium to support staff, CIE subscriptions for OHA/DHS and Medicaid partners, as well as integration of systems with CIE. OHA has been exploring how CIE tools can assist with the COVID-19 response by connecting individuals to community resources by leveraging existing implementations. In summer 2020, OHA began exploratory work in coordination with DHS to consider a phased approach for state program CIE adoption and use.

Oregon Provider Directory (OPD)

The OPD will serve as Oregon's directory of accurate, trusted provider data. It will support care coordination, health information exchange, administrative efficiencies, and serve as a resource for heath analytics. Authoritative data sources that feed the OPD are matched and aggregated to create master records. Data stewards oversee management of the data to ensure the OPD maintains initial and long-term quality information. The Provider Directory Advisory Committee provides stakeholder input and oversight to OHA's development of this program.

The OPD will benefit CCOs by supporting care coordination/health information exchange, administrative efficiencies, and serve as a resource for heath analytics in the following ways:

- Having one place to go for accurate and complete provider data
- Reducing burden on providers and staff time spent on data maintenance activities
- Enabling better care coordination for patients and ability to meet certain meaningful use objectives by supplying complete information on providers and how to contact them
- Improving the ability to calculate quality metrics that require detailed provider and practice information

The OPD went live in September 2019 in a soft launch to a small set of users in Central Oregon. Soft launch users include a CCO, health system, independent practice association, dental care organization, and a federally qualified health center. In mid-March 2020, soft launch activities and engagement were paused to allow organizations to focus on COVID-19. During the pause, OHA analyzed additional uses where the OPD can be leveraged as a statewide resource. OHA is partnering with HIT Commons to develop use case testing in soft launch and to assist with deployment planning for later phases of adoption.

Clinical Quality Metrics Registry (CQMR)

Oregon's CQMR collects, aggregates, and provides clinical quality metrics data to meet program requirements and achieve efficiencies for provider reporting. The CQMR went live in early 2019 for Medicaid EHR Incentive Program/Promoting Interoperability electronic clinical quality measure (eCQM) reporting and the option for reporting eCQMs to CMS for the Merit-based Incentive Payment System (MIPS) and Comprehensive Primary Care Plus (CPC+). The CQMR went live in January 2020 to collect eCQMs and some state-specific measures for the CCO incentive measure program. New dashboards for users to review and validate QRDA 1 (patient-level eCQM) files went live in March 2020. In addition, OHA offered technical assistance through a contract with Oregon Health & Science University (OHSU), to help clinics prepare for patient-level eCQM reporting.

The CQMR was intended to provide a streamlined solution for reporting, delivering efficiencies in data collection and reducing reporting burdens by leveraging national standards like QRDA 1. The new interoperability rules published this year, however, eliminate the requirement for ambulatory EHR vendors to support QRDA 1, as a transition to FHIR-based eCQM reporting is expected in the future. In September 2020,

OHA announced that the CQMR service would be suspended at the end of 2020 and provided FAQs to the public. OHA and the CMS HITECH program officer for Oregon have communicated about the decision and the circumstances driving the decision. During this transitional period between QRDA and FHIR standards for quality reporting, there is no clear path forward to patient-level measure data, and if OHA is not collecting or working toward patient-level data, the CQMR doesn't offer substantial advantages over the previous methods of collecting data (the MAPIR webform for Medicaid EHR Incentive Program and Excel templates for CCOs).

During the suspension, OHA's vendor for the CQMR service will maintain all the configuration to support the service. In the future, the service could be restored and updated to new standards without having to repeat all the work that has gone into implementation to date. OHA remains committed to reducing provider reporting burden and to getting clinical quality measure data to support health system transformation. OHA will work with stakeholders to move forward as new FHIR-based quality reporting approaches become more ready for implementation.

Behavioral Health and HIT

The Behavioral Health HIT Workgroup was formed in August 2018 under the direction of HITOC to review the draft Behavioral Health HIT Scan and provide recommendations and priorities. The BH HIT Workgroup met again in February 2020 to provide input to the OHA on how to prioritize strategies for maximizing SAMHSA Block Grant funds. OHA received $250,000 in 2019 through the SAMHSA Block Grant to support behavioral health providers working with patients with substance use disorders. The funds are specifically for providing technical assistance on the adoption and use of electronic health records (EHR) and health information exchange (HIE) tools.

The strategies identified as priorities by the BH HIT Workgroup included development of provider toolkits and trainings to support providers with privacy and security rules governing health information exchange, as well as guidance on EHR adoption. Additionally, another priority included the planning of a behavioral health peer learning collaboratives where providers can share lessons learned and best practices related to EHRs and HIE tools with their peers. To support efforts around these strategies, in May 2020, OHA began planning a virtual behavioral health learning collaborative centered on EHR adoption and telehealth. Additionally, in June 2020, OHA began planning a second virtual behavioral health learning collaborative focusing on health information exchange tools and the OHA Confidentiality Tool Kit. Both events are scheduled to occur September 2020 and are funded by the SAMHSA Block Grant funds.

Health Information Exchange (HIE) Onboarding Program

The Oregon Health Authority developed the HIE Onboarding Program to connect key Medicaid providers to community-based HIEs that provide meaningful HIE opportunities and play a vital role for Medicaid in their communities. The Program is to support the costs of an HIE entity to onboard providers, with or without an EHR, and to offset the onboarding costs to organizations.

Reliance eHealth Collaborative was the selected community-based HIE to onboard priority physical, oral, and behavioral health Medicaid providers according to a work plan developed in consultation with CCOs. OHA launched the onboarding program in January 2019. Through December of 2019, Reliance has been approved to start the process to onboard providers contracted with eight current CCOs in twelve Oregon counties.

On December 24, 2019, Reliance informed OHA of cashflow concerns. While Reliance formulated a plan to mitigate budget issues, OHA implemented a Stop Work Order for the HIE Onboarding Program to ensure further contract funds were not expended and to reduce risk to potential HIE Onboarding clients. In order to lift the Stop Work Order, Reliance was required to create a sustainability plan. The sustainability plan was provided to OHA in April 2020, and on June 19, 2020, OHA lifted the stop work order and Reliance was able to continue outreach and onboarding for the HIE Onboarding Program. As of June 30, 2020, four of the five regions in the HIE Onboarding Program are drawing down funding from their allocation and a total of $291,000 has been expended on this contract.

