OFFICE OF THE DIRECTOR
Kate Brown, Governor

Oregon Health Authority

500 Summer St NE E20
Salem OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.Oregon.Gov/OHA
www.health.oregon.gov

DATE: May 21, 2019

TO: Chair Salinas and Members of the House Health Care Committee

FROM: Patrick Allen, Director, Oregon Health Authority

SUBJECT: May 7, 2019, Committee Questions

Dear Chair Salinas and Members of the House Health Care Committee:

Thank you for the opportunity to present to the House Committee on Health Care on May 7, 2019, on the issue of collecting of race, ethnicity, language, and disability (REALD) data and its relationship to equitable access to health care. Please find below responses to questions raised during that presentation.

Question 1: Does the Oregon Health Authority (OHA) use a formal equity lens? (**Rep. Alonzo Leon**)

Recently the Health Equity Committee of the Oregon Health Policy Board has worked on a more formal definition of health equity for comprehensive adoption by and use across the agency. The Health Equity Committee is diverse from the perspective of race, ethnicity, language and disability, and includes representatives from across the state. Its health equity definition will serve as a foundation for the further development of the health equity framework and corresponding tools.

From the standpoint of REAL-D, OHA adopted an agency specific policy in July 2018 to implement REAL-D standards across the agency. OHA's intranet page for REALD implementation includes links to tools and resources for internal staff, including the REALD Implementation Guide. This Implementation Guide (100+ pages) was developed by OHA's Office of Equity and Inclusion and includes a strong equity lens specific to the implementation of REALD in OHA systems. The development of checklists in this implementation guide were based on an IDEAS tool (Inclusion, Dignity, Equality, Accessibility and Intersectionality).

For example, the checklist regarding the design of the data collection tool includes:

- *Does the design and decision-making process address and avoid inequitable exclusions of members of the population of interest that result from design features?*
- *Does the data tool lend itself to later intersectional analyses?*
- *Were subgroups most likely to be "hidden" in the margins (e.g. refugees with disabilities) considered in the development of the data collection tool?*

However, we acknowledge that OHA needs to do more to ensure that the development of data systems and data collection tools (such as the ONE Applicant Portal) are guided *as much* by our equity lens as by federal requirements and existing system abilities/limitations.

QUESTION 2: What is the staffing commitment in OHA to REALD work? (**Rep. Keny Guyer**)

OHA's Office of Equity and Inclusion has one FTE dedicated to REAL-D (Dr. Marjorie McGee, OHA REAL D Analyst). When eligibility system changes or updates are needed, the staffing also includes one Medical Eligibility Policy Analyst, one MMIS Business Analyst, and teams from the contractors that support these systems.

QUESTION 3: Do we have comprehensive representation in the metrics workgroups? (Rep. Alonzo Leon)

The Office of Health Analytics recently completed a recruitment process for new members for two citizen committees: the Metrics and Scoring Committee (SB1580, 2012) and the Health Plan Quality Metrics Committee (SB440, 2015).

The Health Plan Quality Metrics Committee (HPQMC) is responsible for developing an aligned set of health care outcome and quality measures that are used by state-funded health plans (CCO incentive measures, and those in PEBB and OEBB contracts). The Governor appoints the 15 members of the HPQMC. (Beginning Jan. 1, 2020, the Oregon Health Policy Board will make these appointments, in alignment with other OHPB committees, as per Enrolled HB 2265 (2019).)

The Metrics and Scoring Committee (M&SC) chooses measures for the Coordinated Care Organization (CCO) quality incentive program from the measures menu created by the HPQMC. The M&SC is also responsible for identifying the targets that CCOs must meet on each measure to earn the incentive payments. OHA's director appoints the nine members of the committee, which must have:

- Three members at large
- Three individuals with expertise in health outcomes measures; and
- Three representatives of CCOs.

Given the importance of the integration of physical, behavioral, and oral health care in OHA's health system transformation strategy, OHA has utilized the member-at-large positions to ensure that the M&SC has oral and behavioral health expertise.

Recent Recruitment: OHA recently completed a recruitment process to fill soon-to-be vacant positions on both committees. The application for membership specifically sought "candidates with experience in health equity promotion, behavioral health, issues of health care cost containment and health care quality measurement." Additionally, OHA made conscious efforts to recruit from organizations most likely to be connected to professionals with diverse cultural backgrounds. These included OHA Office of Equity and Inclusion, organizational partners in the Portland Metro area that work in health equity and diversity, Coordinated Care Organizations, and other health analytics and measurement stakeholders.

