



**The Oregon Health Plan's
Managed Health Care
2013 External Quality Review
Annual Report - Final**

Oregon Health Authority

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The Oregon Health Plan's Managed Health Care: 2013 External Quality Review Annual Report - Final

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EXECUTIVE SUMMARY

The State of Oregon is transforming its health care delivery system to create a more efficient system that promotes better outcomes. Oregon’s “triple aim” is to improve the overall health of Oregonians and improve the quality of health care they receive while decreasing costs.

In 2011, House Bill 3650 established Oregon’s integrated and coordinated health care delivery system, including the implementation plan for health system transformation and the development of community-based coordinated care organizations (CCOs). Senate Bill 1580 approved the creation of CCOs in 2012. Approval of Oregon’s 1115 Medicaid Demonstration Waiver by the Centers for Medicare & Medicaid Services (CMS) enabled Oregon to proceed with the implementation of CCOs as the delivery system for Medicaid.

The CCOs use global budgets to improve the coordination of care and to focus on prevention, chronic illness management, and person-centered care for Oregon Health Plan (OHP) members. In August 2012, CCOs became responsible for physical and behavioral health services formerly provided by various managed care organizations, including fully capitated health plans and community-based mental health organizations (MHOs). Many of these previous organizations joined together to form the state’s current CCOs. OHA approved transformation plans submitted by each CCO. In addition to physical and behavioral health services, some CCOs began providing dental services in July 2013.

At the time of this report, OHA contracted with 16 CCOs, and with one MHO and one managed care organization, to deliver care to OHP enrollees. These organizations, in turn, contract with provider groups to deliver physical and mental healthcare services. The organizations are responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory obligations to provide effective care.

Federal law requires states to conduct an annual external quality review (EQR) of Medicaid services delivered through managed care. OHA contracts with Acumentra Health to conduct the annual review in Oregon. Since this was the first full year of operation for the CCOs, the 2013 review did not address the usual set of mandatory EQR activities. Instead, OHA directed Acumentra Health to conduct readiness reviews of the CCOs to evaluate their capacity to meet federal requirements. In 2013, Acumentra Health reviewed the 15 CCOs in operation at the time for the following:

- Compliance with federal standards: Acumentra Health reviewed the CCOs’ current delegation processes as they relate to EQR compliance reviews.

- Performance measures validation (PMV): Acumentra Health reviewed the CCOs' current readiness for the Information Systems Capabilities Assessment (ISCA), related to calculating and reporting performance measures. This was the only PMV-related activity conducted by Acumentra Health in 2013 because OHA did not submit items for review (see next page for more detail).
- Performance improvement projects (PIPs): Acumentra Health reviewed the CCOs' selected PIP topics and the status of their work on the Statewide PIP.

Reports for individual CCOs detailed specific strengths and areas for improvement to prepare the CCO for the full EQR in 2014. This report presents an overall summary of the CCOs' readiness reviews, including common strengths and areas for improvement for the 2014 EQR.

In 2013, Acumentra Health also conducted an EQR of the one remaining MHO, Greater Oregon Behavioral Health, Inc. (GOBHI). This report includes a brief summary of those results, which were reported in detail to OHA in August 2013.

Compliance: Delegation Process Review

The CCOs are responsible for managing integrated health services for OHP enrollees. Although CCOs may delegate a majority of activities, the CCOs are ultimately responsible for all duties included in their contracts with OHA and must ensure that all their delegates and subcontractors meet requirements.

This delegation process review was based on §438.230 of the Code of Federal Regulations (CFR) on sub-contractual relationships and delegation. Acumentra Health reviewed relevant documentation and interviewed the CCOs' staff and some delegates. Acumentra Health also looked at the CCOs' organizational structures to identify the segments of the organizations responsible for various activities. The organizational structure of the CCOs varied widely. Some were formed from existing managed care organizations—physical and behavioral health—that previously contracted with the state. Other CCOs are new organizations, while some formed as a new part of an existing organization, and others are existing organizations doing business as a CCO.

Overall results

In individual CCO reports, Acumentra Health identified strengths and areas for improvement. At the time of the reviews, many organizations were still transitioning to the CCO model and developing integrated processes, such as

incorporating behavioral and dental health into policies. Below are some of the most common areas for improvement based on the 2013 reviews:

- Many CCOs had not updated materials with their current CCO name; for example, a policy or delegation agreement still contained the name of a parent organization or partner, not the CCO name.
- Many CCOs had not conducted pre-delegation assessments of subcontracting organizations at the time of their reviews.
- Most CCOs' delegation agreements lacked specific monitoring expectations for subcontractors.
- Many CCOs did not fully define delegates' responsibilities related to reporting performance measures for which CCOs are responsible.

This report contains a brief summary of each CCO's structure and delegates and the common strengths and areas for improvement for each review section.

Performance Measure Validation: Information Systems Capabilities Assessment (ISCA) Readiness Review

The purpose of PMV is to determine whether the data used to calculate measures are complete and accurate and whether the calculation adheres to CMS specifications. In a typical EQR, Acumentra Health would review code that the state used in calculating statewide performance measures annually. Every other year, Acumentra Health would conduct an ISCA of the state and CCO information systems. However, in 2013, OHA Health Analytics submitted no items for review; therefore, Acumentra Health could not report on these areas.

Acumentra Health did conduct high-level reviews of the CCOs' information systems to determine their readiness for the full ISCA in 2014. As a part of the PMV, the ISCA examines an organization's information systems, data processing, and reporting procedures to determine the extent to which they support the production of valid and reliable state performance measures and the capacity to manage the health care of their enrollees.

In accordance with Oregon's federal waiver agreement, OHA's Metrics and Scoring Committee selected multiple outcome and quality measures to gauge whether the CCOs are effectively improving care while making care accessible, eliminating disparities, and controlling costs. This report contains highlights of performance measures as reported by OHA in its quarterly reports to CMS.

Overall results

At the time of the reviews, many CCOs had separate reporting databases for physical and mental health data. The CCOs should continue planning toward implementing a single data source with both physical and behavioral health encounters to enable better reporting on integrated care.

The most common areas for improvement were

- integrating data systems so that physical and behavioral health services are handled with similar processes and procedures
- certifying encounter data submitted by delegates and other contracted agencies to the state
- updating out-of-date policies and procedures
- creating more user-friendly, CCO-specific provider directories that include practitioner-level detail for behavioral health providers as well as physical health
- creating or updating comprehensive CCO-specific business continuity/disaster recovery plans that address all CCO activities and are routinely tested
- reducing the volume of paper claims

Performance Improvement Projects (PIPs)

The purpose of PIPs is to assess areas of need and develop projects intended to improve health outcomes. The OHA contract requires CCOs to conduct PIPs that are “designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have favorable effect on health outcomes and OHP Member satisfaction.”

One of the required PIPs, on integrating primary care and behavioral health, is being conducted as a statewide collaborative initiated in 2013. This PIP focuses on diabetes monitoring for members with schizophrenia or bipolar disorder. Aumentra Health is facilitating the documentation of this PIP, while the CCOs select their own interventions.

In addition to the Statewide PIP, CCOs are required to select two additional PIPs as well as one focus project. The OHA Quality Improvement (QI) team provides ongoing assessment and support for the PIPs and focus areas and submits a quarterly progress report to CMS.

Acumentra Health provides ongoing technical assistance directly to CCOs for the Statewide PIP, and gives feedback to the OHA QI team for the CCO-specific PIPs and selected focus areas.

Since Acumentra Health did not validate any CCO PIPs in 2013, this report contains an update on the status of the Statewide PIP and a brief summary of the CCOs' status on other projects.

Highlights

The current Statewide PIP on the integration of primary care and behavioral health focuses on monitoring two elements of comprehensive diabetes care (HbA1c and LDL-C testing) for members who have been diagnosed with diabetes and either schizophrenia or bipolar disorder. All CCOs are participating in the Statewide PIP and are responsible for developing their own interventions.

Most CCOs have selected their interventions and are basing their intervention strategies in the behavioral health sectors of their organizations. A few of the CCOs had not yet finalized their improvement strategies due to the large size of their networks or because they had been focused on reconciling data discrepancies.

Overall Recommendations for OHA

Acumentra Health recommends that OHA

- clarify its definition of “delegation” with respect to CCOs’ oversight responsibilities
- provide more explicit guidance to the CCOs on delegation oversight, including expectations for monitoring
- encourage CCOs to better integrate their data processes so that physical and behavioral health services are handled with similar processes and procedures

For all managed care plans serving OHP members, OHA needs to

- clarify expectations for meeting requirements under federal and state regulations (including Oregon Administrative Rules and CFRs), specifically related to activities that cannot be delegated and oversight of delegated activities with various contractual arrangements

INTRODUCTION

The Balanced Budget Act of 1997 (BBA) requires an annual EQR in states that use a managed care approach to provide Medicaid services. Acumentra Health, as OHA's external quality review organization, presents this report to fulfill the requirements of 42 CFR §438.364.

Review Activities

BBA regulations specify three mandatory activities that the EQR must cover in a manner consistent with protocols established by CMS:

- a review every three years of health plan compliance with federal and state regulations and contract provisions regarding access to care, managed care structure and operation, quality measurement and improvement, and program integrity
- annual validation to determine accuracy of performance measures reported by health plans and their compliance with state requirements for calculation
- annual validation of PIPs required by the state

Since this was the first year of operation for the CCOs, Acumentra Health did not conduct the full set of EQR activities and did not assign scores or ratings to the CCOs. Instead, under OHA's direction, Acumentra Health reviewed CCOs' readiness for the 2014 EQR.

This report summarizes the results of the 2013 readiness reviews, which addressed the following questions:

1. Does the CCO monitor and oversee contracted providers in their performance of any delegated activities to ensure regulatory and contractual compliance?
2. Does the CCO have information systems and data processing and reporting procedures that support the production of valid and reliable state performance measures and the capacity to manage the health care of its enrollees?

This report also contains an update on the status of the Statewide PIP and a brief summary of the CCOs' status on other projects.

In 2014, Acumentra Health will review all CCOs for compliance with standards for Enrollee Rights, Grievances and Appeals, and Certification and Program Integrity; conduct performance measure-related activities, including full ISCA's; and review and score standards that the CCOs have completed for the Statewide PIP and

assign an overall PIP score. Acumentra Health will review and report on other PIPs, but will not score them.

In 2015, Acumentra Health will conduct the rest of the compliance review, covering Quality Assessment and Performance Improvement; review PIPs; and conduct performance measure-related activities, including following up on the 2014 ISCA.

Coordinated Care Organizations and Managed Care Organizations

Acumentra Health reviewed 15 CCOs in 2013. Table 1 lists the CCOs and their enrollment totals as of December 2013.

Table 1. CCOs – OHP Enrollment, December 2013.	
CCO	Total enrollees
AllCare Health Plan	27,878*
Cascade Health Alliance (CHA)	10,153**
Columbia Pacific Coordinated Care Organization (CPCCO)	14,413**
Eastern Oregon Coordinated Care Organization (EOCCO)	29,234**
FamilyCare, Inc.	50,064*
Health Share of Oregon	148,201**
Intercommunity Health Network Coordinated Care Organization (IHN-CCO)	32,728*
Jackson Care Connect (JCC)	18,539**
PacificSource Community Solutions (PSCCO)	36,667**
PrimaryHealth of Josephine County (PHJC)	5,957*
Trillium Community Health Plan	49,677**
Umpqua Health Alliance (UHA)	16,102**
Western Oregon Advanced Health, LLC (WOAH)	11,664*
Willamette Valley Community Health, LLC (WVCH)	63,944*
Yamhill County Care Organization (YCCO)	13,368**
Total	528,589

*Includes physical, dental, and mental health.

**Includes physical and mental health.

Source: State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by County and Medical Care Delivery System: 15 December 2013.

Beginning January 1, 2014, PacificSource Community Solutions – Columbia Gorge became a separate CCO, for a total of 16 CCOs at the time of this report. OHA also contracts with one MHO (GOBHI) and one managed care organization (CareOregon) to deliver care to OHP enrollees.

OHA's Quality Improvement Activities

OHA requires the CCOs to participate in a monthly quality and health outcomes committee (QHOC). Quality staff members from each CCO attend the meetings.

OHA created a Transformation Center to establish and coordinate a statewide learning collaborative, which has dedicated time at the monthly QHOC meetings. Since July 2013, monthly sessions have covered topics such as Prenatal Care and Developmental Screening, as well as Screening, Brief Intervention and Referral to Treatment (SBIRT).

The Transformation Center issues quarterly progress reports on the CCOs' performance on key performance measures (see page 11 for a summary of recent results).

