I. Introduction

To monitor how well Oregon's coordinated care model is achieving its goals of access, equity, quality and outcome improvement, and to help determine whether health system transformation efforts have improved or worsened quality and access in the state, Oregon must have robust performance monitoring strategies and mechanisms to monitor and assess all Medicaid delivery systems (including coordinated care organizations [CCOs], dental care organizations (DCOs) and fee-for-service [FFS]).

As required by CFR 438.340, Oregon assesses how well the CCOs and managed care organizations are meeting requirements through the robust performance measurement process and ongoing analysis of the quality and appropriateness of care and services delivered to enrollees, and member satisfaction.

Oregon has developed a comprehensive program to assess all aspects of the delivery system and the CCO and DCO activities to determine quality improvement and contract compliance. This Quality Strategy describes the components of that program.

II. Overview

Framework for quality

To monitor quality, the Oregon Health Authority will build upon the eight currently implemented focus areas across Oregon's health care delivery system. Continuing the progress in the focus areas, the Oregon Health Authority will intensify key focus areas, such as adding oral health to the existing primary care and behavioral health integration. Working collaboratively across the system, CCOs, DCOs and the Oregon Health Authority will support the framework through quality improvement in these focus areas. Focus areas are detailed in the following "Improvement Strategies" section.

Continuing on the pathway to achieve the Triple Aim, the Oregon Health Authority recognizes the need for alignment across all health care delivery systems for quality. Increased focus on alignment will include programs in Medicare, Medicaid (CCO and FFS systems) and federal improvement programs (for example, value-based payment). Working with a regional quality improvement organization (QIO), OHA's External Quality Review Organization and health care delivery systems (CCOs, DCOs, FFS), the Oregon Health Authority will look for opportunities to align state efforts with federal direction in quality and transformation activities. While maintaining the state's program integrity related to gains in health transformation, the Oregon Health Authority will develop strategic alignment for quality programs to increase organizations' efficiency and decrease burden on the health systems for reporting and communicating common-thread goals that will continue Oregon's work towards the triple aim of better health, better care and decreasing costs.

Accountability summary

To drive innovation, improve health outcomes and maintain compliance with regulatory agencies, OHA is working across a variety of stakeholders, committees and oversight bodies to ensure CCO accountability and improve delivery system quality of care. This work is equity centered and rooted in increasing access and quality of care for Oregon Health Plan/Medicaid and CHIP members. Key attributes of this work include the following:

- Oregon Health Policy Board – develops strategic direction of health system transformation and is equity centered
- OHA Quality Council – monitors clinical quality performance, health system transformation and quality improvement
- Medicaid Advisory Committee – advises the OHA on the policies, procedures, and operation of the Oregon Health Plan.
- Quality management/contract compliance – monitors CCOs and DCOs for contract compliance, external quality review and quality assurance elements (complaints, fraud, waste, abuse)
- Quality Management Committee – provides overall structure for the Oregon Health Plan quality governance to monitor and improve quality initiatives
- Health delivery system (partnership committees with delivery system and OHA)
    - Quality and Health Outcomes Committee – monitors clinical quality performance with improvement strategy development and implementation
    - Health Evidence Review Committee – reviews and develops evidence-based practices for all managed care entities (including FFS)
    - CCO Operations Collaborative and Contracts and Compliance Workgroup – monitors compliance with CCO contract requirements and provides guidance on operational implementation of requirements

Methods and resources for monitoring

Across the Oregon Health Authority's quality programs, the agency utilizes multiple quality strategies as tools for improvement. Continuous quality improvement, Plan-Do-Study-Act models, and LEAN principles are examples of proven methods of improvement. Ongoing use of these methods across the agency supports the transformation in the health care delivery system through train-the-trainer models with CCOs and contractual relationships with FFS. An additional resource for monitoring includes robust data systems to drive a data-decision culture. Key agency data include, but are not limited to, the all payer all claims database, performance monitoring through measures reporting, delivery system network reports, appeal and grievance data, and CCO data dashboards from claims reporting and deliverable tracking.

Standards for managed care contracts

As required by CFR 438.340, Oregon must establish standards for all managed care contracts regarding access to care, structure and operations, and quality measurement

and improvement. Within the CCO and DCO contracts, the federal regulations are outlined with the applicable CCO and DCO deliverables to support quality through monitoring and contract compliance.

Compliance and expectations for CCOs and DCOs

Achieving the policy objectives of CCO 2.0 requires a strong operational foundation with clearly defined performance expectations and a system to monitor compliance with all contract provisions. While some flexibility allows CCOs to meet the unique needs of their communities, OHA also has a responsibility to conduct effective oversight of the program to ensure members across the state receive the care they deserve.

OHA is developing the internal structures necessary to set the standard for accountability throughout the health care delivery system and to consistently apply that standard to all providers. To improve oversight and provide guidance to CCOs and DCOs, OHA created a comprehensive and standardized process for all OHA divisions to proactively evaluate, monitor and manage individual CCO remediation to the new CCO 2.0 contract. The standardized process also applies to monitoring of DCO performance. Aligning contract deliverables with a streamlined, transparent compliance review process will:

- Create a sustainable process that is standardized and driven by deliverable requirements, not variable and people driven.
- Ensure MCEs have clear information and guidance about deliverables for which they are accountable, OHA's review process, and corresponding timelines.
- Strengthen partnership and coordination between CCOs, DCOs and OHA.
- Enable remediation of process gaps and focus on prevention of future findings.