This most recent recruitment is the first year in which the demographic questions in the application used the REALD data standards. Due to the timing of reappointments and

vacancies, only the Health Plan Quality Metrics Committee was able to request demographic data for all committee seats. All future applications will continue to ask demographic questions using the REALD data standards.

HPQMC Representation: Table 1 is a demographic data summary of the final HPQMC roster currently under consideration by the Governor (therefore, the final roster may change). Note that respondents are not required to provide this information, and some declined.

Table 1. Health Plan Quality Metrics Committee – Demographic Summary of Roster Under Consideration	
Total Recommended Committee Members (11 reappointments and 4 new appointments)	15
Number of respondents	12
Gender Identity	Female – 6 Male – 5 Decline to answer – 1
LGBTQ	(check if applicable) – 1 Decline to answer – 1
Requests for written materials in an alternate format	None
Racial and ethnic identity	Western European – 6 Asian Indian – 1 Chinese – 1 Filipino/a – 1 Western European/Eastern European/Slavic – 1 Other White – 1 Decline – 1
Preferred language other than English (spoken or written)	None
Requests for interpreters for spoken or sign language	None
People with disabilities	None
Age range	38 to 57 years (7 respondents)

Metrics and Scoring Committee Representation

Table 2 is a demographic data summary of the final M&SC roster currently under consideration by OHA's Director (therefore, the final roster may change). Seven members are in the middle of their terms, and do not need to reapply. Applicants for the two vacant positions were asked about demographic information using the REALD data standards; however, the REALD data standards were not used when the seven continuing members applied. All future applications will use the REALD data standards.

Table 2. Metrics & Scoring Committee – Demographic Summary of Roster Under Consideration	
Total Recommended Committee Members	9 (7 ongoing; 2 positions for decision): • 1 reappointment • 1 new appointment
Number of respondents	9
Gender Identity	Female – 4 Male – 4 Did not answer – 1
LGBTQ	1
Requests for written materials in an alternate format	None
Race and Ethnicity	Persons of color, including Hispanic/Latinx – 5 White – 3 Did not answer – 1
Preferred language other than English (spoken or written)	None
Requests for interpreters for spoken or sign language	None
People with disabilities	None

QUESTION 4: How many individuals' race and ethnicity data been overwritten in MMIS? (Rep. Mitchell)

In the REALD assessment of MMIS data for new OHP enrollees only, an estimated 1.5% of enrollees who had newer REALD data responses for disability, English proficiency, and / or interpreter needs had an older racial / ethnic identity. We believe that many of these reflect the overwriting of racial / ethnic identity information by legacy systems. This could happen during an audit, or if they initially were found not eligible and then became eligible. The development of the Integrated Eligibility addresses the problem of legacy systems overwriting newer REALD information.

MMIS does not track changes or updates to demographic information such as race and ethnicity. If a member changes their indicated race / ethnicity or if they decide to mark unknown after previously indicating a particular race / ethnicity, the change is not tracked; it is simply updated to the most current information. Because of this, we are unable to confidently attribute a specific number to this process in MMIS.

QUESTION 5: What are other states doing? (Rep. Salinas)

We are unable to find another state that does REALD. There are few state-based models for this and other equity and inclusion work. We often get cited as the state-based model for most of this work. The OEI director also meets with her colleagues from other states through various venues on a regular basis, and none of them are talking REALD. That said, there are a few states that have greater granularity for some racial and ethnic identity categories:

- California specifies extensive racial and ethnic identity categories for state agencies, boards, or commissions that directly or by contract collect demographic data. They also specify this data be tabulated using the granular categories.
- Massachusetts Department of Public Health also has extensive racial and ethnic identity and language standards for hospitals.

- New York State uses the U.S. Centers for Disease Control and Prevention (CDC) Race and Ethnicity code set, version 1.0, in their standards that apply to hospitals. This list is much more expansive than what is used by Oregon.

A data highlight released by CMS in 2017 suggests that, of all those selecting a health plan, 36.5% did not report a race. The percentages of unknowns / missing for race ranged from 16.9% (South Dakota) to 51.5% (Florida). The average percent of unknown / missing responses among states was 30.5%. Oregon is #19 at 28.9%.

Thank you again for the opportunity to discuss this important issue and I look forward to ongoing engagement in the future. Please let me know if you have any questions.