Managed care quality strategy

42 CFR §438.202 requires each state Medicaid agency contracting with managed care organizations to develop and implement a written strategy for assessing and improving the quality of managed care services. The strategy must comply with provisions established by the U.S. Department of Health and Human Services.

OHA's quality strategy was completed in December 2012 and accepted by CMS prior to the approval of the 1115 Medicaid waiver. The waiver described Oregon's implementation of health system transformation:

- CCOs were established to deliver Medicaid services. The CCOs are encouraged to use Medicaid funds for flexible services.
- With a significant federal investment, the state intends to reduce per-capita medical expenditure trends by 2% by the second year of the waiver. If these savings are not realized, the state faces significant penalties.
- The CCOs must realize these savings without compromising quality as measured by a set of quality metrics. Financial incentives are available for CCOs that meet the performance benchmarks.
- The state will make available public information about the quality of care provided by CCOs to advance transparency and accountability.

- The CCOs are expected to incorporate community health workers and navigators into the health care delivery system.

The waiver includes a CCO Quality Strategy with performance goals for better care, including specific objectives under quality of care, access to care, experience of care, and better health.

Consumer surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

OHA is using CAHPS survey results for two CCO incentive measures: access to care and satisfaction with care.

CAHPS data are also used for statewide measures on tobacco use and member health status.

Mental Health Services Surveys

In 2013, Acumentra Health conducted the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey for Adults, the Youth Services Survey for Families (YSS-F), and the Youth Services Survey (YSS) on behalf of OHA's Addictions and Mental Health Division (AMH).¹ AMH added questions to each survey to collect additional data to help evaluate the progress of ongoing programs. Survey participants had the option to complete the survey online or on paper.

Survey for adults in outpatient and residential services

Acumentra Health distributed a survey to adults who had received outpatient services through OHP managed care and adults in residential treatment programs or foster care. Acumentra Health mailed surveys to 13,706 adults who had received mental health services during July–December 2012, including 11,925 adults receiving outpatient services and 1,781 adults in either residential or foster care. In all, 2,800 adults returned surveys, for a response rate of 23.3%.²

¹ MHSIP is supported by the Substance Abuse & Mental Health Services Administration of the U.S. Department of Health and Human Services. The YSS-F is endorsed by the National Association of State Mental Health Program Directors. For more information, see the MHSIP website at www.mhsip.org.

² Acumentra Health. 2013 Oregon Mental Health Statistics Improvement Project Survey for Adults–Outpatient and Residential. December 2013.

The surveys probed issues related to services within seven domains (as defined by MHSIP): general satisfaction, access to services, service quality, daily functioning, social connectedness, treatment participation, and treatment outcomes. Satisfaction decreased in most performance domains for the second year in a row, with scores in five of the seven domains decreasing to their lowest level in five years.

YSS-F and YSS Results

The YSS-F instrument asked questions related to caregivers' perception of services delivered in seven performance domains: access to services, appropriateness of services, cultural sensitivity, daily functioning, family participation in treatment, social connectedness, and treatment outcomes. The YSS-F had an overall response rate of 17.3%, with 1,856 responses from 10,739 caregivers with valid addresses.³

The YSS surveyed young people aged 14 to 18 years about their perceptions of services they received during the same period. The YSS, like the YSS-F, included a cluster of questions designed to assess the young people's perceptions of various aspects of access, appropriateness, cultural sensitivity, participation, and outcomes. The YSS also asked young people about where they had lived in the past six months, school absences, utilization of health care services, medication for emotional/behavioral problems, and arrest history. The YSS received 764 responses from 3,709 young people with valid addresses, for a response rate of 20.6%, up from the 17.9% response rate in 2012.

Overall, domain scores have remained relatively stable over the past six years. Cultural sensitivity and social connectedness received the highest positive responses, consistent with previous years' findings.

CCO Activities Related to Quality, Timeliness, and Access

CMS requires annual EQR reports to assess the strengths and weaknesses of managed care organizations with respect to quality, timeliness, and access to health care services.⁴ Since 2013 was the first full year of operation for the CCOs and Acentra Health conducted readiness reviews rather than a standard EQR, there was limited information on which to base conclusions about access, quality, and timeliness of care. Acentra Health reviewed the information from OHA's

³ Acentra Health. 2013 Oregon Youth Services Survey for Families, and Youth Services Survey Report. January 2014.

⁴ Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS). An Introduction to the External Quality Review (EQR) Protocols. Version 1.0. September 2012.

quarterly reports and other sources to develop the following observations about care delivery in Oregon.

Performance measures

Several of the statewide CCO incentive measures address quality of care and/or access and timeliness.

In the Health System Transformation quarterly report issued in February 2014, OHA reported results from the first nine months of 2013 compared to the baseline 2011 data.⁵ Highlights included:

- Emergency department (ED) visits: 13% decrease in from 2011
- Decreased hospitalizations for
 - congestive heart failure decreased by 32%
 - chronic obstructive pulmonary disease (COPD) decreased by 36%
 - adult asthma decreased by 18%
- Doubling of electronic health record (EHR) adoption from 28% in 2011 to 58% in September 2013
- Early developmental screenings (first 36 months) increased from 21% in 2011 to 32% in the first nine months of 2013
- Spending on primary care increased by 18%

Patient-Centered Primary Care Homes (PCPCHs)

PCPCHs are an important part of Oregon’s health system transformation, and are included in the CCO performance measures and focus projects. According to Oregon Health Policy and Research’s PCPCH web page, “Patient-Centered Primary Care Homes are clinics that have been recognized for their commitment to quality, coordinated care.”⁶

OHA identified 425 PCPCHs statewide in September 2013.⁷ An evaluation of PCPCH implementation in 2012 and 2013 found that over 80% of recognized

⁵ Oregon Health Authority. *Oregon’s Health System Transformation Quarterly Progress Report*. February 2014. Available at: <http://www.oregon.gov/oha/Metrics/Documents/report-february-2014.pdf>.

⁶ OHA, Oregon Health Policy and Research. Patient-Centered Primary Care Home Program. <http://www.oregon.gov/oha/OHPR/pages/healthreform/pcpch/index.aspx>.

⁷ OHA, Division of Medical Assistance Programs. *Oregon Health Plan, Section 1115 Quarterly Report*. Federal Fiscal Year 2013, Quarter 4.

PCPCHs offered at least one new service as a result of implementing the PCPCH model.

The focus of the PCPCH enrollment measure is “improving primary care for all populations; ensuring appropriate care is delivered in appropriate settings; and improving access to effective and timely care.” According to OHA’s quarterly report released in February 2014, there was a 51% increase in PCPCH enrollment in since the 2012 baseline.⁸

Statewide PIP

All CCOs are participating in the Statewide PIP—integration of primary care and behavioral health focused on monitoring two elements of comprehensive diabetes care (HbA1c and LDL-C testing) for members who have been diagnosed with diabetes and either schizophrenia or bipolar disorder. CCOs have begun selecting and implementing their interventions (see pages 33–37 for more detail).

Other CCO PIPs and Focus Projects

CCOs are required to conduct two additional PIPs and a focus project on topics in certain areas (see pages 38–40 for more detail). These projects relate to access, quality, and timeliness of care for different members, including:

- improving timeliness of prenatal care and behavioral health screening
- improving perinatal and maternity care
- reducing preventable rehospitalizations

In addition, five CCOs are conducting focus projects related to PCPCHs.

⁸ Oregon Health Authority. *Oregon’s Health System Transformation Quarterly Progress Report*. February 2014. Available at: <http://www.oregon.gov/oha/Metrics/Documents/report-february-2014.pdf>.

COMPLIANCE: DELEGATION PROCESS REVIEW

The EQR includes reviews of health plan compliance with federal and state regulations and contract provisions regarding access to care, managed care structure and operation, quality measurement and improvement, and program integrity. Since 2013 was the first full year of operation for the CCOs, a full EQR was not conducted; instead, OHA directed Acumentra Health to conduct readiness reviews of the CCOs to evaluate their capacity to meet federal requirements. In 2014, Acumentra Health will review all CCOs for compliance with standards for Enrollee Rights, Grievances and Appeals, and Certification and Program Integrity, and will review the remaining compliance standards in 2015.

Review Process

OHA contracts with the CCOs to provide integrated services through the expertise of delegates, including fully capitated health plans, MHOs, community mental health programs, and others. The CCOs must ensure that all their delegated entities and subcontractors meet requirements.

During 2013, Acumentra Health reviewed the CCOs' delegation processes to assess their abilities to oversee delegated entities in preparation for future compliance reviews. Acumentra Health reviewed relevant documentation and interviewed the CCOs' staff, partners, and delegated entities.

The delegation process review was based on 42 CFR §438.230 on Sub-Contractual Relationships and Delegation. Each organization was asked to submit documentation regarding its

- policies and procedures related to delegation
- process for assessing whether potential delegates had the ability to perform the function(s) the CCO wanted
- written agreements with delegates
- performance criteria
- monitoring of delegates
- ability to take action to correct performance deficiencies

Each CCO also completed a delegation matrix that identified which activities were delegated to which organization, and whether

- a pre-delegation assessment was conducted
- written agreements were in place

- performance criteria were identified
- a monitoring plan was in place

CCO Structure

Acumentra Health also looked at the CCOs' organizational structures to identify the segments of the organizations responsible for various activities. Some CCOs were formed as new organizations, some were formed by existing managed care organizations joining together, and others as the Medicaid line-of-business of larger organizations. Some examples include:

- wholly-owned subsidiaries of larger organizations
- limited liability corporations
- other organizations doing business as the CCO
- organized using infrastructure of an independent provider association or other entity that previously contracted with the Division of Medical Assistance Programs (now MAP) to provide managed care
- a previous MHO became partner in a new CCO, bringing a panel of behavioral health providers to the CCO; in other cases, the CCOs contracted directly with behavioral providers, and the MHOs ceased to exist

Many CCOs do not have employees, but have staff on loan or leased from the partners or parent organizations to perform the required functions.

Some CCOs have multiple partners, some risk-sharing; however, the risk-sharing relationship of the partners was beyond the scope of the delegation process review.

Table 2 lists the 15 CCOs reviewed in 2013, summarizes their organization, and lists their partners and delegates.

Table 2. Summary of CCO Structure, Partners, and Delegates.

CCO	Description - Partners	Delegated Functions
AllCare Health Plan CCO	<p>Mid Rogue Independent Physician Association, Inc., (MRIPA) is doing business as (dba) AllCare Health Plan. The parent company, Mid Rogue IPA Holding Company, Inc. oversees operations and management. The holding company is a for-profit organization and holds the financial risk for AllCare. AllCare has a management agreement with Mid Rogue Management Services Organization, LLC.</p> <p>Service area: all of Curry, Josephine, and Jackson counties and the southern part of Douglas County.</p>	<p>AllCare Health Plan CCO delegates</p> <ul style="list-style-type: none"> • mental health services to Jackson County Mental Health, Curry County Community Health, and Options for Southern Oregon • addiction and drug recovery to OnTrack and opioid treatment services to Allied Health Services • pharmacy benefit management to MedImpact • dental services to Capitol Dental Care, Willamette Dental Group, and Moda Health • Mid Rogue Management Services Organization, LLC, delegates some credentialing functions in Jackson County to PrimeCare. • MRIPA delegates some data management services to PH Tech.
Cascade Health Alliance CCO (CHA)	<p>CHA is a wholly owned subsidiary of Cascade Comprehensive Care, LLC (CCC), and a local physician-owned organization. CHA has no employees. CHA has a lease agreement with the parent organization, CCC, to provide employees to perform the administrative and operational activities.</p> <p>Service area: parts of Klamath County.</p>	<ul style="list-style-type: none"> • CHA delegates pharmacy benefit management to MedImpact
Columbia Pacific CCO (CPCCO)	<p>Wholly owned subsidiary of CareOregon. CPCCO has management agreement with CareOregon to provide CCO support services (including administrative and risk-associated services).</p>	<p>CareOregon delegates</p> <ul style="list-style-type: none"> • behavioral health services to GOBHI • pharmacy services to Catamaran • disease management to Health Integrated