The standard evaluation process will ensure OHA is able to monitor and track CCO and DCO performance across all federal and state requirements. The contract requirements (deliverables) will be updated annually to improve clarity of requirements, reporting and deliverables, due dates, and the accountability process. Through this effort, OHA is developing more prescriptive guidance in areas where stakeholders have expressed concern about barriers to access or inconsistency; providing technical assistance, if needed; and utilizing enforcement mechanisms when necessary to achieve those outcomes.

Through improvements to the monitoring and compliance infrastructure, increased enforcement of new and existing requirements, and clarification of the performance expectations for CCOs, OHA plays an important role in creating the conditions for CCO, DCO and health transformation success.

Health priority alignment

CCO 2.0 priorities

The next phase of Oregon's health care transformation, called CCO 2.0, is focused on four key areas identified by the Governor:

1. Improve the behavioral health system and address barriers to access to and integration of care.
   Integrate behavioral, physical and oral health to allow patients to receive the right care at the right time and in the right place. Focus on behavioral health (mental health and substance use disorder) services. Assure that children with serious behavioral health care needs are addressed as a priority.
2. Increase value and pay for performance.
   Reward providers' delivery of patient-centered and high-quality care. Reward health plan and system performance. Ensure consideration of health disparities and members with complex needs. Align payment reforms with other state and federal efforts.
3. Focus on social determinants of health and health equity.
   Build stronger relationships between CCOs and other sectors. In addition, align outcomes between health care and other social systems to improve health equity. Encourage a greater investment in prevention and the factors that affect our health outside the doctor's office
4. Maintain sustainable cost growth and ensure financial transparency.
   Continue to operate within a sustainable budget and address the major cost drivers in the system. Ensure ongoing financial transparency and accountability.

These focus areas and the associated policies are the foundation of the CCO contracts awarded for 2020–2024.

State Health Improvement Plan

OHA provides backbone support for implementation of the State Health Improvement Plan, Healthier Together Oregon (HTO). Oregon's 2020–2024 HTO identifies efforts needed to advance health equity for priority populations through collective action in five priority areas: institutional bias; adversity, trauma and toxic stress; access to equitable preventive health care; behavioral health; and economic drivers of health, such as housing, food security and living wage jobs. HTO is intended to be an alignment tool for anyone working to improve health, including other state agencies and partners who develop and implement community health improvement plans (CHPs). CCO CHPs are required to align with at least two HTO priorities and strategies. Finally, OHA convenes the PartnerSHIP, a community-based steering committee, to provide oversight and governance of the plan. The PartnerSHIP is made up of representatives of priority populations and implementers of the plan, including CCOs and their community advisory councils.

Equity

To improve health outcomes, there must be a focus on health equity. Oregon will have achieved health equity when all people have the opportunity to attain their full health potential, but there is no easy solution for eliminating health disparities. In fact, there are often many causes for the adverse health outcomes experienced by certain

disadvantaged communities. Some communities are less likely to live in quality housing, less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive culturally and linguistically appropriate care when seeing a health care provider.

OHA utilizes several levers to improve health equity. The coordination of these levers and the monitoring and accountability are essential actions to have the greatest impact. Levers include, but not limited to, measurement monitoring and reporting across racial and ethnic disparities, health equity pay for performance incentive metric, CCO health equity plans, equity components of the CCO Transformation and Quality Strategy, and connections to the community health improvement plans and regional health equity coalitions.

To reinforce Oregon Health Authority's commitment to improve health and equity, OHA adopted a 10-year goal and an equity definition as a foundation for the agency's work. The strategic goal was informed by an extensive community engagement process throughout the state to ensure the agency was especially responsive to people in Oregon most impacted by health inequities stemming from long-standing and contemporary racism and oppression. The process also allowed for understanding where work needs to focus, robust internal and external coordination, and impacts around how to think about and work towards achieving health equity.

OHA 10-year goal: To end health inequities in the state of Oregon by 2030.

10-year goal key questions:

- How do we address the equitable distribution and redistribution of resources and power?
- How does this impact our policy, practice and decision making?
- What do we need to do differently?

Health equity definition

In October 2019 the Oregon Health Policy Board (OHPB) and the Oregon Health Authority (OHA) adopted the health equity definition developed by the Health Equity Committee (a subcommittee of OHPB). The definition states that:

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*
>
> *Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*
>
> - *The equitable distribution or redistribution of resources and power; and*
> - *Recognizing, reconciling and rectifying historical and contemporary injustices.*

III. Methods

Accountability methods

Oregon has developed a comprehensive program to assess all aspects of the delivery system. This program involves routine analysis and monitoring of delivery system performance and consumer satisfaction data, comprehensive on-site operational reviews, and other focused reviews and surveys designed to monitor areas of particular concern (such as provider availability, marketing activities, and other issues identified through routine monitoring). In addition to these activities, OHA conducts ongoing accountability and compliance reviews (described below).