CCO HIT Roadmaps & any other CCO-related Activities/Reporting Requirements under the Contract

The Oregon CCO 2.0 contracts included health information technology (HIT)l requirements for CCOs. The CCOs are required to draft and maintain an OHA-approved HIT Roadmap, which includes the CCO's plans to support physical, behavioral, and oral health providers in Electronic Health Record (EHR) adoption, Health Information Exchange (HIE) for Care Coordination and Hospital Event Notifications, including CCO use of Hospital Event Notifications, and HIT for Value-Based Payment and Population Health Management.

In their CCO 2.0 applications, CCOs included responses to an HIT Questionnaire, which formed the basis of their draft HIT Roadmap for Contract Year One. For Contract Years Two – Five, CCOs are required to submit an Updated HIT Roadmap reporting progress made on the HIT Roadmap, as well as new information, activities, milestones, and timelines. This deliverable is due to OHA by 3/15/21. To support CCOs in this deliverable, OHA is developing an Updated HIT Roadmap template, which will be shared with CCOs in the fall of 2020.

Another component of the HIT Roadmap requirement is for CCOs to collect and annually report data on the rates of contracted providers' adoption and use of HIT and set targets for improvement of rates for over the five-year Contract. This component of the deliverable was initially due to OHA October 2020, but due to the heightened burden on providers due to the COVID-19 pandemic, OHA elected to suspend this requirement for 2020, and will expect to work with CCOs to collect data in 2021. In February/March 2020, OHA provided CCOs with available HIT data for their contracted providers to inform their Updated HIT Roadmaps.

Landscape and Environmental Scan

OHA engages in ongoing environmental scan activities to inform health IT efforts and ensure strategies and programs address evolving needs. OHA continues compiling data across the agency and other sources to serve various purposes, such as informing HITOC's progress monitoring, program oversight, and reporting priorities.

In December 2019, staff presented a 2019 Health IT Report to HITOC which summarizes what is known about Oregon's EHR and HIE landscape, including key health IT concepts and HITOC considerations. This report supports HITOC's data-related responsibilities and helps inform HITOC's 2020 strategic planning work.

Health IT Stakeholder Groups

Health IT Oversight Council (HITOC)

HITOC is tasked with setting goals and developing a strategic health information technology plan for the state, as well as monitoring progress in achieving those goals and providing oversight for the implementation of the

plan. The HITOC HIT 2017-2020 Strategic Plan was approved by the Oregon Health Policy Board in October 2017 and provides a roadmap for Oregon's HIT work ahead.

In February 2020, HITOC reported to the Oregon Health Policy Board on 2019 progress and proposed 2020 priorities, including Strategic Plan update work, and further work related to HIT and social determinants of health and health equity. Due to COVID response, OHA suspended stakeholder meetings starting in April, which put HITOC's work on hold. The work to update the Strategic Plan was begun in 2020, but due to COVID-19 we anticipate this work will restart in 2021. Strategic Plan Update input gathering sessions were held with five stakeholder groups including technology partners, CCO Health IT Advisory Group, Tribal members, oral health, and consumers. Additional sessions will be held when the work resumes in 2021.

Highlights from HITOC's meetings:

- August 2019:
  - Receiving reports on the development of the HIT Commons as an organization and clarifying HITOC and HIT Commons roles
  - Providing feedback on the Oregon Health Leadership Council's social determinants of health and health IT environmental scan and recommended next steps
  - Finalizing a work plan for improving behavioral health provider access to health IT, created in collaboration with behavioral health representatives from across Oregon
- October and December 2019
  - Receiving information on how certified EHR technology (CEHRT) and federal interoperability standards align with REAL+D in some areas and what information related to sexual orientation and gender identity is included in those federal standards
  - Providing feedback on the 2019 Health IT Report, a report that includes trends, impacts, and outcomes of HIT, HIE, and EHR efforts in Oregon
  - Finalizing a work plan to guide HITOC work through 2020
- February 2020:
  - A presentation by Oregon's public health division sharing their State Health Improvement Plan efforts and priorities for their work
  - An update from the Health IT Commons on the Community Information Exchange efforts and roadmap development in Oregon to support referrals for SDOH needs
- April and June 2020 Meetings were cancelled due to COVID

CCO Health IT Advisory Group (HITAG)

HITAG provides input to OHA about CCOs' HIT needs and efforts and informs OHA's HIT work. Each CCO is invited to send a representative to HITAG.

HITAG met in September 2019 and January and March of 2020. Topics included:

- Current and future health information exchange strategies
- Community Information Exchange efforts in Oregon
- The role and scope of HITAG
- CCO 2.0 HIT Data Collection
- 2019 HIT Report to HITOC
- Input on the HITOC Strategic Plan Update
- the 2019 Health IT Report to HITOC
- OHA program updates

H. Metrics development

1. Kindergarten Readiness

As a reminder, this developmental work comprises a four-part, multi-year measurement strategy:

1) Adopt two metrics for the 2020 CCO incentive measure set:

- Well-child visits for children 3-6 years old
- Preventive dental visits for children 1-5 years old

2) Adopt a CCO-level attestation metric focused on children's social-emotional health once specifications are finalized (i.e., for the 2021 or 2022 CCO incentive measure set).

3) Replace the existing developmental screening metric with a new follow-up to developmental screening metric in 2022 or 2023.

In July 2019 the Metrics & Scoring Committee implemented the first part of the strategy by voting to include both Well-child visits for children ages 3-6 and Preventive dental visits for children ages 1-5 in the 2020 Quality Incentive Program.

OHA then continued its partnership with Children's Institute, with technical expertise from the Oregon Pediatric Improvement Partnership (OPIP), to develop the other components of the multi-year-multi-measure strategy.

The workgroup developing the second component of the strategy (a CCO-level measure to improve the social-emotional health of young children) held monthly working sessions during the year (bi-monthly at the beginning of the year). To gather further input on the social emotional health measure, the workgroup fielded an online survey of stakeholders from across health and early learning sectors in November in December; 673 responses were received and reviewed by the workgroup.

Given disruption of the pandemic, the team altered its work plan (for example, consultation with stakeholders and pilot testing will need to occur at a later date). During the pandemic, the team is therefore creating draft high-level specifications (based upon feedback from the survey stakeholder strategy session held in the last quarter). Stakeholders will be engaged at a later date to review the specifications. The team still hopes to have a measure ready for implementation in 2022, though the target date may need to be pushed back due to the pandemic.