	Service area: all of Clatsop, Columbia, and Tillamook counties; parts of Coos and Douglas counties.	
Eastern Oregon Coordinated Care Organization (EOCCO)	<p>EOCCO was formed as an LLC comprised of a 50/50 partnership between Moda Health and GOBHI. The CCO has no employees.</p> <p>Service area: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler counties.</p>	<p>Moda Health delegates</p> <ul style="list-style-type: none"> • credentialing to seven provider groups • pharmacy benefit management to MedImpact • specialty radiology to American Imaging Management <p>GOBHI delegates</p> <ul style="list-style-type: none"> • utilization management, including service authorizations, to community mental health programs, which are capitated and at risk for acute care costs • Information systems management to PH Tech
FamilyCare, Inc.	<p>Before becoming a CCO, FamilyCare was an integrated managed care organization with an established physical and mental health network.</p> <p>Service area: Clackamas, Multnomah, and Washington counties, and part of Marion County.</p>	<p>FamilyCare delegates</p> <ul style="list-style-type: none"> • pharmacy benefit management to CVS CareMark • claims administration and physical and behavioral health data administration to PH Tech <ul style="list-style-type: none"> ○ credentialing to Oregon Anesthesiology Group, Vision Care of Oregon, and Yakima Valley Farm Workers Clinic
Heath Share CCO	<p>All of Health Share’s CCO services are delivered through seven risk-accepting entities (RAEs). The RAEs subcontract with many providers including pharmacy benefit managers. All HealthShare CCO employees are leased employees of CareOregon.</p> <p>Service area: Clackamas, Multnomah, and Washington counties.</p>	<p>Health Share CCO delegates</p> <ul style="list-style-type: none"> • administrative functions such as customer service, human services finance, and IT to CareOregon • all other CCO services to the seven RAEs (Oregon, Inc.; Kaiser Permanente; Providence Health and Services; Tuality Healthcare, Clackamas County Health, Housing and Human Services Department; Multnomah County Health and Human Services Department; and Washington County Department of Health and Human Services)

<p>Intercommunity Health Network Coordinated Care Organization (IHN-CCO)</p>	<p>IHN-CCO is a wholly owned subsidiary of Samaritan Health Services. The CCO is managed by Samaritan Health Plan Operations (SHPO). All staff members are SHPO employees. IHN-CCO is a fully integrated Medicaid line of business within Samaritan Health Services.</p> <p>As of January 2014, all mental health services are provided by IHN.</p> <p>Service area: all of Benton, Lincoln, and Linn counties.</p>	<p>IHN-CCO delegates</p> <ul style="list-style-type: none"> • credentialing to four provider groups • pharmacy benefit management to Envision RX Options
<p>Jackson Care Connect (JCC)</p>	<p>Jackson County CCO, LLC is doing business as Jackson Care Connect.</p> <p>JCC is a wholly owned subsidiary of CareOregon. CareOregon performs administrative, medical management, and physical health risk-associated services through a management services/delegation agreement with JCC.</p> <p>Service area: Jackson County.</p>	<p>JCC delegates</p> <ul style="list-style-type: none"> • Behavioral health to Jackson County Mental Health • residential addiction and drug treatment services to GOBHI <p>JCC contracts with PrimeCare (IPA) to augment CareOregon’s Medford provider panel.</p> <p>CareOregon subcontracts with</p> <ul style="list-style-type: none"> • Catamaran for all pharmacy services • Health Integrated for disease management services
<p>PacificSource Community Solutions (PSCCO)</p>	<p>Joint management contracts with Central Oregon Health Council and Columbia Gorge Health Council give PSCCO fiscal responsibility as the CCO as well as the responsibility of overseeing various activities delegated to subcontractors.</p> <p>Service area: Hood River and Wasco counties.</p>	<p>PSCCO delegates</p> <ul style="list-style-type: none"> • behavioral health services to Mid-Columbia Behavioral Services and Central Oregon Health Board • medical healthcare services credentialing to Central Oregon IPA (COIPA) • data administration to PH Tech • pharmacy benefit management to CVS CareMark

<p>PrimaryHealth of Josephine County CCO (PHJC)</p>	<p>PHJC is solely owned by CareOregon LLC and has no employees. PHJC’s executive director is an employee of Grants Pass Management Services, dba Oregon Health Management Services (OHMS).</p> <p>PHJC has a delegation agreement with OHMS to perform the majority of health care operations and services described in the CCO contract.</p> <p>Service area: Josephine County and parts of Douglas and Jackson counties.</p>	<p>OHMS delegates</p> <ul style="list-style-type: none"> • mental health services to Options of Southern Oregon Mental Health • pharmacy benefit management to MedImpact
<p>Trillium Community Health Plan, Inc. (TCHP)</p>	<p>Owned by Agate Resources, Inc. TCHP and Independent Professional Services, LLC, lease staff from Agate Resources through an administrative services agreement.</p> <p>Service area: all of Lane County</p>	<p>TCHP delegates</p> <ul style="list-style-type: none"> • pharmacy services to Catamaran • Lane County provides behavioral health services as Trillium Behavioral Health
<p>Umpqua Health Alliance (UHA)</p>	<p>DCIPA LLC is doing business as Umpqua Health Alliance. Architrave Health, LLC, a holding company, is the parent company of DCIPA LLC. Mercy Medical Center and Douglas County Individual Practice Association (DCIPA) own Architrave Health, LLC.</p> <p>Service area: most of Douglas County.</p>	<p>UHA delegates</p> <ul style="list-style-type: none"> • pharmacy benefit management to MedImpact • substance abuse treatment services to Adapt (Oregon Treatment Network) • behavioral health services to GOBHI • third-party administrator customer service and claims processing to ABCT, Inc.
<p>Western Oregon Advanced Health (WOAH)</p>	<p>WOAH LLC is a solely owned subsidiary of Southwest Oregon Independent Practice Association (SWOIPA). SWOIPA is doing business as Doctors of the Oregon Coast South (DOCS).</p> <p>WOAH has assigned many administrative functions to SWOIPA, dba DOCS, through a service agreement. DOCS performs administration of all CCO activities for WOAH. DOCS is the employer of the CCO staff with the exception of the CEO.</p>	<p>WOAH delegates</p> <ul style="list-style-type: none"> • behavioral health services to Coos County Health and Human and Curry County Mental Health <ul style="list-style-type: none"> ○ pharmacy benefit management to MedImpact ○ residential addiction claims to Adapt

	<p>Service area: all of Coos and Curry counties</p>	
<p>Willamette Valley Community Health (WVCH)</p>	<p>Willamette Valley Community Health, LLC has no employees, and delegates all OHA-contracted activities. WVCH has multiple risk-sharing partners.</p> <p>Service area: Marion County and most of Polk County.</p>	<p>WVCH delegates</p> <ul style="list-style-type: none"> • administrative and operational functions to Willamette Valley Providers Health Authority, which contracts <ul style="list-style-type: none"> ○ behavioral health to Mid-Valley Behavioral Care Network (MVBCN) • pharmacy services to MedImpact
<p>Yamhill CCO (YCCO)</p>	<p>YCCO is a 501(c)(3) non-profit public benefit corporation. YCCO has no employees; YCCO's executive director and part-time administrative support staff member are employees of CareOregon. YCCO has a management services agreement with CareOregon to provide administrative and management support pertaining to CCO operations.</p> <p>Service area: Yamhill County and parts of Marion, Clackamas and Polk counties.</p>	<p>YCCO delegates adjudication of final appeals to CareOregon.</p> <ul style="list-style-type: none"> • CareOregon subdelegates pharmacy benefits management to Catamaran and disease management to Health Integrated. <p>MVBCN is delegated to perform behavioral health activities and CareOregon to perform physical health activities for:</p> <ul style="list-style-type: none"> • service authorizations • provider network management • utilization management • credentialing • claims management • QI

Summary of Review Results

Individual CCO reports summarized the status of each CCO’s delegated activities at the time of the review, and included strengths and recommendations for improvement intended to guide the CCOs through this transformative period and prepare them for the full compliance review in 2014–2015.

At the time of the reviews, many organizations were still transitioning to the CCO model and were still developing integrated processes, such as incorporating behavioral and dental health into policies. Aumentra Health found that many CCOs did not have current agreements detailing all delegated activities and responsibilities. Many lacked policies and procedures that established oversight of delegates, and most delegation agreements lacked specific monitoring expectations of subcontractors. Many CCOs had not conducted assessments before delegating to organizations, perhaps due in part to previous relationships that organizations had with delegates in their pre-CCO capacities.

Activities that cannot be delegated

Under contract with OHA, the CCOs may delegate a majority of activities to subcontractors and must oversee these activities to ensure proper and timely completion. Although the CCO may subcontract these activities to outside entities, the CCO is ultimately responsible for all duties included in its contract with OHA. The contract states in Exhibit B, Part 4, 10. Subcontract Requirements, a.(1):

“Subject to the provisions of this section, Contractor may subcontract any or all of the Work to be performed under this Contract. No Subcontract may terminate or limit Contractor’s legal responsibility to OHA for the timely and effective performance of Contractor’s duties and responsibilities under this Contract. Any and all Corrective Action, sanctions, recovery amounts and enforcement actions are solely the responsibility of the Contractor.”

Under the OHA contract, the CCOs may not subcontract the following activities:

- Oversight and monitoring of Quality Improvement activities (Exhibit B, Part 4, 10.a.(2))
- Adjudication of final Appeals in a Member Grievance and Appeal process (Exhibit B, Part 4, 10.a.(2))
- Certification of claims and encounter data (Exhibit B, Part 4, 11. d.; Exhibit B, Part 8, 7.c.(1)(2); and Exhibit B, Part 8, 7.e.); also see CFR §438.604 and §438.606

Table 3 shows the most common strengths and areas for improvement found in the 2013 delegation process review.

Table 3. Delegation Process Review Strengths and Areas for Improvement.

Policies and Procedures
<i>Strengths</i>
CCOs experienced with Medicare regulations and National Committee for Quality Assurance (NCQA) and URAC certifications had more robust policies/procedures defining delegation and the downstream roles and responsibilities.
<i>Areas for improvement and recommendations</i>
<p>Many CCOs had not updated their policies and procedures to reflect their new business names and business models, and many had not updated enrollee communications.</p> <ul style="list-style-type: none"> • CCOs need to ensure that all materials pertaining to CCO functions, including policies and procedures, clearly indicate that they apply to the CCO. • Communication to members should clearly be from the CCO. This includes notices of action or responses to grievances sent to members, and all communications sent to members on the CCO's behalf (such as communication by mental health agencies, addiction services, dental and physical providers). <p>Many CCOs delegated utilization management, credentialing, and quality management, but lacked policies/procedures or program descriptions defining the scope of the activities and performance expectations for the delegates.</p> <ul style="list-style-type: none"> • The CCOs' policies/procedures need to define the scope of key delegated activities to ensure they are being conducted properly and consistently in order to meet regulatory requirements as well as the goal of fully integrated care. The delegates need to understand their responsibilities. <p>All CCOs need to ensure that the credentialing policies/procedures include processes specific to all delegated activities, such as behavioral health and dental services, where differences apply.</p> <p>As they develop new policies/procedures, CCOs need to clarify terms, as needed, to ensure a clear understanding of delegated functions such as care coordination, special health care needs, case management, care management, medical management, and utilization management.</p>
Pre-Delegation Assessments
<i>Strengths</i>
Some CCOs with comprehensive pre-assessment evaluations modeled their tools from CMS, NCQA, and/or URAC.
<i>Areas for improvement and recommendations</i>
Many of the CCOs had not yet completed pre-delegation assessments of their delegates. Many CCOs reported that the short timeline for CCO operationalization limited their ability to perform a pre-assessment evaluation.