Ongoing focused reviews

Focused reviews, which may or may not be on-site, are conducted in response to suspected deficiencies that are identified through routine monitoring processes and grievance and appeal reporting. These reviews will also provide more detailed information on areas of particular interest to the state such as emergency department visits, availability and access of services, behavioral health, utilization management, and data collection problems. An example of a focused review is an ongoing review of plans' provider networks to determine if physicians are being listed as practicing in a plan's network when they have had their medical license suspended or revoked.

Appointment and availability studies

The purpose of these studies is to review managed care and FFS provider availability/ accessibility and to determine compliance with contractually defined performance standards. The Oregon Health Authority (OHA) and its external quality review organization (EQRO) conduct a secret shopper telephone survey among primary physical health care providers (PCPs) contracted with one or more CCOs. The primary purpose of this secret shopper survey is to collect appointment availability for Oregon Health Plan (OHP) members new to the provider location and requesting routine well-checks or non-urgent problem-focused ("symptomatic") visits. Specific survey objectives included the following:

- Determine whether PCP service locations accepted OHP members enrolled with the requested CCO and the degree to which CCO and OHP acceptance aligned with the CCOs' delivery system network (DSN) provider capacity report data
- Determine whether PCP service locations accepting OHP for the requested CCO accepted new patients and the degree to which new patient acceptance aligned with the CCOs' DSN provider capacity report data
- Determine appointment availability with the sampled PCP service locations for routine well-checks and non-urgent symptomatic visits

Marketing and member materials review

Managed care contractors are contractually required to submit all marketing materials or advertising, and written member notices to the state for approval prior to use. This

process ensures the information presented to members and potential members is compliant with state and federal requirements.

Performance monitoring

Through the standardized deliverable evaluation process, OHA will have the ability to compare and measure performance across all CCOs and DCOs for a variety of deliverables. OHA is improving the reporting and systems used to measure performance in key priority areas: timely and appropriate denials, appeals, hearings and grievances; access to language translation services; quality of non-emergent medical transportation services; adequacy of provider network; access to care coordination services and intensive care coordination services; and integration of behavioral health services.

On-site operational reviews

On-site reviews will be conducted periodically as a result of, gaps in performance, requested by CCO, or requested by the EQRO for example. Reviews will include, but not limited to, validating reports and data previously submitted by the CCO, an assessment of supporting documentation, and/or conducting a more in-depth review of the CCO's quality assurance activities. Reviews will also serve as an opportunity for in-person, one-on-one technical assistance in identified gap area. For example, a site visit relating to performance improvement projects will include a refresher in CCO deliverable, applicable state and federal requirements and provide technical assistance in root cause development and aim statement objectives.

Furthermore, on-site review(s) supplement the state monitoring program of CCOs with direct and focused areas of improvement.

Quality Management Committee reviews

The OHA Quality Management Committee meets quarterly to review contract compliance issues across all delivery systems in aggregate and performance metrics.

As per STC 24b.ii, OHA will contractually require each CCO to address four of the quality improvement focus areas, using rapid cycle improvement methods to:

- Study the extent and unique characteristics of the issue within the population served,
- Plan an intervention that addresses the specific program identified,
- Implement the action plan,
- Study its events, and
- Refine the intervention.

Performance improvement

Advancing PIPs

Moving forward, the PIP strategies are maturing into use of technology around care coordination and expanding into integrated practices. Allowing for the CCOs who have developed data monitoring systems, case management programs, and measurement

alignment to develop initiatives in the space of social determinants of health will be key continuing to push health transformation. Additionally, lessons learned from the 2012–2017 demonstration for PIP implementation have led to the development of SMART (specific, measurable, attainable, relevant, timely) objectives with a corresponding measurement for monitoring progress. Future technical assistance and monitoring will continue to focus on these quality improvement foundations.

PIP focus areas

To move forward in testing and implementing improvement strategies, the CCOs will be required to conduct four performance improvement projects. Two of the four will be selected from the focus area list by the CCO, the third will be a statewide PIP under the "integration of health" focus area, and the fourth PIP will be a statewide substance use disorder PIP. The quality improvement focus areas, as referenced in Oregon's 2017–2022 1115 Waiver Attachment E are:

1. Reducing preventable re-hospitalizations;
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs;
3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers;
4. Integration of health: physical health, oral health and/or behavioral health;
5. Ensuring appropriate care is delivered in appropriate settings;
6. Improving perinatal and maternity care;
7. Improving primary care for all populations through increased adoption of the Patient- Centered Primary Care Home (PCPCH) model of care, and
8. Social determinants of health

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness. PIP focus areas are subject to change as CCOs mature.

External Quality Review Organization (EQRO) activities

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' (MCEs') performance related to the quality of, timeliness of, and access to care and services provided by each entity, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Oregon Health Authority (OHA) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to perform the assessment. The EQRO performs the following mandatory and optional external quality review (EQR) activities, as described in 42 CFR Part 438 and 42 CFR §438.358.

