



To: Tiffany Reagan, Co-lead, Quality Assurance, Oregon Health Authority
From: CCOs and DCOs indicated at the end of this memo
Date: April 25, 2022
Re: OHP Provider Directory rule

As the Oregon Health Authority (OHA) recently opened 410-141-3500 to 410-141-5380 Oregon Health Plan Managed Care, CCO Oregon members took opportunity to discuss and draft recommendations to better realize the policy goals of the provider directory portions of the rule. We recognize the purpose behind OHA’s requirement to collect and publicly publish information on provider race and ethnicity, or whether providers have verifiable non-English language fluency. We understand the value of this information for our members and see opportunity to leverage the data to improve the system, including informing workforce diversity investment needs and what population groups may be most hesitant to report this information. And, of course, we take our roles in providing health care and meeting regulatory requirements seriously. However, under the current rule, we are expected to collect data that providers may not want to provide or may be more efficacious to collect elsewhere.

Obviously, we are still in a health care workforce crisis and providers are overworked coming out of the pandemic and other recent crises across Oregon. There are efforts to lessen administrative burden and reporting duplication across the delivery system, and the provider directory is another place where we may make gains. Providers already report some of the data requested in the current provider directory rules to other state programs, boards, or payers and thus may feel that this request is duplication.

Below is a sample of CCO provider attestation data from a third-party vendor contracted with to collect race and ethnicity information, along with other provider data. As you can see from this data, CCOs are seeing very low response rates to requests for provider demographic information.

	Year	Race	Ethnicity
CareOregon	2021	3.6%	3.4%
	2022	5.1%	4.7%
PacificSource Community Solutions	2021	0.47%	1.07%
	2022	0.50%	0.54%

This may be for various reasons, including that providers may simply not want to be compelled to share this additional information and some may have concerns about being treated unfairly themselves. While understanding that CCOs and DCOs should monitor their networks for diversity, another CCO reported that they heard discomfort directly from Providers of Color about this collection as many have already experienced incidents of racial discrimination as a provider. Further, we do not believe CCOs or DCOs can require providers – and it would not result in a productive partnership – to identify their race to post publicly.

At the March 30th Oregon Health Plan Managed Care Rules Advisory Committee (RAC), several CCOs raised concerns about the provider directory understanding that OHA did not plan to change that portion of the rule. We appreciated the OHA's invitation to send any comments related to the provider directory now as well as the commitment to address this portion of the rule in a fall 2022 RAC during the conversation. We further appreciate that OHA has launched a provider directory workgroup since the RAC. Below are a few recommendations that may inform how Oregon may collect beneficial provider information while reducing the burden and abrasion providers experience in this data collection effort and potentially improve the quality of that data collection.

1. We recommend that the OHA utilize existing sources to collect demographics data more expediently and limit additional strain on providers. Examples of where providers could provide the information once include:
 - Application for eligibility to accept Oregon Health Plan (aka DMAP enrollment)
 - Provider licensing board processes that already collect some demographic information
 - Patient-centered, primary care home (PCPCH) certification process or site visit
2. Because federal rule does not require a provider director to include race and ethnicity information (42 CFR §438.10(h)), we recommend that the OHA amend OAR 410-141-3585(6)(h) and (j) to allow CCOs to make best efforts to collect information on provider demographics but make disclosure voluntary by the providers.
3. Most licensing boards already require cultural competency training, so licensure should meet the criteria and partnering with licensing boards would be more efficacious for this data collection. Where licensing board do not currently collect this data, there are existing processes to leverage. Further, OHA has not yet provided an operational definition of "cultural competency," which makes data collection across multiple access points less effective.
4. We understand that leveraging other existing processes to collect the requested information would necessitate a process to populate directories at the CCO and DCO levels. We do not seek to remove ourselves from this work but to identify the best means for collection and publishing. We recommend an advisory group [perhaps, this is the new provider directory workgroup] with CCO and DCO expertise to assist the OHA in implementing and maintaining these efforts. Moreover, the OHA could reconsider a statewide provider directory that, again, we could offer technical assistance to help inform, build, and sustain.
5. Under the current rule, we ask that in compliance audits or other CCO oversight reports, there is a safe harbor from action if a CCO has made best efforts to collect information. As many of the circumstances are beyond the control of CCOs and DCOs, we should not face audits or other actions if despite best efforts there are gaps in the data or an overall lower than desired response rate.

Finally, beyond limiting data duplication, provider strain, and undue risk on CCOs and DCOs, these recommended changes may also improve:

- The consistency of the data collected and definitions influencing data collection, such as “cultural competency”
- Streamlined communication to providers about the value of this data and how the data will be employed, which may increase provider response
- Alignment with other areas of state statutes, such as expectations for patient records and the Chapter 943 rules, which also discuss demographic data collection
- The ability of the State to assess gaps in data collection by various categories and continue to improve the process

We appreciate the OHA’s consideration of these recommendations and points. We want to be a partner in this work and understand not only the value of the data and its access to our members as they may seek the best provider to meet their health, identity, linguistic, and cultural needs. We look forward to ongoing conversation in the provider directory workgroup and fall 2022 RAC but also welcome additionally conversation at any point to collaborate on solutions and offer technical assistance.