<ul style="list-style-type: none"> The CCOs should perform pre-delegation assessments to ensure that the prospective delegate has the ability to fully perform the work.
<p>Written Agreements</p>
<p>Strengths</p>
<p>Where applicable, all CCOs had management agreements with the parent organization defining the activities delegated to the parent.</p>
<p>Many CCOs had long-standing relationships with pharmacy benefit management companies and organizations providing disease management and credentialing services. Those written agreements pre-dated the advent of the CCOs.</p>
<p>Areas for improvement and recommendations</p>
<p>Some CCOs did not have delegation agreements for all delegated activities. As a result of the delegation reviews, the CCOs realized that additional delegation agreements were necessary.</p> <ul style="list-style-type: none"> CCOs need to have delegation agreements for all delegated activities.
<p>Some of the delegation agreements were written for organizations that now are doing business under different names.</p> <ul style="list-style-type: none"> The CCOs should update their delegation agreements to reflect current business names.
<p>Performance Expectations</p>
<p>Strengths</p>
<p>All CCOs developed comprehensive transformation plans to guide the development of an integrated health system. The plans have domains and serve as continuous QI programs. Each domain contains measurement and timelines.</p>
<p>Most CCOs with delegation agreements for pharmacy benefit management have well-defined performance expectations.</p>
<p>Areas for improvement and recommendations</p>
<p>Many of the CCOs' delegation agreements did not define each delegate's responsibilities related to individual performance measures. In some cases, the CCO referenced the entire CCO contract.</p> <ul style="list-style-type: none"> The CCOs' delegation agreements should more clearly define performance expectations for all delegated activities.
<p>Many CCOs need to continue to develop operational processes with delegates regarding the shared management of grievances and appeals to ensure regulatory requirements are met.</p>
<p>Many CCOs need to include language in their behavioral health contracts related to credentialing of non-medical staff.</p>

Monitoring
<i>Strengths</i>
Many CCOs have robust reporting schedules for the pharmacy benefit manager and some CCOs have developed and implemented a monitoring schedule for other delegated activities.
Some CCOs were beginning to have shared electronic systems, access to data pertaining to integrated health services, and could compile reports as needed.
<i>Areas for improvement and recommendations</i>
Many CCOs need to ensure that all delegates have processes to perform monthly monitoring for excluded providers, including subdelegates.
Most CCOs' delegation agreements lacked specific monitoring expectations for subcontractors. <ul style="list-style-type: none"> • CCOs need to ensure that their delegation agreements include monitoring expectations if the delegate subcontracts to another entity.
Many CCOs did not perform an annual evaluation of all delegated activities. <ul style="list-style-type: none"> • CCOs need to perform an annual evaluation of all delegated services and of each delegated entity.
Some CCOs' governing board bylaws and/or charters need to address how the CCO oversees activities that cannot be delegated to other entities (e.g., oversight and monitoring of QI activities and adjudication of final appeals in a grievance and appeal process). <ul style="list-style-type: none"> • CCO documents need to describe how the governing board oversees duties that cannot be delegated to other entities.
<i>Ability to require remedial efforts</i>
<i>Strengths</i>
Most CCOs provided examples of action taken when non-performance was identified and processes for corrective action up to and including de-delegation and/or contract termination.
<i>Areas for improvement and recommendations</i>
Many CCOs' service agreements and/or delegation agreements did not describe how delegation was established (pre-delegation assessment), or the reporting responsibilities and frequency of monitoring. <ul style="list-style-type: none"> • The CCOs should include in their service agreements and delegation agreements how delegation is established, reporting responsibilities, and monitoring. The description of the monitoring process should include an annual evaluation and how non-compliance or inadequate performance is addressed through corrective action, including revocation of the delegation.

Recommendations for OHA

Delegation

Acumentra Health found that CCOs had varying interpretations of what the state considers to be delegation.

- OHA needs to clarify its definition of “delegation” and provide more explicit guidance to the CCOs on delegation oversight and expectations for monitoring.
- OHA should provide guidance to CCOs in defining delegation in risk-bearing and partner relationships.

Quality management oversight

Acumentra Health found that many CCOs’ governing boards performed oversight of QI activities. In a few CCOs, oversight of QI activities was handled separately by each partner.

- OHA needs to provide guidance on its expectations regarding oversight of QI management programs, including whether the function should be integrated.

Adjudication of final appeals

The OHA contract requires the CCO to be the adjudicator of final appeals. During the delegation process review, it became apparent that the CCOs interpreted this requirement in multiple different ways. Some CCOs have partners and delegates with internal grievance systems. In some cases, an appeal could be resolved by a contractor or subcontractor.

- OHA needs to clarify whether all appeals must be conducted by the CCO.

Credentialing

- To increase efficiency, decrease administrative burden, and minimize duplication, OHA should work toward standardizing the credentialing process for health care providers; for example, through administrative simplification to allow CCOs that use the same providers or facilities to coordinate credentialing or accept another organization’s (such as URAC or NCQA) as adequate.

PERFORMANCE MEASURE VALIDATION: ISCA READINESS REVIEW

The purpose of performance measure validation (PMV) is to determine whether the data used to calculate each performance measure are complete and accurate and whether the calculation adheres to CMS specifications.

The only PMV-related activity that Acumentra Health conducted for OHA in 2013 was the ISCA readiness review. In a typical EQR, Acumentra Health would review code that the state used in calculating statewide performance measures annually. However, in 2013, OHA Health Analytics did not submit the information needed for PMV; therefore, Acumentra Health could not conduct this activity for OHA in 2013.

Performance Measures

As part of Oregon’s 1115 waiver agreement, 17 incentive measures were selected to gauge whether the CCOs are effectively improving care. CCOs will receive funds from the “quality pool” based on their performance in these measures and whether they meet state or national benchmarks or demonstrate improvement from their own baselines. The quality pool is designed to reward CCOs for value and outcomes rather than pay for service utilization. The 17 measures, selected by the Metrics and Scoring Committee, cover a variety of topics from depression screening to diabetes control.

CCO Incentive Measures:

- Alcohol and drug misuse: screening, brief intervention, and referral for treatment (SBIRT)
- Follow-up after hospitalization for mental illness
- Screening for depression and follow-up plan
- Mental and physical health assessment within 60 days for children in Department of Human Services custody
- Follow-up care for children prescribed ADHD medication
- Prenatal and postpartum care: timeliness of prenatal care
- Elective delivery before 39 weeks
- Ambulatory care: outpatient and emergency department utilization
- Colorectal cancer screening
- Developmental screening in the first 36 months of life

- Adolescent well-care visits
- Controlling high blood pressure
- Diabetes: HbA1c poor control
- PCPCH enrollment
- Access to care: getting care quickly
- Satisfaction with care: health plan information and customer service
- Electronic health record (EHR) adoption

There is also a variety of additional statewide performance measures, including measures related to hospital readmission, tobacco cessation, diabetes care, and well-child visits.

ISCA Readiness Reviews

As part of PMV, the ISCA examines an organization's information systems and data processing and reporting procedures to determine the extent to which they support the production of valid and reliable state performance measures and the capacity to manage the health care of the organization's enrollees.

In 2013, Acentra Health conducted ISCA readiness reviews of each CCO in preparation for the full ISCA in 2014. Acentra Health reviewed each CCO's documentation related to its information systems and conducted interviews with relevant staff members and the CCO's partners. Acentra Health summarized the CCO's IT infrastructure, including delegates, in individual reports. Acentra Health also identified strengths, areas for improvement, and corresponding recommendations in the eight ISCA review sections:

- Information Systems
- Hardware
- Security
- Administrative Data
- Enrollment Systems
- Ancillary Systems
- Provider Compensation Structure and Monitoring
- Electronic Health Records

The recommendations were intended to guide the CCOs through the transition period and prepare them for future reviews. Table 4 below includes the most common strengths, areas for improvement, and recommendations for the CCOs.

Table 4. ISCA Readiness Review Strengths and Areas for Improvement.

Information Systems
<i>Strengths</i>
All but two CCOs used version control software and processes.
Ten CCOs' physical health data warehouses were updated daily and the data were used for reporting purposes.
Twelve CCOs had staff or delegate to experienced staff and who used strong software development practices.
Seven CCOs received all encounter data submissions and verify the data prior to submitting to OHA.
<i>Areas for improvement/recommendations</i>
<p>Under contract with OHA, CCOs may not delegate certification of claims and encounter data (see Exhibit B–Part 4, 11.d; Exhibit B–Part 8, 7.c (1)(2); and Exhibit B–Part 8, 7.e).</p> <p>Only two CCOs ensured through a certification process the completeness, accuracy, and truthfulness of all data submitted to them by providers and had processes in place to verify all data prior to submission to OHA.</p> <p>Many CCOs were combining data from multiple sources and do not have a current process to validate the completeness and accuracy of data. Some CCOs had difficulty developing a process with meaningful verification and not just an automatic signature process.</p> <ul style="list-style-type: none"> • The CCOs need to develop both a certification process to ensure the completeness, accuracy, and truthfulness of all data submitted to them and a process to verify all data prior to submission to OHA.
<p>Since many CCOs were formed by combining multiple organizations, many CCOs are in varying stages of integrating their physical and behavioral health systems. In many cases, their information systems still operate as if the physical and behavioral health care sides are separate entities with little communication between them. Some CCOs were in a transition phase with plans to merge data systems, while other CCOs planned to maintain a decentralized approach, using separate systems and processes.</p> <ul style="list-style-type: none"> • CCOs need to better integrate their processes so that physical and behavioral health services are handled with similar processes and procedures.
CCOs without a single data source for reporting purposes tend to rely on OHA-supplied data for PM improvement strategies and some PIP projects. Several CCOs need to continue planning toward implementing a single data source with both physical and behavioral health encounters to enable better reporting on integrated care.
All CCOs need to clearly define roles and responsibilities for monitoring the quality, completeness, and accuracy of all health data. This is especially important for delegates, risk-sharing members, partners, subcontractors, and provider agencies.

Hardware
<i>Strengths</i>
The majority of CCOs performed backups daily and replicated the backups to off-site locations.
<i>Areas for improvement/recommendations</i>
Only eight CCOs had encryption policies for transporting and storage of protected health information. <ul style="list-style-type: none"> All CCOs need to develop encryption policies for transporting and storing protected health information.
Security
<i>Areas for improvement/recommendations</i>
Only seven CCOs had reviewed and updated their data security policies in the last two years.
The majority of the CCOs need to determine which IT policies and procedures should be under the CCOs and which can be delegated.
All CCOs need to develop and/or update their own business continuity/disaster recovery plans. <ul style="list-style-type: none"> The plans should address all CCO activities and be tested annually and updated when significant changes occur.
Administrative Data
<i>Strengths</i>
Fourteen CCOs encouraged providers to check Medicaid eligibility information on a per-service basis.
<i>Areas for improvement/recommendations</i>
All CCOs received paper claims for both behavioral and physical health, though the percent of paper claims varied widely among CCOs and claim types. <ul style="list-style-type: none"> The CCOs should identify ways to reduce the number of paper claims received.
Most CCOs need to consider conducting ongoing studies to validate samples of their encounters in order to assess the completeness and accuracy of encounter data. Many CCOs had established new relationships with providers. Encounter data validation would be a good mechanism to monitor training, data quality, and expectations.
Over half of the CCOs need to expand/develop their knowledge of behavioral and physical health services so they can effectively oversee and monitor data submissions and administrative activities. They also need to develop and implement plans to integrate mental and physical health data for a more concise quality-of-care picture.

Enrollment Systems
<i>Strengths</i>
Most CCOs are encouraging Medicaid eligibility checks on a per-service basis.
<i>No recommendations included in this report.</i>
Ancillary Systems
<i>Strengths</i>
The majority of the CCOs are continuing to work with their vendors to ensure that the CCOs receive appropriate data from the vendors for the CCOs reporting needs.
<i>No recommendations included in this report.</i>
Provider Compensation Structure and Monitoring
<i>Areas for improvement/recommendations</i>
All CCOs, by contract with OHA, must submit 90% of claims within 180 days to the state. To align with the contract, the CCOs should consider setting and monitoring requirements for their providers to ensure timely data submission.
All CCOs should develop a process to monitor providers for IT security, business continuity planning, and data submission trends.
All CCOs need to develop their own provider directories that include both physical and mental health providers, their specialties, languages spoken, and provider types.
Electronic Health Records
<i>Areas for improvement/recommendations</i>
Most CCOs need to develop and implement EHR policies and procedures which include the CCO's expectations for EHR implementation, plans for transition periods when data may not be available, and the CCO's role in EHR adoption.
The CCOs should consider monitoring data for quality, completeness and accuracy, during and after implementation of EHRs.
All CCOs should consider monitoring data for quality, completeness, and accuracy throughout EHR implementation, including a post-implementation review.

Recommendations for OHA

Certifying data

Many CCOs are combining encounter/claims data from multiple sources and do not have a current process to validate the completeness and accuracy of data. Some CCOs had difficulty developing a process with meaningful verification and not just an automatic signature process.

- OHA needs to work with the CCOs to ensure that the CCOs develop both a certification process to ensure the completeness, accuracy, and truthfulness of all data submitted to them by providers, and a process to verify all data prior to submission to OHA.