- Compliance monitoring reviews to determine MCE compliance with federal (42 CFR §438) and State standards that address requirements related to access, structure and operations, and quality measurement and improvement. CMR activities also included follow-up on the status of past CMR findings and related improvement plans for the DCOs from calendar year 2019.
- Validation of performance improvement projects and focus studies.
- Performance measure validation of seven specific measures to evaluate the accuracy and validity of OHA's calculation of the performance measure rates for the State's CCOs.
- Validation of network adequacy involving the comprehensive review of MCE delivery system network (DSN) provider capacity reports and DSN provider narrative reports regarding compliance in accordance with the State's standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN.
- An encounter data validation study to evaluate CCO processes for collecting, maintaining, and submitting encounter data to OHA.
- A mental health parity analysis to ensure that coverage and access to mental health/substance use disorder benefits were provided in parity with medical/surgical benefits.

Surveys

OHA conducts an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of approximately 45,000 members, asking them to report on and evaluate their experiences with health care. The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. Surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

Seventeen CAHPS measures (ten for adults and seven for children) are included as state quality measures under the current (2017–2022) waiver and are reported annually in the CCO Performance Report. Comprehensive CCO-level and OHP-level CAHPS survey results are also reported annually in separate reports.

IV. Quality components

Quality management plans

Managed care plans are required to have internal quality management plans to participate in the Medicaid managed care program. Plans must document structures and processes in place to assure quality performance.

Transformation and quality strategy

The transformation and quality strategy (TQS), developed in 2017, incorporates all components of the Quality Assessment and Performance Improvement (QAPI) program. The QAPI has been incorporated into the CCO's TQS and will address health transformation, quality and performance management while ensuring compliance with state and federal regulations. The TQS specifically focuses on CCO documentation of key efforts across the following components, as well as documentation of the CCO's overall quality program within the CCO's larger strategic plan:

- Access: quality and adequacy of services
- Access: cultural considerations
- Access: timely
- Behavioral health integration
- CLAS standards
- Grievance and appeal system
- Health equity: data
- Health equity: cultural responsiveness
- Oral health integration
- Patient-centered primary care home: member enrollment
- Patient-centered primary care home: tier advancement
- Serious and persistent mental illness
- Social determinants of health & health equity
- Special health care needs
- Utilization review

CCO TQS documentation will be monitored to ensure a robust CCO quality and transformation program, in accordance with best practices and CFR. This includes a formal OHA assessment and scoring of each CCO TQS submission with actionable feedback to support continuous quality improvement. The TQS will also be used as a basis for peer sharing of evidence-based and emerging best practices to further health transformation across CCOs. See "Expectations of CCOs" section above for further details.

Health equity plan

As a CCO 2.0 contract deliverable, CCOs are required to develop and submit a yearly health equity plan. The health equity plan aims to provide the CCO and its stakeholders a clear framework to becoming an organization that values and prioritizes health equity. The framework includes an action plan detailing where the CCO is headed, what it plans to achieve, the methods it will use, and milestones to monitor progress. A successful health equity plan is built on a thorough analysis of the existing CCO structure, governance, staff, program or service mix, collaborations and resources, including financial, human, technical and material. This analysis is vital because it

allows an organization to understand which components it must change to achieve its goals related to health equity.

OHA requires all CCOs to develop a health equity plan that:

- Acts as a catalyst to initiate the deep organizational changes needed to build equity and diversity into service planning and delivery in the organization, community and provider network;
- Creates the foundation to build equity into ongoing accountability, resource allocation and performance management relationships between OHA, the CCO and the provider network;
- Provides a visible and concrete context for widespread discussion of health equity – within individual organizations, within sectors, across sectors, and in the wider community; and
- Incorporates and operationalizes the health equity definition.

Performance improvement projects

Overview of CCO PIPs

Under Oregon's 1115 2012–2017 demonstration waiver, CCOs developed performance improvement projects (PIPs) in a few key areas: high utilizers, maternal care, increased patient assignment within PCPCH medical homes, and diabetes care for individuals with serious and persistent mental illness. Development of effective coordination strategies across health systems, primary care, specialty care and hospital systems for high utilizers and reducing rehospitalizations is an ongoing effort. The PIPs initially focused on breaking down the silos of care and expanding care delivery to team-based approaches. A few key lessons learned from adolescent well-care visits and maternal health have been helpful in providing for patients' social determinants of health (food insecurity, stable transitions, supportive services); therefore, an additional focus area has been added for CCOs to test new models in the area of social determinants of health.

Access

Network adequacy

Federal and State regulations require each Medicaid managed care contractor to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. As of December 2020, CMS has not published the validation of network adequacy protocol referenced in federal regulations for managed care. Each contractor must submit documentation to the State Medicaid

authority[1] demonstrating the contractor's capacity to serve enrolled members in its service area in accordance with the State's standards for access to care.[2]

The Oregon Health Authority (OHA) is currently performing an analysis to document the accessibility of CCO provider networks and to assess compliance with existing network standards and requirements. OHA is looking at three key dimensions to explore and understand beneficiary access to care (network capacity, geographic distribution, and availability of service). Network capacity addresses the underlying foundation of the provider network and refers to the supply of provider services available to beneficiaries. Using a variety of measures (for example, provider-to-beneficiary ratios and provider counts), an assessment of the underlying capacity of a provider network can be obtained. If services are available and an adequate supply of providers and services are present, the opportunity to obtain health care exists, suggesting that beneficiaries may have access to services.