Oregon was one of only eight states selected to participate in the Aligning Early Childhood and Medicaid (AECM) initiative, supported by the Robert Wood Johnson Foundation, and which aims to improve the health and social outcomes of low-income infants, young children, and families through cross-agency collaboration. This national program is led by the Center for Health Care Strategies in partnership with the National Association of Medicaid Directors and ZERO TO THREE. OHA and partners from Children's Institute and OPIP participated in monthly technical assistance meetings as a part of this initiative, focused on the developmental social emotional health measure. In addition, the national AECM team conducted a site visit to

Oregon in October, sponsoring a strategy session about this measure, which included members of the Metrics & Scoring Committee and thought leaders in health and early learning from around the state. The technical assistance from the AECM team continued throughout the year under review.

OHA's partner, OPIP, is leading development of this measure. During this quarter OPIP continued to pilot the draft metric in various clinics with various EHRs across the state. Pilot findings demonstrate sensitivity and specificity to improvement efforts, face validity to pilot primary care sites.

2. SDOH/Health-related Social Needs Measure

At its August 2019 meeting the Metrics & Scoring Committee clarified that while long-term aims are to address the social determinants of health, initial measure development should focus on addressing individual health-related social needs. After these decisions, OHA formed an internal planning team to conduct research and staff the to-be-formed public workgroup which would make recommendations on the measure.

The internal workgroup made plans for the recruiting members of the public workgroup which will consider and develop recommendations back to the Metrics & Scoring and Health Plan Quality Metrics Committees. The solicitation for applications for workgroup membership began in January 2020, with appointments made by March 2020. Over fifty applications were received. The final Workgroup roster includes fifteen workgroup members; in addition, representatives from the National Committee for Quality Assurance will serve as national, non-voting advisors to the Workgroup. A webpage for the Workgroup was established and can be found here: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx.

The OHA internal planning secured HITEC funding for contractor assistance in developing the measure One contractor was utilized as an independent facilitator of the public workgroup, while the team also sought assistance in creating technical specifications for the measure and pilot testing the metric with clinics.

The public Workgroup initially planned to begin meeting on April 1, 2020. However, given the pandemic, the Workgroup's meeting was paused. OHA implemented a plan to ensure the Workgroup can accomplish its goal of providing a social needs screening metric concept by the end of the year, while balancing the current priorities of OHA and our partners to address the COVID-19 pandemic.

Therefore, the full Workgroup will not convene until October 2020, and will have fewer, more targeted meetings. A smaller Extended Planning Team met (virtually) in the interim and create a set of options for the Workgroup to consider. This group includes representatives from: OHA; consultants from Nancy Goff & Associates and the Oregon Rural Practice-based Research Network (ORPRN); DHS; the Oregon Community Information Exchange; and, our national advisors from the National Center for Quality Assurance. The Extended Planning Team first met in May 2020, with monthly meetings set through September 2020.

The full Workgroup will review the options prepared by the Extended Planning Team and finalize a recommendation for the Metrics & Scoring Committee, to be presented in early 2021.

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

In early 2018, the Metrics and Scoring Committee and Health Plan Quality Metrics Committee requested the development of an incentive metric focused on obesity using evidence-based strategies. Since May 2018, the Oregon Health Authority has been working on the development of an evidence-based obesity prevention

measure for use in the state of Oregon. Workgroup membership includes Oregon Health Authority staff from the Public Health Division and the Health Policy and Analytics Division, and CCO and Local Public Health representatives.

The evidence-based obesity measure has two-parts. Part One addresses obesity prevention and reducing the prevalence of obesity through evidence-based multisector community interventions. Part Two, an outcome measure, will rely on BMI measurement and interventions completed to assess the decrease in obesity prevalence. Part Two is still in development and is slated for rollout at a later date. The two-part measure aligns with CCO 2.0 goals because it encourages interventions outside of the clinic while building relationships with community partners.

From September to December 2019, the workgroup conducted a pilot test for Part One of the measure. 10 of 15 CCOs participated in this pilot project. The CCOs in this pilot were not expected to implement obesity MSI interventions during the pilot time period.

Purpose of the pilot:

- Test the attestation process for the Obesity Multisector Interventions component of the metric. (Part One of the measure utilizes an attestation model with a point system across five areas.)

Results of the pilot:

- Successes: Existing relationships with community partners and local public health agencies; CCO leadership will help to make this measure a success.
- Barriers: Lack of resources; competing priorities; lack of local programs to promote multisector interventions.
- Solutions: Allocating CCO resources; identifying partnerships; ongoing technical assistance from OHA through the Transformation Center

Results of the pilot test and final measure technical specifications were presented to the Metrics and Scoring Committee (MSC) on January 17, 2020. At the March 12, 2020 Health Plan Quality Metrics Committee (HPQMC) meeting, MSC Chair Amit Shah recommended that the Evidence-based Obesity Measure be added to the 2021 HPQMC measure menu set. The HPQMC voted and approved adding Part One of the measure to the 2021 measure menu set at this meeting. The MSC will discuss and consider including the measure in the CCO 2021 incentive measure set at the July 2020 meeting.

During the period of July 1, 2019 to June 30, 2020, the workgroup for Part Two (documentation and assessment of BMI) continued to work on developing measure specifications that maintain the intent of the measure while also being technically feasible with multiple EHR vendors. Further development of this measure will depend on the implementation and rollout of Part One.

The workgroups did not meet between April 1, 2020 and June 30, 2020 due to the redirection of staff resources to COVID-19 response.

4. Health Equity Measurement Workgroup (Development measure workgroup)

In early 2018, the Oregon Health Policy Board tasked the Oregon Health Authority with developing recommendations for measuring health equity in Oregon's healthcare system. The Health Equity Measurement Workgroup convened in October 2018. The workgroup is co-chaired by the Director of OHA's Equity and Inclusion Division, and the Director of the OHA Office of Health Analytics.

The workgroup has met continuously since October 2018 to develop the measure for inclusion in the CCO incentive measure set. Included in these efforts is the addition of a CCO 2.0 contract requirement to report the total number of interpreters and type of interpreter services provided per quarter. The reporting requirement was effective January 1, 2020 with the first reporting expected in April 2020. The contract requirement is separate from the measure development.

The health equity metric measures the proportion of visits with spoken and sign language interpreter needs that are provided by OHA qualified and certified interpreters. The goal of the measure is to ensure meaningful language access to health care services for all CCO members through quality language services and the delivery of culturally responsive care. The measure is titled: Meaningful Language Access for Culturally Responsive and Quality Health Care.

From October to December 2019, the workgroup conducted a pilot project to test data reporting feasibility and data quality. Nine of 15 CCOs participated in this pilot project.