Integrating data

OHA needs to

- encourage the CCOs to better integrate their processes so that physical and behavioral health services are handled with similar processes and procedures
- encourage the CCOs to continue implementing a single data source with both physical and behavioral health encounters to enable better reporting on integrated care

Defining delegated activities and responsibilities

OHA needs to

- continue to work with the CCOs to ensure that they define all delegated activities, including roles and responsibilities for monitoring the quality, completeness, and accuracy of data (this should include monitoring provider agencies)
- encourage CCOs to develop a process for monitoring and setting requirements for their providers for timely data submission, IT security, and business continuity planning

Policies, procedures, and disaster recovery plans

OHA needs to

- ensure that all of the CCOs have encryption policies for transporting and storing all protected health information

- ensure that the CCOs review and update their own policies and procedures at least every two years, as well as their delegates' policies and procedures
- work with the CCOs to help them develop and update their own business continuity/disaster recovery plans, which should address all CCO activities and be tested annually and updated when significant changes occur

PERFORMANCE IMPROVEMENT PROJECTS

The purpose of PIPs is to assess areas of need and develop projects intended to improve health outcomes. The OHA contract requires CCOs to conduct PIPs that are “designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have favorable effect on health outcomes and OHP Member satisfaction.” The PIPs must focus on improving care in at least four of the following seven areas:

1. Reducing preventable rehospitalizations
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, and aligned federal and state programs
3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by “super-users”
4. Integrating primary care and behavioral health
5. Ensuring that 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 PCPCH model of care throughout the CCO network

One of the required PIPs addresses the integration of primary care and behavioral health and is being conducted as a statewide collaborative. In addition to the Statewide PIP, CCOs are required to select two additional PIPs and one focus project from the above list of seven areas.

Acumentra Health provides ongoing technical assistance directly to CCOs for the Statewide PIP, and gives feedback to the OHA QI team for the CCO-specific PIPs and selected focus areas. None of the PIPs were validated as part of the 2013 EQR.

PIP Scoring and Validation

In September 2012, CMS published a new version of its PIP validation protocol. Acumentra Health revised its PIP validation protocol to comply with the new CMS protocol and to incorporate feedback and address challenges from past PIP reviews. The 2012 CMS PIP protocol changed the order of some review standards and included a new requirement related to cultural competency and a new

emphasis on certain aspects of the study design. Table 5 lists the PIP standards and Appendix B contains Acumentra Health’s current scoring criteria.

Table 5. Standards for PIP Validation.	
Demonstrable improvement	
1	Selected study topic is relevant and prioritized
2	Study question is clearly defined
3	Study population is clearly defined and, if a sample is used, appropriate methodology is used
4	Study indicator is objective and measurable
5	Data collection process ensures valid and reliable data
6	Data are analyzed and results interpreted according to generally accepted methods
7	Reported improvement represents “real” change
8	Improvement strategy is designed to change performance based on the quality indicator
Sustained improvement	
9	CCO has analyzed and interpreted results for repeated remeasurement of the study indicator
10	CCO has sustained the documented improvement

In fall 2014, Acumentra Health will assign a score to each completed standard for the Statewide PIP and will calculate the overall score. Individual CCOs will be scored on their submissions for Standard 8 (Improvement Strategies).

PIP Activities

Statewide PIP

The current Statewide PIP on the integration of primary care and behavioral health, initiated in 2013, focuses on monitoring two elements of comprehensive diabetes care (HbA1c and LDL-C testing) for members who have been diagnosed with diabetes and either schizophrenia or bipolar disorder. All CCOs are participating in the Statewide PIP.

After discussions with CMS and CCO representatives, OHA determined that the Plan-Do-Study-Act (PDSA) model for rapid cycle improvement would be used for the Statewide PIP interventions. OHA offered CCOs the option of documenting their Statewide PIP interventions using an OHA-developed PDSA form or the Acumentra Health PIP review tool. All of the CCOs chose the PDSA format;

therefore, Acumentra Health revised the PDSA template to include the Standard 8 criteria.

Although there is a single topic for the Statewide PIP, the CCOs are responsible for developing their own interventions. To date, Acumentra Health has documented the first five standards and has begun documenting Standard 8 (Improvement Strategies), as most CCOs have selected and started the process of implementing their interventions. Documentation for Standards 6 and 7 will not begin until after the conclusion of the first remeasurement period on June 30, 2014. (Please see Appendix A for the current Statewide PIP Report.)

In June 2013, OHA provided baseline data on individual HbA1c and LDL-C tests and the study indicator (at least one HbA1c test and at least one LDL-C test) for each CCO. According to the data, many CCOs had good penetration rates for HbA1c, but lower rates for LDL-C testing. All CCOs had room for improvement regarding the study indicator, which is a composite score of both tests. Acumentra Health encouraged the CCOs to use the baseline data as a basis for further exploration of their individual study populations.

OHA requires that CCOs submit quarterly reports documenting their progress on the Statewide PIP. At the time of this report, each CCO had submitted two quarterly reports.

Table 6 shows a current list of improvement strategies by CCO.

Table 6. Improvement Strategies by CCO.		
CCO	Root Cause/Barriers	Improvement Strategies
AllCare	<ul style="list-style-type: none"> Behavioral health (BH) services that include medication and some social and rehabilitation services are isolated from physical health (PH) services Members may not feel as comfortable with PH providers as with BH providers 	<ul style="list-style-type: none"> Locate primary care provider (PCP) at outpatient BH office Establish PCPCH at outpatient BH office as a pilot Hire and use peer wellness specialist to assist
CHA	<ul style="list-style-type: none"> New CCO New BH provider agency No access to BH records from previous BH provider agency 	<ul style="list-style-type: none"> Incentive program for members to complete testing Health fair Use of non-emergent transport and traditional health workers to assist high-risk members

CPCCO	<ul style="list-style-type: none"> • No trends found in terms of PH provider assignment • Majority of members missing tests are engaged with BH services • Sharing gaps in service between PH and BH will be initial focus for improvement 	<ul style="list-style-type: none"> • Engage BH providers to assist with reinforcing importance of testing • Notify PH providers of members due or overdue for testing
EOCCO	<ul style="list-style-type: none"> • People with severe and persistent mental illness (SPMI) have cognitive barriers and need frequent reminders about disease management • Need to engage PH and BH providers and encourage them to talk with and coordinate care for SPMI members 	<ul style="list-style-type: none"> • RN case manager will contact PH providers to discuss members who have not completed labs • Licensed professional counselor will contact BH providers to inform them of project, discuss members who need tests, and care coordination expectations
FamilyCare CCO	<ul style="list-style-type: none"> • Majority of members missing tests have an assigned case manager • 3 BH provider agencies are assigned majority of members • 2 PH provider agencies are assigned majority of members • Cultural barriers – need for more frequent reminders to address the challenges for this population 	<ul style="list-style-type: none"> • Still in development • Collaborating with Health Share to put together a team of PH and BH providers
Health Share	<ul style="list-style-type: none"> • Very large CCO with considerable member churn • Discrepancies between local and state data • Members missing tests are spread across many PH providers, but fewer BH providers • Confusion about BH provider assignment 	<ul style="list-style-type: none"> • Still in development • Locus of intervention will be with BH providers
IHN CCO	<ul style="list-style-type: none"> • Clinic where members are missing tests has been identified; PIP will initially be focused at this clinic • Discrepancies between local and state data 	<ul style="list-style-type: none"> • Still in development; master list created • Reconciling data discrepancies

JCC	<ul style="list-style-type: none"> • No patterns identified among assignment of PH providers or disparities based on race or ethnicity • Majority of members missing tests are receiving BH services • Need to improve sharing of gaps in care for PH and BH 	<ul style="list-style-type: none"> • Engage BH providers and inform them of members who need testing and ask that they reinforce healthy behaviors • PH providers informed of members due or overdue for labs and medication adherence information
PSCCO	<ul style="list-style-type: none"> • Members don't return for LDL testing that requires fasting • BH providers do not know how to incorporate and bill for PH promotion 	<ul style="list-style-type: none"> • Educate PH providers about non-fasting LDL test • Educate BH providers about incorporating PH treatment goals into BH treatment plans and services, and bill appropriately
PHJC	<ul style="list-style-type: none"> • No consistent lab monitoring for members in the study population • Incomplete BH data • Discrepancies between local and state data 	<ul style="list-style-type: none"> • Continuing data analysis and barrier analysis around provider ordering and lab data entry/documentation
TCHP	<ul style="list-style-type: none"> • Discrepancies between local and state data • Difficulty contacting members of the study population • PH providers have limited ability to participate due to workload 	<ul style="list-style-type: none"> • Use community health workers to assist with diabetes management • Inform PH and BH providers of members in the study population • BH personnel will assist members with getting labs • Integration of care plans
UHA	<ul style="list-style-type: none"> • Lack of integration between PH and BH providers 	<ul style="list-style-type: none"> • Established extended care clinic where members can receive integrated PH and BH services in one location
WOAH	<ul style="list-style-type: none"> • Need to improve communication between PH and BH providers and members in the study population • Need to improve coordinated tracking of members in the study population 	<ul style="list-style-type: none"> • Bimonthly meetings between PH and BH case managers • Create list that is continually updated to track members in the study population: current PCP, BH prescriber, and labs received
WVCH	<ul style="list-style-type: none"> • Metabolic monitoring not occurring as planned for members in study population at BH clinics 	<ul style="list-style-type: none"> • PH providers informed of project • PH offices contacted for members not receiving BH services • Outreach strategy developed with

	<ul style="list-style-type: none"> No systems of outreach and support from PH or BH for members who do not complete tests as ordered 	<ul style="list-style-type: none"> BH providers for members who do receive BH services Engaged integrated federally qualified health center to assist
YCCO	<ul style="list-style-type: none"> Late-starting CCO with large number of chronically ill members Primary BH provider has been slow to incorporate metabolic monitoring for people taking psychotropic medications No previous care coordination system – development is underway 	<ul style="list-style-type: none"> PH providers informed of project and asked to encourage testing RN case manager contacted PH offices for members receiving BH services to discuss available services and challenges Planning to establish PH services at BH agency

Technical assistance

From the inception of the Statewide PIP, Acumentra Health has provided support and technical assistance to the CCOs. At monthly state QHOC meetings, Acumentra Health representatives have facilitated training sessions and assisted with coordinating communication between the CCOs. Training topics during QHOC meetings have included rapid cycle improvement using PDSA, monitoring improvement by using run charts, building an effective team, diabetes management of the SPMI population, overview of 2014 PIP Review Tool, and presentation of a sample Statewide PIP PDSA.

In September 2013, Acumentra Health contacted all CCOs to arrange meetings either in person or by telephone to provide technical assistance and support. A review of the quarterly reports revealed that CCOs are at different points in the process of developing and implementing interventions for this project due to variations in size, CCO structure, and presence or absence of existing integrated programs.

A majority of the CCOs have selected their interventions and are basing their intervention strategies in the behavioral health arena of their systems. A few CCOs have not yet finalized their improvement strategies due to the large size of their networks or because they have been focused on reconciling data discrepancies. Examples of the rationale behind the decision to house interventions in the behavioral health sector include:

- many CCOs had fewer behavioral health providers than physical health providers, making it easier to organize and establish in this sector

- enrollees in the study population are more likely to engage in a consistent way with the mental health system
- physical health providers have very limited time and resources available to assist with implementing the selected interventions

To date, Acumentra Health has met with representatives from 13 of the 15 CCOs at least once. Acumentra Health plans to continue to offer these individualized technical assistance meetings on a quarterly basis or by request in 2014.

CCO-specific PIPs and focus projects

Each CCO selected two additional PIPs and one focus project. The OHA QI team provides ongoing assessment and support regarding the PIPs and focus areas, and submits quarterly progress reports to CMS.

Table 7 lists the CCO PIPs and Table 8 the focus projects.

Table 7. CCO-Specific PIP Topics by CCO.	
CCO	PIPs
AllCare	<ul style="list-style-type: none"> • Increase percentage of referrals to community substance abuse treatment programs for expectant mothers • Increase percentage of members 50 years and older who are disabled or dual eligible with an advanced directive embedded in PCPCH EMR
CHA	<ul style="list-style-type: none"> • Promote single evidence-based guideline for the treatment of chronic obstructive pulmonary disease (COPD) • Improve access and quality of care for maternity and perinatal care
CPCCO	<ul style="list-style-type: none"> • Addressing population health issues: best practices in the treatment of chronic pain syndromes with opioids • Improving perinatal and maternity care: improve timeliness of prenatal care and behavioral health screening
EOCCO	<ul style="list-style-type: none"> • Improving maternity and child health outcomes • Increasing early childhood developmental screening, referral to treatment, and coordination of care
FamilyCare CCO	<ul style="list-style-type: none"> • Improving primary care: Well-child visits • Improving primary care: Colorectal screening
Health Share	<ul style="list-style-type: none"> • Deploying care teams to improve care and reduce utilization for high-utilizing members • Reducing preventable re-hospitalizations
IHN-CCO	<ul style="list-style-type: none"> • Reducing preventable re-hospitalizations • Improving initial screening and identification of members with

	cardiovascular risk factors
JCC	<ul style="list-style-type: none"> Improving timeliness of prenatal care and behavioral health screening (including screening for substance abuse and depression) Best practices in the treatment of chronic pain syndromes with opioids
PSCCO	<ul style="list-style-type: none"> Improving post-partum care Integrating chronic pain management into primary care
PHJC	<ul style="list-style-type: none"> Design and implement a local maternal medical home Design and implement community outreach program for members who are “super utilizers”
TCHP	<ul style="list-style-type: none"> Reducing preventable hospital readmissions Developing clinical guidelines for the screening and treatment of depression
UHA	<ul style="list-style-type: none"> Identifying addiction issues in pregnancy Decreasing emergency room utilization in the Douglas County Medicaid population
WOAH	<ul style="list-style-type: none"> Risk screening to reduce the number of inappropriate prescriptions for opioids Reducing the number of re-hospitalizations for members with congestive heart failure, pneumonia, and COPD
WVCH	<ul style="list-style-type: none"> Improving perinatal and maternity care Deploying care teams to improve care and reduce preventable or unnecessary utilization by “super users”
YCCO	<ul style="list-style-type: none"> Improving timeliness of prenatal care and behavioral health screening Increasing the number of PCPCH clinics and member assignment to PCPCH clinics; continuing development of current PCPCH clinics

Table 8. Focus Areas by CCO.