Once capacity and infrastructure are established, it is important to understand the extent to which beneficiaries can gain access to reported services. However, gaining access to and utilization of services are dependent upon physical accessibility and acceptability of services, not simply on adequacy of supply. Geographic distribution addresses whether or not the distribution of available services is adequate to facilitate access to all beneficiaries. Key measures for assessing the geographic distribution of providers include time/distance analyses and compliance with network adequacy requirements. When combined with beneficiary and provider characteristics, these analyses will determine the extent to which the supply of providers is distributed appropriately relative to the beneficiary population. However, even with adequate capacity and appropriate distribution of services, assessing the availability of relevant services is critical in making sure beneficiaries have access.

The third dimension of access, availability of services, is important for understanding the extent to which network services are relevant and effective in producing positive health outcomes. The availability of services will be assessed in terms of appointment availability, utilization and/or outcomes of services. Taken together, the three dimensions offer a broad understanding of the factors impacting beneficiaries' access to care. The framework addresses the intersection of a network's underlying infrastructure (making services available), distribution (getting the services to beneficiaries) and availability (having the right kind of services available when needed). The analysis will help OHA identify network adequacy gaps and improve the network adequacy requirements at the state level.

Network adequacy monitoring

Pursuant to 42 CFR §438.206 and 42 CFR §438.207, the MCEs are required to demonstrate to OHA, with supporting documentation, that all covered services are

[1] 42 CFR §438.358(b)(1)(iv) and 42 CFR §438.604(a)(5).

[2] See 42 Code of Federal Regulations (CFR) §438.206 and §438.207; Oregon Administrative Rules (OAR)410-141-3515.

available and accessible to members and that they have adequate provider capacity. To support federal and state network adequacy requirements, the MCEs are contractually required to develop and submit DSN reports that consist of two components, an annual DSN provider narrative report and quarterly DSN provider capacity reports, that crosswalk to the network standards in the MCEs' contracts with the State.

DSN provider narrative

The DSN provider narrative report requirement defines five categories based on OHA's MCE contract requirements. Each category includes corresponding elements that require the MCEs to describe and submit comprehensive narrative responses and analysis demonstrating how the MCEs ensure, monitor and evaluate adequate provider capacity, including geographic location of network providers and members, considering distance, travel time, member needs, coordination of care and performance metrics. MCEs must, at a minimum, incorporate the provided specifications into their comprehensive written responses and supplemental documentation (for example, policies, procedures, manuals, analytics) and demonstrate how the DSN is monitored to ensure adequate provider capacity and member access.

If any component of a MCE's DSN is subcontracted or delegated, the MCE must also include a narrative response and supplemental documentation (for example, policies, procedures, manuals, analytics), including three OHA-defined time and distance standards for each geographic classification in its service area, describing how delegated services are integrated with the MCE's overall DSN, and how the MCE monitors its delegated providers, ensuring compliance with federal and State provider network requirements.

The DSN provider narrative report additionally requires each MCE to document its compliance with OHA's travel time and distance standards pursuant to OAR 410-141-3515. MCEs demonstrate compliance by reporting the time and distance standards of minutes and miles of overall member access for each geographic classification in its service area.

DSN provider capacity report

MCEs submit a DSN provider capacity report, which is an inventory of the MCEs' providers and facilities, using a template provided by OHA. All participating providers, either employed directly or through subcontract with an MCE and providing services to Medicaid members, were included. Required data elements of the report are outlined in the OHA 2020 Health MCE Contracts (Exhibit G(2)(a)). Each provider capacity report is evaluated on four domains:

- Quality of DSN provider capacity reporting
- Provider network count
- Provider accessibility
- Geographic distribution

Using member data, a time and distance analysis is performed looking at the following key measures:

- Percentage of members living within the time/distance standards.
- Average time (in minutes) and distance (in miles) to the nearest three providers for each provider type evaluated (for example, primary care providers and hospitals)

Provider directory validation

OHA is also carrying out a variety of supplemental activities to assess access to providers and provider information. For example, OHA contracted with its EQRO to perform a provider directory validation activity to ensure members have appropriate access to provider information. For the provider directory validation, key elements published in the online provider directories were compared with the data in the provider capacity reports and will confirm each MCE's website meets the federal requirements in 42 CFR §438.10(h), OAR 410-141-3585, and relevant State contractual requirements.

Secret shopper survey

OHA contracted its EQRO to conduct a secret shopper telephone survey among primary physical health care providers (PCPs) contracted with one or more CCOs. The primary purpose of this secret shopper survey is to collect appointment availability for Oregon Health Plan (OHP) members new to the provider location and requesting routine well-checks or non-urgent problem-focused ("symptomatic") visits. Specific survey objectives include the following:

- Determine whether PCP service locations accept OHP members enrolled with the requested CCO and the degree to which CCO and OHP acceptance aligns with the CCOs' delivery system network (DSN) provider capacity report data.
- Determine whether PCP service locations accept OHP for the requested CCO accepted new patients and the degree to which new patient acceptance aligned with the CCOs' DSN provider capacity report data.
- Determine appointment availability with the sampled PCP service locations for routine well-checks and non-urgent symptomatic visits.