Purpose of the pilot:

- Test the reporting template (reporting requirements begin Jan 1, 2020)
- Evaluate the quality of data
- Support CCOs in the reporting requirement

Results of the pilot:

- Challenges: Reporting turnaround time; matching records between data systems; workflows not in place to capture services by provider networks; not all CCOs have the ability to identify additional members needing interpreter services
- Successful CCO practices in place: Investment in language access services; provider education and frequent communication with network providers; matching patient with bilingual providers; workflows are in place for tracking certified and qualified providers

Results of the pilot test and final measure technical specifications were presented to the Metrics and Scoring Committee (MSC) on January 17, 2020 and the Health Plan Quality Metrics Committee (HPQMC) on February 13, 2020. At the March 12, 2020 HPQMC meeting, MSC Chair Amit Shah recommended that the Meaningful Language Access Measure be added to the 2021 HPQMC measure menu set. The HPQMC voted and approved adding the measure to the 2021 measure menu set at this meeting. The MSC will discuss and consider including the measure in the CCO 2021 incentive measure set at the July 2020 meeting.

I. Budget neutrality

Refer to Budget Neutrality Reports filed as separate attachments.

J. Legislative activities

During this reporting period there was no significant legislative activity specific to achieving demonstration goals or impacting the demonstration.

K. Litigation status

Open lawsuits and legal actions related to the Oregon Health Plan (OHP), to which the State Medicaid agency (Oregon Health Authority) is a party to, are listed, in aggregate. Lawsuits and legal actions include anything that is currently open in court, excluding estate recovery, during the reporting period.

Family Care v. OHA

A CCO, FamilyCare, has filed a lawsuit making the following claims against OHA and its current and former Directors. Some of the trial court's decisions have been taken up on immediate appeal, and the trial court action has been stayed pending the outcome of those appeals. There was no significant activity during the reporting period.

Bay Area Hospital v. Oregon Health Authority

In December of 2019, Bay Area Hospital, formed by a health district, filed an administrative appeal to challenge a supplemental assessment on hospital to support the Oregon Health Plan. The Oregon Tax Court ruled against the Hospital on the issue of the assessment, in May of 2019. The Hospital appealed to the Oregon Supreme Court but later dismissed the appeal and an appellate judgment dismissing the appeal was issued December 27, 2019. A proposed order from the administrative law judge is expected to be issued by the next reporting period.

Sarepta Therapeutics Inc. v. OHA

This is a petition for judicial review of the agency's prior authorization criteria that are the rule for determination for Oregon Health Plan coverage of the prescription medication Exondys 51. There was no significant activity during the reporting period.

L. Public forums

Medicaid Advisory Committee

The Medicaid Advisory Committee (MAC) is a federally mandated body that advises the State Medicaid Director on the policies, procedures, and operation of Oregon's Medicaid program (OHP) through a consumer and community lens. The MAC develops policy recommendations at the request of the governor, the legislature and OHA.

The work plan for this period focused largely on MAC's monitoring role and included presentations from OHA staff on the 1115 Waiver, program evaluation work, developmental CCO metrics and Consumer Advisory Councils. MAC received quarterly reports from the OHA Ombuds Program. MAC also explored a formal reporting relationship with the Oregon Health Policy Board.

October 2019 -Public Charge Rule

Inadmissibility and deportability on public charge grounds

In the fall of 2018, the Department of Homeland Security released a proposed rule on inadmissibility and deportability on public charge grounds, including a proposal to add Medicaid and other critical programs related to food and housing assistance to the set of programs that can be considered when weighing an immigrant's application for naturalization and citizenship. The Governor's office coordinated a response from various state agencies, including OHA, and the MAC added the committee's voice with comments in opposition of the proposed rule.

February 2020 - Health Equity Measure
MAC sent a letter in support the proposed Health Equity measure, *meaningful language access to culturally responsive health care services*, for inclusion in the Health Plan Quality Metrics Committee's 2021 menu of measures and in the 2021 CCO Incentive Metrics Program.

Additional monitoring and advisory to OHA and DHS

- CCO quality metrics program
- Substance Use Disorder 1115 Waiver for which OHA is applying.
- SB770 – A task force set up to develop a plan for a Public Option or Medicaid Buy-in.

The MAC meetings scheduled for April 29, 2020 and May 27, 2020 were cancelled due to the COVID pandemic. The MAC reconvened in July 2020 using a virtual meeting format.

IV. Progress toward demonstration goals

A. Improvement strategies

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

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

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

Patient-Centered Primary Care Homes

Due to the impact of COVID-19 on primary care practices in Oregon, the PCPCH program suspended all site visits to primary care clinics in the final quarter of this reporting period. The program plans to resume site visits virtually in July 2020. Site visits include verification that the clinic is meeting PCPCH standards, assistance with identifying barriers to PCPCH model implementation, and support to address barriers.

As of June 30, 2020, 654 clinics were recognized as PCPCHs (two more than the prior quarter). This is approximately three-quarters of all primary care practices in Oregon. Seventy-eight PCPCHs have been designated as 5 STAR, the highest tier in the PCPCH model.

The Oregon Health Authority has proposed revisions to the PCPCH recognition standards based on the recommendations from the PCPCH Standards Advisory Committee, a multi-stakeholder body that provides OHA with policy and technical expertise for the PCPCH model of care, and input from other community partners and subject matter experts. Notable revisions include the addition of new measures to address oral health, social determinants of health and substance use disorders, as well as language to improve health equity in all standards. The revised PCPCH standards were scheduled be implemented in mid-2020, but the implementation has been delayed until January 2021 because of Oregon's response to the COVID-19 pandemic.

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

Comprehensive Primary Care Plus (CPC+)

The Transformation Center manages the Medicaid fee-for-service implementation of CPC+. Per-member, per-month care management fees and performance-based payments are key components of the CPC+ payment model.

The Oregon CPC+ payers met in May to discuss opportunities to coordinate and align to support the Oregon CPC+ practices. The payers shared and discussed changes to payment models to support clinics during the pandemic, including interim payments, extending reporting dates, relaxing quality metrics, paying out quality bonuses early and removing prior authorization requirements.

Value-based payment (VBP) innovations and technical assistance

The Transformation Center has been gathering information from CCOs and their providers during the COVID-19 public health emergency through collaborative efforts with the OHA Actuarial Services Unit and OHA's newly developed short-term provider financial stability work group. The center will use the data gathered this quarter to develop technical assistance to support CCOs and their providers within the context of the COVID-19 response so they are able to continue to implement and adopt VBPs as designed within the OHA CCO VBP roadmap.