CCO	Focus Area
AllCare	<ul style="list-style-type: none"> • Increase the percentage of members with SPMI who receive a primary care visit
CHA	<ul style="list-style-type: none"> • Integration of dental, behavioral health, and substance use treatment in a single coordinated location (PCPCH)
CPCCO	<ul style="list-style-type: none"> • Increase rates of use of standardized developmental screening tool for children birth to 36 months
EOCCO	<ul style="list-style-type: none"> • Increase the percentage of children ages 0–6 years and their caregivers receiving needed mental health services
FamilyCare CCO	<ul style="list-style-type: none"> • Increase the percentage of practices rated PCPCH by tier
Health Share	<ul style="list-style-type: none"> • Increase surveillance and standardized developmental, social, and emotional screening for children birth to 3 years
IHN-CCO	<ul style="list-style-type: none"> • Improving perinatal and maternity care by screening all pregnant women and identifying those in need of additional assistance
JCC	<ul style="list-style-type: none"> • Implementing outreach team for members with high levels of ED and inpatient utilization
PSCCO	<ul style="list-style-type: none"> • Increase preventive care services for members diagnosed with SPMI
PHJC	<ul style="list-style-type: none"> • Design and implement an educational program to promote strategies for improved communication between PH providers and members with mental health conditions
TCHP	<ul style="list-style-type: none"> • Improving perinatal and maternity care
UHA	<ul style="list-style-type: none"> • Increase the number of local certified PCPCHs
WOAH	<ul style="list-style-type: none"> • Increase the number of CCO members with access to a PCPCH
WVCH	<ul style="list-style-type: none"> • Improving primary care through increased adoption of the PCPCH model
YCCO	<ul style="list-style-type: none"> • Increase the use of a standardized developmental screening tool for children birth to 36 months

Future Steps

In 2014, Acumentra Health will undertake the following activities:

1. Technical assistance meetings will continue to be offered to the CCOs on a quarterly basis or by request.
2. The first remeasurement period for the Statewide PIP will conclude on June 30, 2014. Data will be analyzed approximately 90 days later to allow time for submission and processing of relevant claims data.
3. Individual CCOs will be scored on their submissions for Standard 8 of the Statewide PIP in fall 2014. Acumentra Health will also assign a score to each completed standard for the Statewide PIP and calculate the overall score.
4. Presentations, trainings, and facilitated discussions related to PIP activities will continue to be made available at QHOC meetings or other venues by request.

Overall recommendations

Based on the quarterly reports submitted by CCOs and technical assistance meetings that have taken place to date, Acumentra Health recommends the following:

1. OHA should continue to encourage CCOs to participate in technical assistance meetings with Acumentra Health so that documentation issues, study modifications, and/or problems with data can be addressed in a timely manner.
2. OHA should continue to encourage CCOs to use and develop their own data sources.
3. CCOs should continue to work toward developing their own systems and processes for tracking their data for projects, including the Statewide PIP, thereby decreasing reliance on state-generated data.
4. CCOs should continue to adequately document their Statewide PIP activities in accordance with Standard 8 criteria provided by Acumentra Health.

2013 MENTAL HEALTH ORGANIZATION EQR SUMMARY

In 2013, Acumentra Health conducted a review of one MHO, Greater Oregon Behavioral Health, Inc. (GOBHI), which included a follow-up on the MHO's 2012 compliance review, PIP validation, and a full ISCA. This report summarizes the review results, which were reported in detail to OHA in August 2013.

Summary of 2013 GOBHI EQR

Results of compliance review follow-up

In 2012, Acumentra Health reviewed GOBHI for compliance with federal and state regulations and contract provisions regarding access to care, managed care structure and operation, quality measurement and improvement, and program integrity. Of the 10 compliance sections, GOBHI fully met the criteria for two, substantially met the criteria for four, partially met the criteria for three, and did not meet the criteria for one.

In 2013, Acumentra Health followed up with GOBHI regarding the 2012 findings and found that GOBHI had partially addressed the majority of those findings. The MHO fully resolved only two, and had not resolved nine of the findings.

PIP validation

Acumentra Health reviewed two PIPs conducted by GOBHI: a nonclinical PIP, Mental Health First Aid, and a clinical PIP, Early Childhood Assessment and Intervention Training.

The new nonclinical PIP aimed to increase the percentage of children (ages 6–18 years) accessing mental health services by offering Mental Health First Aid workshops to school staff, teachers, and police officers in Gilliam County. This PIP received an overall score of 41, Partially Met, on a 90-point scale. The MHO fully met one, substantially met two, minimally met two, and did not meet three of the eight standards reviewed (the MHO addressed Standards 1–5.)

The clinical PIP, in its third year, aimed to increase services for members age 5 and younger by training clinicians to recognize emotional and behavioral disturbances in young children. The overall score for this PIP was 100, Fully Met, on a 100-point scale. The MHO fully met nine and substantially met one of the 10 standards reviewed.

ISCA results

During the review year (2012), GOBHI began outsourcing claims processing, encounter verification and data submission, enrollee eligibility verification, and payments to capitated providers to PH Tech. The ISCA found that GOBHI needed to develop and implement safeguards and oversight measures to ensure proper oversight and performance monitoring of PH Tech.

GOBHI partially met standards related to data processing procedures and personnel to support the production of state performance measures. The MHO also partially met data acquisition capabilities standards to ensure the validity and timeliness of encounter and claims data.

DISCUSSION AND RECOMMENDATIONS

The past year was a transformative one in Oregon health care with the transition to CCOs. The areas for improvement that Acentra Health identified in the 2013 CCO reports were written with the requirements of future EQR reviews in mind, as well as the goals of long-term improvement and the state's triple aim.

Overall Recommendations for OHA

Delegation

According to the contract with OHA, the CCOs may delegate most activities, except for the following: oversight and monitoring of quality improvement activities, adjudication of final appeals in a member grievance and appeal process, and certification of claims and encounter data. In the delegation reviews, Acentra Health found that CCOs had varying interpretations about what the state considers to be delegation and what is not.

OHA needs to

- clarify what it considers to be delegation
- provide further guidance to the CCOs delegation oversight, including expectations for monitoring
- more clearly define the contract language pertaining to adjudication of final appeals

Certification of encounter data

Many CCOs are combining data from multiple sources and do not have a current process to validate the completeness and accuracy of data. Some CCOs had difficulty developing a process that included meaningful verification and not just an automatic signature process.

- OHA needs to work with the CCOs to ensure that the CCOs develop both a certification process to ensure the completeness, accuracy, and truthfulness of all data submitted to them, and also a process to verify all data prior to submission to OHA.

Integration of data

Several of the CCOs should continue implementing a single data source with both physical and behavioral health encounters to enable better reporting on integrated care. CCOs that do not have a single data source for reporting purposes tend to rely on OHA-supplied data for PM improvement strategies and some PIP projects.

- OHA needs to encourage the CCOs to better integrate their processes so that physical and behavioral health services are handled with similar processes and procedures.

Review requirements

To ensure that all managed care plans serving OHP members understand their responsibilities regarding meeting requirements under federal and state regulations (including CFRs and Oregon Administrative Rules), OHA should

- clarify expectations for the plans
- ensure the MHO follows up on previous review results

APPENDIX A – STATEWIDE PIP

Report: Oregon Statewide Performance Improvement Project: Diabetes Monitoring for People with Diabetes and Schizophrenia or Bipolar Disorder

1. Study Topic

This statewide performance improvement project (PIP) addresses one of the seven quality improvement focus areas in the state Accountability Plan, related to “integrating primary care and behavioral health.” The potential benefits of adopting an integrated care model are multifold. In addition to increased opportunities to provide comprehensive care for both mental and physical health disorders that frequently co-occur, integrated care provides improved access to mental health services while simultaneously decreasing stigma and controlling costs.¹ Within the focus area of care integration, the selected topic for this PIP addresses monitoring diabetes care for individuals diagnosed with diabetes and schizophrenia or bipolar disorder. This topic will promote integration of physical and mental health services, and improve continuity and quality of care for a high-risk population.

Diabetes mellitus (diabetes) is recognized as a leading cause of death and disability in the United States.² Serious complications include heart disease and stroke, high blood pressure, blindness and severe vision loss, kidney disease, nervous system disease (neuropathy), and lower-limb amputation. The American Diabetes Association has calculated that medical costs are 2.3 times higher for individuals with diabetes than they would be without diabetes.

Increased prevalence of diabetes and cardiovascular disease has been documented among individuals with severe mental illness, primarily with diagnoses of schizophrenia or bipolar disorder, due to metabolic syndrome conditions associated with the use of antipsychotic medications.³ A National Quality Forum quality

¹ Collins C, Levis Hewson D, Munger R, and Wade T, Milbank Memorial Fund. *Evolving Models of Behavioral Health Integration in Primary Care*. 2010. Available online: <http://www.milbank.org/uploads/documents/10430EvolvingCare/10430EvolvingCare.html>

² American Diabetes Association. *Diabetes Statistics*. Jan. 26, 2011. Available online (Feb. 12, 2013): www.diabetes.org/diabetes-basics/diabetes-statistics/?loc=DropDownDB-stats

³ Cohen D, Stolk RP, Grobbee RD & Gispen-de Wied CC. Hyperglycemia and diabetes in patients with schizophrenia or schizoaffective disorders. *Diabetes Care*. 2006; 29(4): 786–791.

measure (NQF #1934)⁴, adopted from Healthcare Effectiveness Data and Information Set (HEDIS®)* 2013 indicators, focuses on “Diabetes monitoring for people with diabetes and schizophrenia” and measures testing rates for both HbA1c and LDL-C. Data summarized for the NQF measure, from 22 states in 2007, indicate a performance gap among Medicaid (fee-for-service). The percentage of individuals in the plans, with both diabetes and schizophrenia, who had both tests (HbA1c and LDL-C) ranged from a minimum of 9% to a maximum of 82% (median=62%; 75th percentile=68%). Moreover, in the Oregon Accountability Plan, low rates of HbA1c and LDL-C testing for individuals in the general population was identified as an area of concern by the Oregon Metrics and Scoring Committee. The committee was composed of representatives from CCOs and members at large, and used a public process to identify objective outcome and quality measures and benchmarks.

Topic Selection

Acumentra Health was directed by the Oregon Health Authority (OHA) to focus the Statewide PIP on the integration of physical and behavioral health. In order to align the PIP with existing CCO incentives, Acumentra Health composed a list of potential topics from the CCO incentive measures associated with integration. An additional topic combined a core measure for chronic illness (diabetes control) with a focus on individuals with serious and persistent mental illness (SPMI):

- Alcohol and drug misuse (Screening, Brief Intervention, and Referral to Treatment [SBIRT])
- Screening for clinical depression
- Follow-up after mental health hospitalization
- Physical and mental health assessment within 60 days for children in Department of Human Services custody
- Care for children prescribed attention deficit hyperactivity disorder (ADHD) medications
- Diabetes management for SPMI population

⁴

National Quality Forum. Diabetes monitoring for people with diabetes and schizophrenia (NQF #1934). Jan. 25, 2013. Available online (Feb. 13, 2013): www.qualityforum.org/Search.aspx?keyword=1934

*HEDIS is a registered trademark of the National Committee for Quality Assurance.

