Oregon Health Authority Managed Care

2014 External Quality Review Annual Report

February 2015

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Table of Contents

Index of Tables

Index of Figures

EXECUTIVE SUMMARY

Coordinated care organizations (CCOs) were formed as part of Oregon's health care system transformation. Following state legislation and the approval of Oregon's 1115 Medicaid Demonstration Waiver by the Centers for Medicare & Medicaid Services (CMS), Oregon implemented CCOs as the delivery system for Medicaid in August 2012. The current 16 CCOs manage physical, behavioral, and dental health services for Oregon Health Plan (OHP) members statewide.

Federal law requires states to conduct an annual external quality review (EQR) of Medicaid services delivered through managed care. The Oregon Health Authority (OHA) contracts with Acumentra Health to perform the annual EQR in Oregon. Acumentra Health has conducted the EQR for Oregon since 2005.

The major review areas for 2014 were:

- *Compliance* with federal and state regulations and contract provisions related to enrollee rights, grievance systems, and certifications and program integrity
- *Validation of statewide performance measures*, including an Information Systems Capabilities Assessment (ISCA) of state and CCO information systems, data processing, and reporting procedures
- *Validation of performance improvement projects (PIPs)* that the CCOs conducted with the goal of improving care for OHP members, including a Statewide PIP

Acumentra Health conducted onsite reviews of 15 CCOs in 2014. (For compliance and ISCA activities, PacificSource was reviewed as a single CCO rather than as the current two separate CCOs.) Reports for the individual CCOs identified specific strengths and areas for improvement. This annual report summarizes the CCO reviews, focusing on common strengths and areas for improvement. Detailed profiles of the individual CCO reviews appear in Appendix A.

Acumentra Health also conducted reviews of Greater Oregon Behavioral Health, Inc. (GOBHI), a managed mental health organization, and of CareOregon, a fully capitated health plan. Results of these reviews appear in a separate section of the report narrative.

CCO Compliance Review

The past year has been both transformative and challenging for the CCOs. Early in 2014, most CCOs experienced a very large increase in enrollment due to Medicaid expansion, which created challenges in meeting member needs for access to care. By July 1, 2014, all CCOs had incorporated dental services into their health care delivery systems; some also began offering non-emergency transportation services. While many CCOs spoke enthusiastically about the opportunity to play a major role in health care redesign and are creating system innovations, most have struggled to keep pace with all of the various requirements.

In 2013, Acumentra Health conducted "delegation reviews" of the CCOs in preparation for the 2014 EQR. The results of these delegation reviews foreshadowed some of the 2014 review results when Acumentra Health reviewed each CCO for compliance with Enrollee Rights, Grievance Systems, and Certifications and Program Integrity standards. These reviews evaluated the status of each CCO's compliance as of the review date, rather than using an extended look-back period as is typical with compliance reviews. Acumentra Health identified areas for improvement bearing mind the requirements of future EQR reviews, as well as the goals of long-term improvement and the state's triple aim—better care for patients, better population health, and reduced costs.

Overall strengths

- Many CCOs were able to expand their delivery networks in response to Medicaid expansion, whether by increasing practitioner caseloads or adding new clinics and providers. Some CCOs extended their customer service hours to provide evening and weekend availability.
- The CCOs have implemented initiatives to transform care at the provider level—for example, through local partnerships with traditional health workers and peer wellness specialists.
- All CCOs have developed an integrated member handbook. Most CCOs' websites presented the handbook in both English and Spanish.
- All CCOs worked with providers to ensure that they were aware of and honored enrollee rights.
- CCOs are using a variety of methods to gather input from enrollees about their satisfaction with services and to identify service gaps.
- Most CCOs have robust grievance systems in place for physical health. Most CCOs thoroughly investigate and analyze enrollee grievances.

Major areas for improvement and recommendations

Acumentra Health presented recommendations for the CCOs in individual reports and in the compliance review section of this report, as well as recommendations for OHA to assist the CCOs in addressing these areas.

Overall, the CCOs are still transitioning to systems that fully coordinate care for members. The lack of standardization and integration across physical, dental, and mental health services limits the CCOs' ability to address compliance issues, and may impede the effectiveness of the CCOs' quality improvement, utilization management, and care coordination efforts.