The center continues to add resources to the VBP online toolkit for CCOs, available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx

Staff continue to review all 2020 VBP reporting requirements to ensure the CCOs can appropriately prioritize staff to focus on the COVID-19 response, but the five-year CCO VBP Roadmap targets and longer-term goals remain unchanged.

Primary Care Payment Reform Collaborative

OHA convenes the Primary Care Payment Reform Collaborative, a legislatively required multi-stakeholder advisory group tasked with assisting OHA with the development and implementation of a Primary Care

Transformation Initiative. The collaborative's three work groups support work in the following areas: metrics, evaluation, and implementation/technical assistance.

OHA canceled the April meeting to enable members to focus on responding to the pandemic. The collaborative will reconvene in July.

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

Statewide Performance Improvement Project

The current statewide PIP, based upon calendar year (CY) 2020, is in the baseline year. Brief overview of the topic is below.

Background:

Study Topic: *Acute Opioid Prescribing*

Study Question:

Do targeted interventions decrease the percentage of members in the study population who received greater than seven days' supply for the first opioid prescription?

Measurement:

The measure is currently defined as:

Percent of patients with at least one opioid prescription in one year, who have no opioids prescribed in the prior six months, among patients in the population by days' supply (i.e., ≤3, 4–7, 8–13, and ≥14).

Validation:

External Quality Review (EQR) of the statewide PIP, in accordance with CMS EQR Protocol 1: Validation of Performance Improvement Project, was conducted for calendar year 2019 activities. The final report for PIP validation can be found on the OHA website: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA.aspx

Next Steps:

OHA will be reviewing the statewide PIP due to the impacts of COVID-19 to the health systems including but not limited to the statewide PIP focus, timeline and topic selection. In light of the unprecedented effects of the COVID-19 pandemic, health disparities and health system priorities need to be analyzed and supported through performance improvement that will address these results of the analysis and drive quality care and equitable access for the Medicaid population in Oregon.

As part of the CMS 1115 OHA waiver, attachment E, CCOs are expected to develop and implement three additional PIPs and/or focus study; outside the statewide integration PIP focus.

The PIP summary for the CCO projects covered can be found on the web at https://www.oregon.gov/oha/HPA/DSI/QIDocs/CCO-PIP-Quarterly-Summary.pdf

Roadmap to Oral Health

Oregon Medicaid took several important steps forward regarding oral health integration.

OHA embarked on an effort to draft oral health integration performance indicators for coordinated care organizations (CCOs) starting in 2021. The authority anticipated completing this process in March 2020. However, in light of the COVID-19 public health emergency, OHA chose to postpone completion of the oral health integration performance indicators until 2022.

From April to June 2020, OHA's efforts regarding oral health turned to focus on understanding and working to maintain workforce capacity and patient access to dental care during the public health emergency. The agency surveyed coordinated care organizations and dental care organizations on their efforts to support the dental contractors who provide services to Medicaid members.

Starting on January 1, 2020, OHA finalized rules under the state Medicaid program allowing dentists to perform HbA1c tests to aid in the diagnosis and treatment of people with diabetes and to administer vaccines.

The Metrics and Scoring Committee, which recommends outcomes and quality measures for CCOs, adopted a set of incentive metrics that includes two which directly encourage integration of oral health care. One measures the rate of preventive dental care for children ages 1-14, with a special emphasis on the 1-5 age group. The other measures the rate of oral exams for adults with diabetes.

Oregon and national oral health efforts

To increase awareness and understanding of oral health among OHA staff and the general public (OHA Roadmap outcome), OHA sponsored a visit by the Assistant Surgeon General, Rear Admiral Tim Ricks, DMD, MPH. OHA and Dr. Ricks gave a public presentation on the upcoming Surgeon General's Report on Oral Health, Oregon's oral health metrics, and the successes and challenges of oral health integration nationally and in Oregon.

The OHA dental director took part in a listening session with the Surgeon General to provide input on Oregon's efforts to encourage responsible opioid prescribing among dentists and to give input on the importance of community water fluoridation. Both topics will be covered in a Surgeon General report on oral health to be released this fall.

Oregon's dental director

OHA's statewide dental director left the agency in March 2020. Recruitment efforts to replace the dental director will take place after June 30, 2021.

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

Sustainable Relationships for Community Health program

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

The COVID-19 pandemic led to SRCH delays within the four 2019-20 teams, and SRCH Institute 3 scheduled for the Spring was delayed. OHA extended the SRCH grant year to December 2020 to continue to support the SRCH teams to implement and sustain their work. OHA and contractors have continued to provide technical assistance to teams during this extension, including a planned adapted SRCH 3 Institute in early Fall. Instead of a two-day in-person convening, we will meet as a series of virtual institutes with each SRCH team. This pivot allows teams the flexibility to re-engage with SRCH work at their own pace, as their team capacity allows and with the option to adapt SRCH work based on the pandemic.

Progress and Findings: During this period, OHA provided technical assistance to the Tillamook SRCH team. This work focused on integrating prediabetic screening and referrals to the National DPP in clinic workflows using PDSA cycles (Plan-Do-Study-Act). Tillamook SRCH team will review PDSAs and create a new cycle of PDSAs in the first SRCH 3 virtual convening in August. For each intervention, teams co-developed shared goals, measurable outcomes, identified and refined PDSAs, and assigned specific actions to partners using a 90-day plan. All SRCH teams learned techniques that are critical to establishing, nurturing and sustaining partnerships to improve health outcomes in their communities.

Trends, Successes, or Issues: Though much progress was made between Institute 1 and 2, the experience of COVID-19 has slowed the SRCH teams' progress and in some cases halted planned strategies all together. SRCH teams are working with OHA staff to pivot and adapt work to meet the new reality that COVID 19 presents related to telehealth and the importance of supporting self-management of chronic conditions that intensify the impacts of COVID 19. OHA and all four SRCH teams will ensure sustainability of the partnerships developed through SRCH and to develop a plan for carrying the quality improvement processes forward for chronic disease prevention and management, with a focus on reaching populations experiencing higher rates of chronic disease disparities.

Innovator Agents

During the demonstration year, innovator agents assisted with gathering feedback and input for OHA about proposed policies from CCOs, community advisory committees (CACs) and communities. They continued to provide information to these same partners about the CCO 2.0 application process, dates for deliverables and important policy updates.

Most CCOs, CACs and communities developed new Community Health Assessments and Community Health Improvement Plans. Innovator agents led and participated in community-planning meetings, provided information and feedback, and assisted with connecting CCOs and communities to technical assistance.