Provider Oversight

Credentialing

CCOs and MCO plans must institute a credentialing process for their providers that includes, at a minimum, obtaining and verifying information such as valid licenses; professional misconduct or malpractice actions; confirming that providers have not been sanctioned by Medicaid, Medicare or other state agencies; and the provider's National Practitioner Data Bank profile. FFS providers are also enrolled through the state's Provider Enrollment Unit, which confirms that Medicaid, Medicare or other state agencies have not sanctioned providers. Additionally, all credentialed providers must

verify regularly through the Office of Inspector General and SAMHSA for compliance with conflict of interest standards.

Policy requirements include standards on credentialing, privileging, conflict of interest compliance including time and interval of credentialing functions. CCOs must also work with OHA to assure proper credentialing of mental health programs, associated providers and traditional health care workers.

Licensing

CCOs and MCOs must ensure all licensed or certified providers maintain active licenses or certifications. The CCOs and MCOs must monitor provider licenses and certifications for any adverse action from a licensing or certifying entity and develop a process for reviewing a provider's contractual status due to any adverse action. All actions against a provider's license, certification or contractual status with a CCO or MCO must be immediately reported to the Provider Enrollment Unit through the OHA.Provider.Review@dhsoha.state.or.us email address. Adverse action reports must include the provider information, the action taken by the CCO or MCO and all supporting documents.

Member Satisfaction

Ombuds team

Pursuant to Oregon Revised Statute (ORS) 414.712, OHA provides Ombuds services to individuals who receive medical assistance through Oregon's Medicaid program. The Ombudsperson serves as the advocate for Oregon Health Plan (Medicaid and Children's Health Insurance Program) recipients in these areas:

- Access to care;
- Quality of care; and
- Channeling member experience into recommendations for system improvement.

The OHA Ombuds position is a formal, internal voice for process and system improvements responsive to identified trends impacting services for the more than 1.2 million Oregonians served by the Oregon Health Plan. This work is essential for health care transformation that is grounded in the needs of Oregonians and informs the Ombuds Program recommendations for client-focused process and system improvements with OHA and ODHS. As required by ORS 182.500, the OHA Ombuds Program provides a quarterly report to both the Governor and the Oregon Health Policy Board. Each person who makes it to the Ombuds Program deserves nurturing and support. The stories they share often illustrate challenges many others experience. Each story brings lessons for ways to improve Oregon's Medicaid delivery system.

Medicaid Advisory Committee

The Medicaid Advisory Committee (MAC) is a federally mandated body that advises OHA and DHS leadership, the Oregon Health Policy Board, the Legislature and the Governor's office about the operation and administration of the Oregon Health Plan

from a consumer and community perspective. The MAC's role includes reviewing Oregon's Medicaid Quality Strategy, changes to OHA's quality rating strategy for managed care organizations, managed care marketing materials, and the access monitoring plan for OHP members enrolled in the Open Card plan (FFS Medicaid). Additionally, the MAC receives information about CAHPS survey findings, Ombuds Program updates, grievance and complaint data trends, and CCO deliverables that provide visibility into Oregon's health transformation from a consumer experience lens.

Grievances and appeals

The state's contracted EQRO evaluates MCE's compliance with Grievance and Appeal System requirements including: grievance and appeal processes, provision of information to members and contracted providers, and adherence to time frame and notification requirements, pursuant to 42 CFR §438.400-424, applicable Oregon Administrative Rules (OARs), and contractual requirements. The MCE's are evaluated against the following requirements:

- Implementing written procedures for accepting, processing and responding to all grievances and appeals, consistent with requirements.
- Providing information about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.
- Providing members with information on their rights regarding grievances, appeals and contested case hearings and allowing for members to freely exercise their rights without discouragement or retaliation.
- Adhering to content requirements for notifications sent to members.
- Adhering to required time frames for notifications, resolution of grievances and appeals, expedited requests, extended time frames and contested case hearings.
- Advising members of the process for continuation of benefits and adhering to delivery of services and payment requirements.
- Complying with record-keeping requirements for grievances and appeals.

In addition, OHA requires MCEs submit a quarterly report including a log of complaints, denials, appeals, and all NOABDs issued for Applied Behavioral Analysis and Hepatitis C issued to members during the previous quarter. OHA selects a random sample of denials from the log and each MCO must submit the selected sample of Notices of Adverse Benefit Determination (NOABDs) and associated Prior Authorization (PA) documentation. The NOABD sample submitted by each MCO is evaluated against criteria inclusive of state and federal requirements.

The summary of all complaints registered during that quarter, along with a more detailed record of all complaints that have been unresolved for more than 30 days. A uniform report format has been developed to ensure that complaint data is consistent and comparable. OHA uses complaint data to identify developing trends that may indicate a

problem in access, quality of care, and/or education. Grievance and appeals report also identify FFS provider trends.

Improving upon the uniformed report will be the next step with administrative simplification through technology updates to the report, which will lead to deeper analysis for trend reporting. Analysis through the updated automated report will provide greater detail for health system (oral health, behavioral health, physical health) delineation of complaints origin and tracking of topic issues (e.g. non-emergency medical transportation) across the CCOs simpler. Potential changes also include developing systems for details regarding dual eligible client complaint tracking to ensure a smooth transition from passive enrollment.