Acumentra Health presented the options to CCO representatives gathered at a PIP training sponsored by OHA on January 17, 2013. Discussion with the CCOs eliminated four of the options and added one, resulting in a revised list with three options:

- Diabetes management for the SPMI population
- Screening for clinical depression
- SPMI engagement in Patient-Centered Primary Care Home

Following the training, Acumentra Health emailed a prioritization matrix and instructions to each CCO. The e-mail asked CCOs to rank the three choices, along with any other option they might want to add, after discussions with stakeholders. During the January 2013 training, Acumentra Health underscored the importance of including enrollees in the PIP topic selection and prioritization process, but did not require CCOs to document stakeholder input in their forms.

According to the survey, a majority of CCOs favored the topic of diabetes and the SPMI population. OHA preferred this topic over the others as it was the most likely to engage CCOs and promote integration.

In order to better inform further discussion on the PIP topic, Acumentra Health analyzed comorbidity data provided by OHA to estimate the size of the study population for each CCO (Attachment E). This information was presented to the Quality and Health Outcomes Committee (QHOC) on February 11, 2013. The CCO data for the target population demonstrated that several of the smaller CCOs had few members with co-occurring diagnoses of schizophrenia or bipolar disorder and diabetes. In response to concerns, OHA stated that it had decided to aggregate population data for a statewide total to measure overall improvement in the study indicator. After much discussion, the CCOs chose the topic of diabetes management in the SPMI population as the Statewide PIP and defined the study population (Standard 3) and indicator (Standard 4).

CCOs identified several reasons that support the decision to focus interventions on individuals diagnosed with diabetes and severe mental illness. First, data showing the high prevalence of co-occurring diagnoses of diabetes and severe mental illness support the selection of the topic. Second, there has been increased concern at a local and national level related to improving the quality of care provided for this population. Finally, developing improvement strategies related to monitoring individuals with these diagnoses can serve as an ideal vehicle for working toward adopting an integrated care model.

CCOs were given the option of declining participation in the Statewide PIP and developing their own PIP around the topic of integration of primary care and

behavioral health. As of the time of this report, all CCOs had chosen to participate in the Statewide PIP.

CCOs are required by contract with OHA to improve coordination of care for enrollees with SPMI. This Statewide PIP, focusing on enrollees with co-occurring diagnoses of diabetes and schizophrenia or bipolar disorder, aligns with one of the primary objectives of Oregon’s health system redesign.

Acumentra Health will coordinate the project with participating CCOs and provide technical assistance. OHA will provide data for the indicator. CCOs will develop interventions that are relevant to local community needs.

Acumentra Health developed options for defining the study population and indicator for the topic in preparation for a meeting with the CCOs at a Quality and Health Outcomes Committee (QHOC) meeting on February 11, 2013. Discussion with representatives from the CCOs and OHA resulted in the definitions below:

- SPMI = individuals diagnosed with schizophrenia or bipolar disorder
- Study population = individuals with co-occurring SPMI and diabetes
- Indicator measures = HbA1c and LDL-C tests

2. Study Question

All participating CCOs will operate with the same topic, indicators, and objectives, but may have different interventions. Consequently, the definition of the intervention in the study question is left open.

Study question: Will local integrated care interventions by CCOs increase the percentage of individuals with co-occurring diagnoses of diabetes and schizophrenia or bipolar disorder who receive both: at least one or more HbA1c test and at least one or more LDL-C test during the measurement year?

3. Denominator (Study Population) Data Collection

The target population for this PIP is Medicaid and Children’s Health Insurance Program (CHIP) enrollees with co-occurring diabetes and schizophrenia or bipolar disorder.

Denominator Inclusion Criteria

- Medicaid/CHIP-enrolled
- Continuous enrollment

- Adults: age 18–75 years at final day of the measurement year
- Diagnosis of diabetes
- Diagnosis of schizophrenia or bipolar disorder

Key element denominator definitions:

- *OHP enrollment* – Enrolled in Medicaid/CHIP at the time of service. The study population includes enrollees with dual eligibility in Medicaid and Medicare and enrollees in CHIP who meet the rest of the study criteria. The baseline study population is not mutually exclusive between CCOs because baseline data were pulled before the establishment of the CCOs. CCO membership is attributed by any enrollment during 7/1/11-6/30/12 in predecessor plans and certain enrollable fee-for-service clients based on residential zip code. OHA will calculate the number of duplicates in the baseline list in order to provide an aggregate baseline for the state.
- *Continuous enrollment* – The HEDIS specifications define enrollment as continuous enrollment with only one enrollment gap allowed of no more than 45 days during the measurement year. For the baseline, this enrollment definition was applied to OHP (Medicaid and CHIP) members overall without regard to fee-for-service or plan enrollment. It is planned that when calculating the re-measurement, this enrollment definition will be applied to the individual CCOs. For the purposes of the intervention only, OHA will provide the CCOs with a list quarterly of members for which continuous enrollment is not required to maximize the number of members included in the intervention.
- *Adults* – The HEDIS measure on diabetes monitoring for people with diabetes and schizophrenia defines adults as “18-64 years as of December 31 of the measurement year.” CHIP enrollees are included in the definition because the program “serves uninsured children up to age 19.”⁵ The HEDIS measure that addresses diabetes care for the general population defines age as “18-75 years as of December 31 of the measurement year.” At the February 11, 2013, QHOC meeting, OHA and CCO representatives expressed an interest in the expanded age range (18-75 years). An expanded age range might result in a slight increase in the study population, which could benefit smaller CCOs. The final decision by OHA and the CCOs was

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Center for Medicaid and CHIP Services. CHIP Eligibility Standards. Available at: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Eligibility-Standards-.html>

to define “adult” as enrollees ages 18-75 years as of December 31 of the measurement year.

- *Diagnosis of diabetes* – Diabetes will be defined using HEDIS specifications:

“There are two ways to identify members with diabetes: by pharmacy data and by claim/encounter data. The organization must use both methods to identify the eligible population, but a member need only be identified by one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table CDC-A).”

Claim/encounter data: Members who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes (Table CDC-B) or one face-to-face encounter in an acute inpatient or ED setting, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Refer to Table CDC-C for codes to identify visit type.”

The complete HEDIS specifications, including prescription, diagnosis, and visit type codes, are available in Attachment A.

- *Diagnosis of schizophrenia or bipolar disease:* Schizophrenia and bipolar disorder are defined according to HEDIS code specifications. Definitions for the event/diagnose and tables with the codes are in Attachment B. The HEDIS measure on diabetes monitoring includes people with a diagnosis of schizophrenia, but not bipolar disorder. Inclusion of individuals with bipolar disorder is supported by a recent study demonstrating that rates of Type 2 diabetes mellitus are three times higher in people with bipolar disorder than the general population. The researchers also noted that the increased morbidity and mortality in people with co-occurring bipolar disorder and diabetes may be partly due to a disparity in medical care.⁶

⁶ Calkin CV, Gardner DM, Ransom T, Alda M. The relationship between bipolar disorder and type 2 diabetes: more than just co-morbid disorders [Abstract]. *Ann Med.* 2013; 45(2):171-81. Available online (March 1, 2013): www.ncbi.nlm.nih.gov/pubmed/22621171

In addition, at the February 13, 2013 QHOC meeting, CCO representatives decided to define SPMI and the study population as people with either schizophrenia or bipolar disorder. Although the inclusion of individuals diagnosed with bipolar disorder in the study population differs from that which is specified in the HEDIS measure, we will be adhering to the majority of the HEDIS specifications for this PIP. Including individuals with bipolar disorder in the study population will increase the study populations for individual CCOs.

Denominator Exclusion Criteria

- Exclusion criteria follow the HEDIS exclusions specifications (see Attachment C).

The study population is expected to increase over the study period due to expansions in Medicaid eligibility planned during the health system transformation. Each of the CCOs will receive quarterly data reports from the State, which they can use to update their list of eligible enrollees and to compare against their own data for the purpose of reconciling any discrepancies.

This PIP will target the entire study population.

4. Study Indicator

Following the OHA goal of standardization and comparability for its Measurement Strategy performance measure, this PIP will adopt, as closely as possible, the indicator and indicator definitions from the HEDIS measure, “Diabetes monitoring for people with diabetes and schizophrenia.” The indicator definitions have been modified to better reflect conditions in the local environment. These modifications were discussed under Standard 3.

The study indicator will measure both of the recommended clinical tests that can be documented in state administrative data: HbA1c and LDL-C. The indicator definitions were discussed and approved by CCO representatives at the February 11, 2013 QHOC meeting.

Study Denominator: *OHP-enrolled adults with co-occurring diagnoses of diabetes and schizophrenia or bipolar disorder.*

Study Numerator: *Both: at least one or more HbA1c test and at least one or more LDL-C test during the measurement year.*

Target goals will be set by each of the CCOs as they will be conducting their own root cause analyses and implementing interventions designed to address the specific needs of their individual Medicaid populations.

Numerator Inclusion Criteria

An enrollee must receive both HbA1c and LDL-C tests to be included in the numerator:

- Hemoglobin A1c (HbA1c) test: HbA1c codes are the same as those specified by HEDIS (see Attachment D)
- LDL-C: LDL-C codes are the same as those specified by HEDIS (see Attachment D)

There are no exclusion criteria for the numerator.

5. Data Collection and Analysis Plan

Data Collection

As noted in Standard 4, this PIP will be collecting administrative data. At the state, data will be collected and aggregated by a data analyst to establish the baseline and to provide quarterly lists of client names to each of the CCOs. Quality management personnel at each of the CCOs are then responsible for reviewing the state data and comparing these data against their own data reports in order to reconcile any discrepancies. Each of the CCOs will maintain an ongoing list of enrollees eligible for inclusion in the study population that can be updated on a quarterly basis.

Data Verification and Validation

OHA uses the Medicaid Management Information System (MMIS) claims adjudication engine to process Medicaid encounters submitted by CCOs. Before submitting to the state, CCOs perform automated edits and validation checks to ensure completeness and correctness of submitted claims. OHA uses an encrypted system of web-based electronic mailboxes to receive Medicaid claims and encounter data. This system ensures that data transfers are consistent with HIPAA confidentiality provisions. The state has established formal processes to validate the completeness of encounter data. CMS encounter data specifications are not currently contractual requirements. While some Oregon Administrative Rules include requirements related to validation, they are not as specific and detailed as the CMS requirements.

Study Time Periods

- **Baseline Measurement:** July 1, 2011–June 30, 2012
- **Intervention:** Begin third quarter 2013
- **First Remeasurement:** July 1, 2013–June 30, 2014

The baseline measurement period has been determined by the availability of CCO encounter data. CCOs, OHA, and Acumentra Health selected the date range for the first remeasurement period based on the expected start date for intervention implementation. The data results will be tested for statistically significant improvement between baseline and remeasurement. A chi-square test is appropriate for the categorical data that will result from the indicators.

OHA will report PIP data to the CCOs and Acumentra Health on a quarterly basis. However, only the CCOs will receive the list of their members. In addition to study indicator data (both HbA1c and LDL-C tests), OHA will also report individual HbA1c and LDL-C testing rates.

OHA will apply the following criteria to quarterly data pulls:

- The HEDIS continuous enrollment criteria will not be applied.
- The most current “fifteenth of month” database is used to determine CCO membership. This list is mutually exclusive between CCOs.
- The initial quarterly report (5/3/13) pulled tests for a 21-month period (7/1/11–3/30/13). Subsequent quarterly reports will look for tests for one year preceding the last day of the quarter.
- Evidence of diabetes will be determined by looking back two years (HEDIS specifications) from the last day of the quarter.
- Evidence of schizophrenia or bipolar disorder will be determined by looking back one year (HEDIS specifications) from the last day of the quarter.

In addition to patient ID, OHA will also include the date of the most current HbA1c and LDL-C tests and the provider name and ID in the quarterly reports to CCOs.

Standard 6. Study Results

Table 1: Aggregated statewide results: Percentage of enrollees with co-occurring diagnoses of diabetes and schizophrenia or bipolar disorder who received both: at least one or more HbA1c test and at least one or more LDL-C test.

Study Indicator	Baseline*	First remeasurement
Numerator	1,373	
Denominator	2,084	
Calculated indicator	65.88%	

*Denominator contains an unduplicated count of clients (before they were assigned to CCOs).⁷

Baseline measurement results for the individual HbA1c and LDL-C tests as well as the study indicator (both: at least one or more HbA1c test and at least one or more LDL-C test during the measurement year) for each CCO are presented in Attachment F.

Individual CCOs analyzed their own baseline data according to a number of different factors (location; primary care provider assignment; assignment to mental health care provider; documentation of one, both or neither LDL-C, or HbA1c). After the first remeasurement, Acumentra Health will report on any high-level relevant descriptive analyses of the data.