CCOs developed their second Transformation Quality Strategy plans, which replaced the former CCO Transformation Plan and Quality Assessment and Performance Improvement deliverables. Innovator agents assisted by participating in work groups, connecting CCOs with appropriate technical assistance and providing CCOs with feedback on their plans.

Innovator Agents continued to work with Coordinated Care Organizations' (CCO) Community Health Improvement Plans and provided education and support of new rules to Community Advisory Committees as they related to Coordinated Care Organization 2.0. Informed Community Advisory Committee members on new 2.0 related contract changes.

Additionally, Innovator Agents assisted in navigating relationships and inclusion with the Native American tribes who resides in their prospective CCO regions. Supported CCO engagement with OHA lead staff on 2.0 contractual areas regarding health equity; tribal connections, and health related services.

Innovator Agents worked with their local CCOs to secure five - year contracts with Oregon Health Authority. Two Innovator Agents worked on the closeout of their CCOs. One CCO decided not to reapply for the new CCO 2.0 contract, while another CCO did not meet the requirements of their proposal for CCO 2.0. During these transitions, Innovator Agents were involved in making sure Oregon Health Plan members' health and behavioral needs were addressed adequately by bringing concerns to Oregon Health Authority leadership for resolution. Support was provided to members during member choice period (Jan. 1, 2020 – March 21, 2020).

Innovator Agents supported the COVID-19 response and assumed lead positions in the Health Information Committee. Innovator agents were the conveyor of knowledge and information to CCOs and community partners.

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

Health-related services

CCOs receive a global payment for each member, which provides CCOs the flexibility to offer health-related services (HRS) to improve the health of Oregon's Medicaid population.

Staff assessed the annual CCO HRS expenditure data for 2019 and shared feedback with CCOs. CCOs submitted additional information to further describe or justify expenditures. In July, staff will make a final determination about which spending met HRS criteria and will complete an analysis of spending across CCOs.

To improve future use of and support potential increases to HRS spending, staff are updating guidance for HRS housing and developing HRS traditional health worker guidance. Health information technology was also prioritized as a future topic needed. All HRS guidance documents for CCOs and external partners are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx

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

This is a narrative providing an overview of the current quarter's: 1) activities supporting or resulting in health improvements (e.g., technical assistance or other improvement strategies); 2) overview of progress of evaluation activities and interim findings, including key milestones accomplished, as well as other challenges encountered and how they were addressed; and 3) trends, successes, or issues. Improvement strategies noted in the quarterly reports may include, but are not limited to the following:

These items will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact on health transformation goals.

Community Advisory Committee activities

Narrative including dates of meetings held, topics discussed (agenda items) and relevant activities for the reporting period.

Transformation Center activities

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

Behavioral health integration

The center presented a TA webinar on suicide prevention to help CCOs fulfill the behavioral health goals of CCO 2.0 and respond to the pandemic. The center facilitated the development of behavioral health measures for the CCO Behavioral Health Report in the CCO 2.0 contract. In addition, the center reviewed OHA data and findings from Oregon Certified Community Behavioral Health Clinics to develop a report summarizing the impact of the program on cost and quality. This report will be used by leadership to determine next steps for the program.

The center supported the development of a virtual learning collaborative to assist behavioral health organizations with their adoption or upgrade of electronic health record systems and adoption of health information exchange tools. The meeting will be in September.

Community advisory council activities

The center continued to host monthly CAC learning collaborative calls on CAC member recruitment and engagement and other topics, as well as separate monthly calls for CAC coordinators. Topics included the state health improvement plan, tribal CAC member engagement, virtual CAC meetings, CAC members serving on CCO governing boards, CAC role in reviewing CCO spending programs and CAC member recruitment strategies.

Staff also updated a CCO 2.0 CAC FAQ and fielded a CAC needs assessment survey to CAC coordinators.

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

In March 2020, OHA waived the annual CHP progress report submission due to COVID-19 response efforts. Staff also worked with the consultant updating the CHA/CHP development curriculum to 1) shift curriculum to online modules with an emphasis on remote participant engagement, and 2) add activities to support a shift in CHP health priorities to support COVID-19 response and recovery efforts, based on community input.

A graduate intern worked with staff to review all recent CCO CHPs, local public health CHPs, and nonprofit hospital community health needs assessments and implementation strategies to detail shared health priorities. One goal of detailing the shared health priorities is to support increased collaboration and collective impact at the local level. It will also inform updates to the interactive story map of community health needs assessments, CHAs and CHPs by county that is hosted in partnership with the OHSU Office of Rural Health.

CCO incentive metrics technical assistance

Most of the TA for supporting 2020 CCO incentive metrics was on hold due to COVID-19 response.

Diabetes (HbA1C and a new oral health visit metric)

The Transformation Center is planning three webinars focused on implementing the National Diabetes Prevention Program. The webinars will be tailored for CCO staff, community-based organizations, and clinics.

Screening, brief intervention and referral to treatment (SBIRT)

The Transformation Center is partnering with ORPRN to offer TA to primary care clinics in support of the SBIRT metric. The TA is a three-year study funded through the Agency for Healthcare Quality and Research. The project is designed to address unhealthy alcohol use, chronic pain management and opioid prescribing in primary care. Moving forward, the TA is also addressing ramifications COVID-19 may have on SBIRT workflows and concerns about a rise in unhealthy alcohol and drug use concurrent with the physical distancing needed to suppress COVID-19 morbidity and mortality. Thirty-seven clinics across Oregon have signed up to participate so far; additional recruitment strategies are in development as clinic recruitment began to slow during the pandemic. The team also began working on a supplement to the grant to address depression and anxiety.

Tobacco cessation

The center continues to host a short, online course for tobacco cessation counseling strategies with free continuing medical education credits. The course is open to all care team members and aims to improve their ability to help patients quit tobacco through brief tobacco intervention and motivational interviewing techniques. This quarter 51 people accessed the training. Of the 12 participants who completed the evaluation, 100% rated the training overall as excellent or good.

Cross-cutting supports

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

OHA suspended the CCO learning collaborative while CCOs focused on COVID-19 response.

Transformation and Quality Strategy (TQS) technical assistance

Center staff managed the review and feedback process for CCO TQS submissions and released CCOs' written assessments in May, which included a new process for formal scoring and evaluation of submitted projects. Staff began the process of updating guidance documents and evaluation criteria for 2021 submissions.

Social Determinants of Health Measurement Workgroup

The Transformation Center and Office of Health Analytics are partnering to develop a social needs screening measure at the request of Oregon's Metrics and Scoring Committee. This is in line with the Oregon Health Policy Board's CCO 2.0 policy recommendations, which included encouraging the Metrics and Scoring Committee to include population health, social determinants of health, and health equity measures in the CCO Quality Incentive Pool.