On an annual basis, the OHA reviews MCO Grievance and Appeal System Policies and Procedures (P&Ps) to ensure they meet the requirements of OARs, 42 CFR §438.406, and address how the MCE will accept, process, and respond to Grievances, Notices of Adverse Benefit Determinations, Appeals, and Hearings.

Surveys

Seventeen CAHPS measures (ten for adults and seven for children) are included as state quality measures under the current (2017–2022) waiver and are reported annually in the CCO Performance Report. Comprehensive CCO-level and OHP-level CAHPS survey results are also reported annually in separate reports.

Quality payment programs

Medicaid Efficiency and Performance Program

Performance Based Reward (PBR) is a financial incentive program under CCO 2.0 designed to incentivize spending on health-related services, while controlling costs, maintaining quality and improving efficiency. One component of PBR is the Medicaid Efficiency and Performance Program (MEPP); CCOs must participate in MEPP work to be eligible for PBR. MEPP is based on an efficiency and quality algorithm that reviews claims data and identifies adverse actionable events (AAE) — downstream medical complications that could potentially be avoided with better upstream care. CCOs are asked to design interventions for three different types of episodes (such as diabetes, SUD, and asthma) with the goal of improving outcomes as measured by AAE.

Qualified directed payments

CCOs are required by contract to administer qualified directed payments (QDPs) as directed by OHA, and as approved by CMS. OHA will continue to follow federal guidance on how to reference this quality strategy to support the quality improvement goals of each QDP.

Fiscal monitoring

Fraud, waste and abuse

The CCOs must submit complaints of or allegations of suspected fraud or abuse, within 7 days, that are made to or identified by the CCO and warrant preliminary investigation. The CCO must also submit the following information on an ongoing basis for each case of fraud and abuse it identifies through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees or any other source:

- The name, NPI and tax ID (or member ID number) of the individual or entity that is suspected of committing the fraud or abuse;
- The source that identified the fraud or abuse;
- The type of provider, entity, or organization that is suspected of committing the fraud or abuse;
- A description of the fraud or abuse;
- The approximate dollar amount of the fraud or abuse;
- The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred; and
- Other data or information as requested.

The CCOs also conduct audits of providers, subcontractors and other third parties to identify overpayments and uncover suspected fraud and abuse. CCOs provide quarterly and annual audit reports to OHA and report any recouped overpayments from their audit activities on the quarterly and annual Exhibit L financial reports.

OHA Office of Program Integrity conducts audits on an ongoing basis of FFS providers as well as managed care participating providers, CCO subcontractors and third parties or downstream entities receiving Medicaid funds through a CCO.

Surveys

CAHPS

OHA conducts an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of approximately 45,000 members, asking them to report on and evaluate their experiences with health care. The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. Surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

MHSIP

The Mental Health Statistics Improvement Program (MHSIP) are a set of validated surveys to measure clients' perceptions of the quality and efficiency of the mental health services they receive. The program consists of four surveys fielded annually, which vary

based on the client's age and the type of services they received. These surveys are: 1) adults who have received outpatient services; 2) adults who have received residential treatment services; 3) parents or guardians of youth 0-17 years of age who have received mental health services; and 4) youth 14-17 years of age who have received mental health services. The four surveys assess perception of mental health services across several domains, such as access to services, quality of services, satisfaction with surveys, and treatment outcomes and participation.

V. Quality measurement

Performance measures

Established in the 2012 waiver, and corresponding state legislation, the CCO quality incentive program is a mechanism for focusing CCO efforts and driving continuous quality improvement. Financial incentives are a key strategy for stimulating quality of services and for moving from a capitated payment structure to value-based purchasing. Oregon's strategy has been to annually increase the percentage of CCO payment at risk for performance, providing a meaningful incentive to achieve significant performance improvement and affect transformative change in care delivery. To date, the CCO incentive metrics program has been a success, and CCOs show improvements in a number of incentivized areas, as documented in the 2019 CCO Metrics Performance Report.

Measures in the CCO quality incentive program are selected annually by the Metrics and Scoring Committee, from the menu of measures established by the Health Plan Quality Metrics Committee (HPQMC). The Metrics and Scoring Committee also sets the benchmark for each measure. Detailed measure specifications, technical documentation and additional guidance are all published online.

VI. Quality Strategy governance

Quality structure

The Oregon Health Authority (OHA) is comprised of subject matter experts in evidence-based care, contract compliance, quality assurance, population health management, performance management, and quality improvement across the agency to support the monitoring and improvement of the health delivery system. Quality and health transformation elements are monitored at the programmatic level with key agency-wide committees responsible for oversight and planning. Underpinned across the quality and health transformation elements are health equity and social determinants of health with key contributions at the leadership committee level.

Oregon Health Authority structure to support quality and access monitoring:

- Oregon Health Authority
  - Oregon Health Policy Board
  - OHA Quality Council
  - Medicaid Advisory Committee

    - Quality Management Program and contract compliance
    - Quality Management Committee
- Health delivery systems
    - Quality and Health Outcomes Committee
    - Health Evidence Review Committee
    - CCO Operations Collaborative and Contracts and Compliance Workgroup

Review of Quality Strategy

The OHA Quality Strategy shall be reviewed annually by OHA. The OHA Quality Strategy review and update will be completed by December of each year and submitted to CMS, upon significant changes, in the subsequent quarterly report update.