Standard 7: Interpretation of Results

No changes have been made to the study design at the time of this report.

The following factors could threaten the internal or external validity of the study results:

- Discrepancies between data provided by the state and the individual CCO's data
- CCOs did not exist during the baseline measurement year
- Each CCO is responsible for developing and implementing its own intervention

⁷

Source: email from Susan Arbor, Research Analyst, OHA, 9/20/2013.

- CCOs are at varying levels of physical and behavioral health system integration

Standard 8: Improvement Strategies

After several discussions with the Centers for Medicare and Medicaid Services (CMS) and CCO representatives, OHA determined that the Plan-Do-Study-Act (PDSA) model for rapid cycle improvement would be used for the Statewide PIP interventions. In addition, OHA offered CCOs the option of documenting their Statewide PIP interventions using an OHA-developed PDSA form or the Acumentra Health PIP review tool. All of the CCOs elected to use the PDSA format; therefore, Acumentra Health revised the PDSA template to include the Standard 8 criteria.

To assist CCOs in their understanding and implementation of the PDSA methodology, Acumentra Health conducted presentations and led discussions on team building, the PDSA model, and run charts for quality improvement managers at monthly QHOC meetings. In addition to presentations, Acumentra Health also facilitated small group discussions at these meetings as a means of enhancing communication and support between CCOs as they developed their individual interventions.

In June 2013, OHA provided baseline data on individual HbA1c and LDL-C tests and the study indicator (at least one or more HbA1c test and at least one or more LDL-C test) for each CCO (Attachment F). According to the data, many CCOs had good penetration rates for HbA1c (and lower rates for LDL-C). However, all CCOs demonstrated room for improvement with regard to the study indicator. Acumentra Health encouraged the CCOs to use the baseline data as a basis for further exploration of their individual study populations.

OHA requires that CCOs submit quarterly reports documenting their progress on the Statewide PIP. At the time of this report, the CCOs had submitted two quarterly reports. Beginning in September 2013, Acumentra Health began meeting with individual CCOs to provide technical assistance and support. A review of the quarterly reports reveals that CCOs are at different points in the process of developing and implementing interventions for this project due to variations in size, CCO structure, and presence or absence of existing integrated programs. Acumentra Health intends to continue to offer these individualized technical assistance meetings on a quarterly basis or by request to the CCOs. The attached table (table still under construction) includes information on the current status of each CCO's progress.

From a high-level perspective, a majority of the CCOs have selected their interventions and are localizing their intervention strategies within the behavioral health arena of their organizational systems. A few of the CCOs reported that they have not yet finalized their improvement strategies due to the large size of their networks or because they have been focused on reconciling data discrepancies. Examples of the rationale behind the decision to house interventions in the behavioral health sector include having fewer mental health providers involved with the study population compared to physical health providers; enrollees in the study population are more likely to engage in a consistent way with the mental health system; and physical health providers have very limited time and resources available to assist with implementing the selected interventions.

Attachments

Excerpted from the NCQA HEDIS® 2013 Technical Specifications for Health Plans, Volume 2

Statewide PIP, Attachment A: Prescription, Diagnosis, and Visit Type Codes for Diabetes

Table CDC-A: Prescriptions to Identify Members With Diabetes (updated November 2, 2012)

SUMMARY OF CHANGES

- Added Linagliptin-metformin and Metformin-saxagliptin to *Antidiabetic combinations* row.
- Added Linagliptin to *Miscellaneous antidiabetic agents* row.

Description	Prescription
Alpha-glucosidase inhibitors	• Acarbose • Miglitol
Amylin analogs	• Pramlintide
Antidiabetic combinations	• Glimepiride-pioglitazone • Linagliptin-metformin • Metformin-saxagliptin • Glimepiride-rosiglitazone • Metformin-pioglitazone • Metformin-sitagliptin • Glipizide-metformin • Metformin-repaglinide • Sitagliptin-simvastatin • Glyburide-metformin • Metformin-rosiglitazone
Insulin	• Insulin aspart • Insulin isophane human • Insulin aspart-insulin aspart protamine • Insulin isophane-insulin regular • Insulin detemir • Insulin lispro • Insulin glargine • Insulin lispro-insulin lispro protamine • Insulin glulisine • Insulin regular human • Insulin inhalation • Insulin zinc human • Insulin isophane beef-pork
Meglitinides	• Nateglinide • Repaglinide
Miscellaneous antidiabetic agents	• Exenatide • Liraglutide • Sitagliptin • Linagliptin • Saxagliptin
Sulfonylureas	• Acetohexamide • Glimepiride • Glyburide • Tolbutamide • Chlorpropamide • Glipizide • Tolazamide
Thiazolidinediones	• Pioglitazone • Rosiglitazone

Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

NCQA posted a complete list of medications and NDC codes to www.ncqa.org on November 2, 2012.

Claim/encounter data. Members who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes (Table CDC-B), or one face-to-face encounter in an acute inpatient or ED setting, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Refer to Table CDC-C for codes to identify visit type.

Table CDC-B: Codes to Identify Diabetes

Description	ICD-9-CM Diagnosis
Diabetes	250, 357.2, 362.0, 366.41, 648.0

Excerpted from the NCQA HEDIS® 2013 Technical Specifications for Health Plans, Volume 2

Table CDC-C: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Excerpted from the NCQA HEDIS® 2013 Technical Specifications for Health Plans, Volume 2

Statewide PIP, Attachment B: Schizophrenia and Bipolar Disorder Codes

Members identified with schizophrenia or bipolar disorder are those who have met at least one of the following criteria during the measurement year.

- At least one acute inpatient claim/encounter (Table SSD-A) with any diagnosis of schizophrenia (Table SSD-B) or bipolar disorder (Table SSD-C).
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting (Table SSD-A), on different dates of service, with any diagnosis of schizophrenia (Table SSD-B).
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting (Table SSD-A), on different dates of service, with any diagnosis of bipolar disorder (Table SSD-C).

Table SSD-A: Codes to Identify Visit Type

Description	UB Revenue			
Acute inpatient	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987			
	CPT		POS	
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	WITH	21, 51	
Outpatient, intensive outpatient and partial hospitalization	CPT	HCPCS	UB Revenue	
	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485		0510, 0513, 0516, 0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983
	CPT		POS	
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72	
ED	CPT		UB Revenue	
	99281-99285		045x, 0981	
	CPT		POS	
	90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291	WITH	23	
Nonacute inpatient	CPT	HCPCS	UB Revenue	
	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	H0017-H0019, T2048		0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x, 1000, 1001, 1003-1005
	CPT		POS	
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291	WITH	31, 32, 56	

Excerpted from the NCQA HEDIS® 2013 Technical Specifications for Health Plans, Volume 2

Statewide PIP, Attachment B (continued)

Table SSD-B: Codes to Identify Schizophrenia

ICD-9-CM Diagnosis
295

Table SSD-C: Codes to Identify Bipolar Disorder

ICD-9-CM Diagnosis
296.0, 296.1, 296.4, 296.5, 296.6, 296.7

Excerpted from the NCQA HEDIS® 2013 Technical Specifications for Health Plans, Volume 2

Statewide PIP, Attachment C: Denominator Exclusion Criteria

- Members with a diagnosis of polycystic ovaries (Table CDC-O) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (Table CDC-B) during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member’s history, but must have occurred by December 31 of the measurement year. OHA looked back as far as 7/1/2002 for members with a diagnosis of polycystic ovaries.
- Members with gestational or steroid-induced diabetes (Table CDC-O) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (Table CDC-B) during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by December 31 of the measurement year.

Table CDC-O: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Polycystic ovaries	256.4
Steroid induced	249, 251.8, 962.0
Gestational diabetes	648.8

Excerpted from the NCQA HEDIS® 2013 Technical Specifications for Health Plans, Volume 2

Statewide PIP, Attachment D: Hemoglobin A1c and LDL-C Codes

At least one of the following must be performed in the measurement year.

Table CDC-D: Codes to Identify HbA1c Tests

CPT	CPT Category II	LOINC
83036, 83037	3044F, 3045F, 3046F	4548-4, 4549-2, 17856-6, 59261-8, 62388-4

Table CDC-H: Codes to Identify LDL-C Screening

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2

Statewide PIP Attachment E: Comorbidity of Schizophrenia–Bipolar Disorder and Diabetes by CCO, 2012.

Coordinated Care Organizations	Schizophrenia or Bipolar Count	Percent CCO Enrollees with Schizophrenia or Bipolar	Schizophrenia or Bipolar and Diabetes Count	Percent of Schizophrenia or Bipolar with Diabetes
Health Share of Oregon	6,321	4.0	1,242	19.6
Trillium Community Health Plan	2,332	4.7	328	14.1
Willamette Valley Community Health	2,023	3.4	399	19.7
Intercommunity Health	1,511	4.6	275	18.2
PacificSource Community Solutions	1,055	2.9	151	14.3
AllCare Health Plan	900	3.5	164	18.2
Eastern Oregon CCO	865	3.1	170	19.6
FamilyCare	775	1.9	92	11.9
Umpqua Health Alliance	770	4.7	144	18.7
Jackson Care Connect	619	3.4	84	13.6
Cascade Comprehensive Care	588	5.4	94	16.0
Western Oregon Advanced Health	439	3.7	95	21.6
Columbia Pacific CCO	362	2.6	62	17.2
Yamhill County CCO	274	2.0	29	10.6
PrimaryHealth Josephine County	231	4.0	45	19.4
Totals	19,065	3.6%	3,374	16.8%

Source: Compiled by Acumentra Health from Oregon Health Authority Health Analytics November 2012 documents.

Statewide PIP Attachment F: Statewide PIP – Baseline – CCO Members with Diabetes and Schizophrenia/Bipolar Disorder

HbA1C Test, LDL-C Screen and Composite Measures (derived from HEDIS)

CCO	Denominator	HbA1c Numerator	% HbA1c	LDL-C Numerator	% LDL-C	Composite	% Composite
AllCare Health Plan	82	67	81.71%	60	73.17%	56	68.29%
Cascade Comprehensive Care	66	48	72.73%	48	72.73%	41	62.12%
Columbia Pacific CCO	46	36	78.26%	37	80.43%	32	69.57%
Eastern Oregon CCO	46	42	91.30%	34	73.91%	33	71.74%
FamilyCare CCO	136	99	72.79%	94	69.12%	87	63.97%
Health Share of Oregon	841	662	78.72%	586	69.68%	550	65.40%
Intercommunity Health Network	151	127	84.11%	119	78.81%	112	74.17%
Jackson Care Connect	49	43	87.76%	32	65.31%	32	65.31%
PacificSource Community Solutions	77	64	83.12%	54	70.13%	50	64.94%
PrimaryHealth of Josephine County	30	23	76.67%	18	60.00%	17	56.67%
Trillium Community Health Plan	219	136	62.10%	116	52.97%	109	49.77%
Umpqua Health Alliance	67	57	85.07%	52	77.61%	47	70.15%
Western Oregon Advanced Health	41	37	90.24%	34	82.93%	32	78.05%
Willamette Valley Community Health	237	195	82.28%	201	84.81%	176	74.26%
Yamhill County CCO	49	40	81.63%	37	75.51%	33	67.35%

- Baseline lists are not mutually exclusive.
- Denominator Baseline: list of members is derived from predecessor plans and certain (enrollable) FFS clients determined by zip code.
- HEDIS continuous enrollment criteria applied to OHP overall.
- Numerator Baseline: credit for the numerator service (HbA1c test or LDL-C screen or composite) was given to the CCO if the member was enrolled in their predecessor plan (or specific zip codes for enrollable FFS clients) at the time of the test or screen.
- The member/client must receive both HbA1c test and LDL-C screen to be counted in the composite.
- Data source: DHS/DHS DSS warehouse: dateload: April 2013: OHA, Office of Health Analytics, H-PAM Unit.

APPENDIX B – PIP SCORING

This section contains Acumentra Health’s current PIP scoring ranges. Each standard has a potential score of 100 points. The scores for each standard are weighted and combined to determine an overall score. The maximum overall score is 85 points for Standards 1–8 and 100 points for Standards 1–10. The overall score corresponds to a compliance rating that ranges from Fully Met to Not Met.

Table B-1. PIP Scoring Ranges.			
Compliance rating	Description	100-point scale	85-point scale
Fully met	Meets or exceeds all requirements	80–100	68–85
Substantially met	Meets essential requirements, has minor deficiencies	60–79	51–67
Partially met	Meets essential requirements in most, but not all, areas	40–59	34–50
Minimally met	Marginally meets requirements	20–39	17–33
Not met	Does not meet essential requirements	0–19	0–16