The SDOH Measurement Workgroup: Screening for Social Needs, a public workgroup, will develop a measure concept for consideration by the Metrics and Scoring and Health Plan Quality Metrics Committees. In preparation, OHA convened a smaller planning team including OHA and Department of Human Services staff, consultants and technical experts, including the National Center for Quality Assurance and Bailit Health. The partnership with Bailit Health is funded through the Robert Wood Johnson Foundation and State Health and Value Strategies. The planning team will develop three to five social needs screening measure concepts for consideration by the public work group when it convenes in the fall.

B. Lower cost

Two-percent test data (reporting on an annual basis)

Reported separately as Attachment E.

C. Better care and Better health (ANNUAL)

Throughout the demonstration year, the Oregon Health Authority (OHA) produced regular reports as well as final calendar year 2019 data at the state and coordinated care organization (CCO) level. OHA continued to work with stakeholders to refine measure specifications, such as the Assessments for Children in DHS Custody and to develop new measures, including an evidence-based obesity measure and kindergarten readiness measure. OHA has also maintained updated measure specifications and guidance online.

Progress reporting

The Oregon Health Authority (OHA) continued to provide coordinated care organizations (CCO) with monthly metrics dashboards, an interactive tool to analyze performance on CCO incentive and quality and access test measures. Measure results are reflected for a rolling 12-month period and member-level detail is included for claims-based measures to facilitate measure validation and quality improvement activities. OHA continued to work with its vendor to add measures as well as refine dashboard filters, including gender, race/ethnicity, disability status, and geography.

Final 2019 Performance Report

The Oregon Health Authority (OHA) published a report on the coordinated care organization (CCO) incentive, state performance and core performance measures to the Oregon Health Policy Board and the public for the 2019 calendar year.

All 15 CCOs had performance data successfully reported for the year. A final calendar year 2019 report was published in September 2020. This report is available online here:

https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-CCO-Performance-Report.pdf

In 2019, the report included for the first time a supplemental section that describes the quality of services delivered to members who are dual-covered by both Medicaid and Medicare health plans. The report indicated that the coordinated care model continues to demonstrate improvement in several areas, such as smoking cessation, decrease in emergency department utilization among members with mental illness and postpartum care.

Specific successes include:

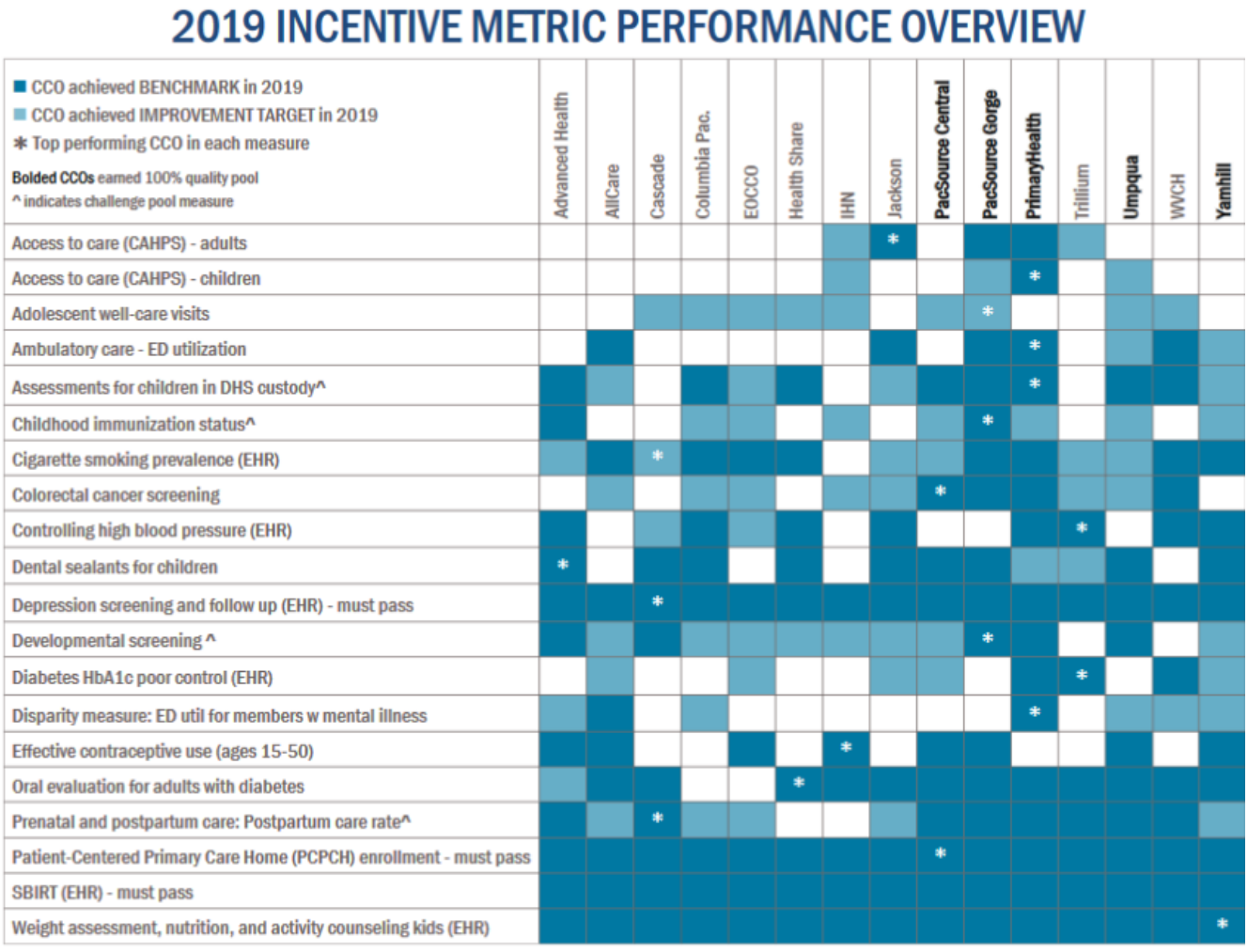
- Assessment for Children in DHS Custody – Since 2014, CCOs have improved more than 200% from 27.9% to 87.8% in 2019 on this measure.
- Cigarette Smoking Prevalence – Prevalence decline among 13 out of 15 CCOs in 2019 with three CCOs demonstrating substantial improvement. The overall smoking prevalence in the state decreased by almost nine percent.