The OHA Quality Council shall have overall responsibility to guide the annual review and update of the Quality Strategy. The review and update shall include an opportunity for both internal and external stakeholders to provide input and comment on the Quality Strategy. Key stakeholders shall include, but are not limited to:

- Addictions and Mental Health Planning and Advisory Council*
- Medicaid Advisory Committee*
- Health Systems Division Executive Team
- Health Policy and Analytics Management Team
- OHA Executive Team
- CCO medical directors
- FFS contractors
- CCO quality management coordinators
- Local Government Advisory Committee*
- DHS internal stakeholders
- OHA internal stakeholders
- Health Equity Committee*

* Committees including consumer representatives.

Final versions will be posted on the OHA website.

Enforcement

The OHA managed care program has an enforcement policy for data reporting, which also applies to reporting for quality and appropriateness of care, contract compliance and reports for monitoring. If a plan cannot meet a reporting deadline, a request for an extension must be submitted in writing to the division. The division will reply in writing as well, within one week of receiving the request. Plans that have not submitted mandated data (or requested an extension) are notified within one week of non-receipt that they must: (1) contact the division within one week with an acceptable extension plan; or (2) submit the information within one week.

Enforcement options for plans that are out of compliance are progressive in nature, beginning with collaborative efforts between OHA and the plans to provide technical assistance and to increase shared accountability through informal reviews and visits to plans, or increased frequency of monitoring efforts. If these efforts are not producing results, a corrective action plan may be jointly developed, and the plan monitored for improvement. More aggressive enforcement options that OHA may apply include restricting enrollment, financial penalties and ultimately, non-renewal of contracts.

Conditions that may result in sanctions:

1. Fails to authorize or otherwise substantially provide Medically Appropriate services that Contractor is required to authorize and provide to a Member in accordance with applicable State or federal law or as required under this Contract;
2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under this Contract or applicable State or federal law; Contractor shall not charge Members any Premiums for any services provided pursuant to this Contract.
3. Acts to discriminate among Members on the basis of their protected class such as race, ethnicity, national origin, religion, sex, sexual orientation, marital status, age, disability, health status, or need for health care services. Acts that may be evidence of discrimination include, but are not limited to: (i) Disenrollment of, or refusal to reenroll, a Member, except as permitted under this Contract, (ii) any practice that would reasonably be expected to discourage Enrollment, or (iii) any practice that seeks or encourages the Disenrollment of individuals whose protected class, medical condition or history indicates probable need for substantial future Medical Services;
4. Misrepresents or falsifies any information that is required to be submitted to CMS, the State, or their designees under this Contract, including but not limited to any such information submitted in: (i) or in connection with Contractor's Application, or enrollment with CMS, (ii) any certification made in connection with this Contract, (iii) any report required to be submitted under this Contract, or (iv) any other documentation or other communication provided to the State, CMS, or their designees relating to the care or services provided to a Member or as otherwise required to be made under this Contract;
5. Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care Provider;
6. Fails to comply with the requirements for Physician Incentive Plans, as the requirements are set forth in 42 CFR §422.208 and §422.210 and this Contract;
7. Fails to comply with the operational and financial accounting and reporting requirements required under Ex. L of this Contract
8. Fails to maintain a Participating Provider Network sufficient to ensure adequate capacity to provide Covered Services to its Members under this Contract;

9. Fails to implement and maintain an internal Quality Improvement program, a Fraud, Waste and Abuse prevention program, a Quality Assurance and Performance Improvement Program, or to provide timely reports and data in connection with the such programs as required under this Contract;
10. Fails to comply with Grievance and Appeal System requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, or record keeping and reporting requirements;
11. Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services as required under this Contract;
12. Fails to make timely claims payments to Providers or fails to provide timely approval of authorization requests;
13. Fails to disclose required ownership information or fails to supply requested information to OHA relating to Contractor's Subcontractors or suppliers of goods and services;
14. Fails to submit accurate, complete, and truthful Pharmacy or Non-Pharmacy Encounter Data in the time and manner required by Ex. B, Part 8;
15. Distributes directly or indirectly through any Agent or independent contractor, Marketing Materials that have not been approved by the State or that contain false or materially misleading information;
16. Violates of any of the other applicable requirements of sections 1903(m), 1932 or 1905(t) of the Social Security Act and any implementing regulations; or
17. Violates any of the other applicable requirements of 42 USC §1396b(m) or §1396u-2 and any implementing regulations.

Technical report

The technical report provides a feedback loop for ongoing quality strategy direction and development of any technical assistance training plans. In addition to the statement of deficiencies and resulting plans of correction, findings from the operational reviews may be used in future qualification processes as indicators of the capacity to provide high-quality and cost-effective services, and to identify priority areas for program improvement and refinement.

Appendix A: CCO Contract

The CCO managed care contract template can be found on the OHA website for CCO contract forms. https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx

Appendix B: Quality definitions

Disability in adults

The law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) that

can be expected to result in death or that have lasted or can be expected to last for a continuous period of not less than 12 months.

Disability in children

Under title XVI, a child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

Source: https://www.ssa.gov/disability/professionals/bluebook/general-info.htm