- Emergency Department Utilization among members with mental illness – In 2019, 9 out of 15 CCOs improved on this measure and seven achieved their improvement target.

Areas for improvement include:

- Asthma in Young Adults – In 2019, asthma as a cause of hospital stay increased 12% in 2019.
- Prenatal Care – 2019 is the first year that timeliness of prenatal care is no longer incentivized (although it is being monitored as a state quality metric.) Statewide performance on this measure dropped from 92.6% to 80.6% and no CCOs demonstrated improvements in the rate of women who received a prenatal visit in the first trimester of within 42 days of enrollment.

The table below is included in the 2019 Final Performance Report and displays performance results for each CCO in achieving benchmarks or improvement targets for each 2019 incentive metric.



Coordinated Care Organization Incentives

Disbursement of the coordinated care organization (CCO) quality pool funds continues to be contingent on CCO performance relative to both the absolute benchmark and improvement targets for the selected measures.

The COVID-19 global pandemic hit Oregon in March 2020. 60% of the quality pool dollars were released earlier than normal by OHA to infuse money into the medical system as many clinics faced closure during the shutdown. Normally, the full quality pool is disbursed to CCOs in June of every report-out year that follows the measurement year. But for 2019 measurement year, 60% of the quality pool was paid out early on April 1, 2020 while 40% was released in June 2020.

Pay for Performance

This is the seventh year of Oregon's pay-for-performance program. The pay-for-performance model rewards coordinated care organizations (CCO) for the quality of care provided to Medicaid members. This model increasingly rewards CCOs for outcomes, rather than utilization of services, and is one of several key health system transformation mechanisms for achieving Oregon's vision for better health, better care and lower costs.

The Oregon Health Authority (OHA) made the seventh annual quality pool payments to CCOs in June 2019. To earn their full incentive payment, CCOs must meet benchmarks or improvement targets on at least 12 of the 16 measures, report data for minimum population thresholds for both the SBIRT and depression screening measures and achieve a score of 68 or higher for the patient-centered primary care home (PCPCH) measure.

The amount a CCO can earn through the program is based on a percentage of their capitated payments each year. In 2019, the quality pool was more than $166 million which is 3.5% of all payments made to CCOs. Money left over from the quality pool formed the challenge pool, which was distributed to CCOs that met the benchmark or improvement target on a subset of 4 measures:

1. Assessments for children in DHS custody

2. Childhood immunization status (combo 2)

3. Development screenings in the first 36 months of life

4. Postpartum care rate

The 2019 challenge pool was more than $45 million.

2019 QUALITY POOL DISTRIBUTION

CCO	Phase 1 Distribution				Challenge Pool		Total	
	# Measures met (of 19 possible)	Early distribution (April 2020), 60% of available quality pool	Total payment earned in Phase 1*	% Quality pool funds earned	# Challenge measures met	$ Challenge pool earned	Total payment (Phase 1 + Challenge pool + MCO tax)	Total % quality pool earned
Advanced Health	14	$ 2,467,110	$ 3,224,354	80%	4	$ 1,858,037	$ 5,186,114	126%
AllCare Health Plan	14	$ 5,130,021	$ 6,702,564	80%	3	$ 2,954,951	$ 9,854,607	115%
Cascade Health Alliance	11	$ 2,158,805	$ 2,118,524	60%	2	$ 807,550	$ 2,985,790	83%
Columbia Pacific	14	$ 3,359,730	$ 4,391,338	80%	4	$ 2,329,769	$ 6,858,272	122%
Eastern Oregon	14	$ 6,271,365	$ 8,195,384	80%	4	$ 4,607,979	$ 13,064,656	125%
Health Share of Oregon	11	$ 35,210,323	$ 34,504,781	60%	2	$ 11,009,403	$ 46,443,045	79%
Intercommunity Health Network	11	$ 6,545,549	$ 6,414,383	60%	2	$ 2,784,290	$ 9,386,401	86%
Jackson Care Connect	14	$ 3,308,094	$ 4,322,769	80%	3	$ 1,885,368	$ 6,334,834	115%
PacificSource – Central Oregon	15	$ 5,938,535	$ 9,697,879	100%	4	$ 4,406,439	$ 14,392,161	145%
PacificSource – Gorge	16	$ 1,349,245	$ 2,203,725	100%	4	$ 1,095,056	$ 3,366,103	150%
PrimaryHealth of Josephine County	17	$ 1,091,029	$ 1,781,824	100%	4	$ 943,444	$ 2,780,886	153%
Trillium	11	$ 10,732,163	$ 10,515,418	60%	1	$ 2,271,094	$ 13,047,461	73%
Umpqua Health Alliance	16	$ 3,006,890	$ 4,912,276	100%	4	$ 2,467,088	$ 7,529,962	150%
Willamette Valley Community Health	14	$ 10,573,756	$ 13,815,506	80%	2	$ 4,178,192	$ 18,360,916	104%
Yamhill Community Care	16	$ 2,866,386	$ 4,713,749	100%	4	$ 2,266,390	$ 7,122,591	148%
Total		$ 100,029,001	$ 117,514,473			$ 45,865,050	$ 166,713,799	

* Quality pool distribution is based on number of measures met and CCO size (number of members). See page 17 for CCO enrollment.

Quality Pool – Coordinated Care Organization Incentives

Disbursement of the CCO quality pool funds continues to be contingent on CCO performance relative to both the absolute benchmark and improvement targets for the selected measures. Funds from the quality pool will be distributed on an annual basis, with the calendar year payment made by June 30 of the following year.

V. Appendices

A. Quarterly enrollment reports

1. SEDS reports

Attached separately as Attachment A

2. State reported enrollment table

Enrollment	April/2020	May/2020	June/2020
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	992,056	1,010,288	1,022,304
Title XXI funded State Plan	92,402	90,447	91,450

Title XIX funded expansion Populations 9, 10, 11, 17, 18	N/A	N/A	N/A
Title XXI funded Expansion Populations 16, 20	N/A	N/A	N/A
DSH funded Expansion	N/A	N/A	N/A
Other Expansion	N/A	N/A	N/A
Pharmacy Only	N/A	N/A	N/A
Family Planning Only	N/A	N/A	N/A
Enrollment current as of	Month/Date/Year	Month/Date/Year	Month/Date/Year

3. Actual and unduplicated enrollment

Attached separately as Attachment B

B. Complaints and grievances

Attached separately.

C. CCO appeals and hearings

Attached separately.

D. Neutrality reports

Budget monitoring spreadsheets

Attached separately.