The 2014 reviews revealed that the CCOs had not integrated their policies and procedures (e.g., for enrollee rights and grievances) for all service types. For example, the discrepancies in handling grievances for physical health and mental health were notable. Few CCOs had fully integrated mental and dental health into their program integrity activities.

- ***OHA should provide guidance to the CCOs in developing integrated policies and procedures that apply to all types of services.***

The CCOs often had a different set of enrollee rights for the different types of services.

- ***OHA should define a single set of enrollee rights for the CCOs to address across all types of services.***

The CCOs generally had not established mechanisms to monitor the compliance of their partner organizations and subcontractors with managed care requirements.

- ***OHA should specify in more detail the monitoring methods the CCOs and their downstream entities should use to monitor enrollee rights and grievances.***

Most CCOs required disclosure of conflict-of-interest attestations from governing board members, but few applied disclosure requirements to CCO staff or delegates. Screening for exclusion from federal healthcare programs typically was conducted only during credentialing and recredentialing of licensed practitioners, rather than on a monthly basis. Most of the CCOs lacked a compliance plan that was based on an organization-wide risk assessment.

- ***OHA should guide the CCOs in developing effective compliance programs, including monitoring of downstream entities.***

For more detail, see the compliance review section of this report (pages 20–39).

CCO Performance Measure Validation (PMV)

Acumentra Health validated 10 of the state's 17 incentive performance measures for CCOs. The purpose of the PMV was to determine whether the data used to calculate the performance measures were complete and accurate and whether the calculation adhered to CMS specifications. The associated ISCA examined state and CCO information systems and data processing and reporting procedures to determine the extent to which they supported the production of valid and reliable performance measures.

PMV results

Acumentra Health's PMV assigned a "partially met" compliance rating to 9 of the 10 measures reviewed, because of concerns about the validity of the data used to calculate the measures. The Timeliness of Prenatal Care measure received a "not met" rating because OHA's contractor performed no code review for that measure.

Acumentra Health recommends that OHA document processes, policies, and procedures specific to each performance measure. This documentation should specify steps to ensure that:

- OHA receives complete encounter data from all CCOs in a timely manner
- the data flow between and within OHA systems is documented and understood
- OHA communication with CCOs and provider agencies is documented and consistent
- code review is conducted on all performance measure calculations that use encounter data

For additional details, see pages 40–43.

State ISCA results

The ISCA review found that OHA fully met the criteria for two subsections (Enrollment Systems and Vendor Data Integration), partially met the criteria for seven sections, and did not meet the criteria for the Security section. Appendix C presents a brief description of OHA's data systems, along with the detailed ISCA results.

CCO ISCA results

In 2013, Acumentra Health conducted an ISCA readiness review for the newly formed CCOs in preparation for the full ISCA in 2014. A full ISCA is required

every two years, and Acumentra Health conducts follow-up reviews in alternate years. In 2014, Acumentra Health conducted an ISCA for each CCO and CareOregon, and conducted a follow-up of GOBHI's 2013 ISCA.

Major areas for improvement and recommendations

The 2014 reviews of identified common deficiencies in the following areas.

Integration of IT systems and data reporting across CCO services

- OHA should encourage the CCOs to continue efforts to integrate the administration of physical, mental, and dental health services, and to integrate their service data into single data repositories to enable better reporting on integrated care.

Certification of encounter data

- OHA should ensure that the CCOs implement a certification process to ensure the completeness, accuracy, and truthfulness of all data submitted by providers, and a process to verify all data before submitting to OHA.

CCO oversight of delegated IT activities and responsibilities

- OHA should continue working with the CCOs to define their roles and responsibilities and their delegates' roles and responsibilities in monitoring the quality, completeness, and accuracy of encounter data.
- OHA should encourage the CCOs to develop processes for monitoring providers to ensure contractual requirements are met.

Security policies/procedures and disaster recovery plans

- OHA needs to ensure that the CCOs regularly review and update their data security policies and procedures and those of their delegates.
- OHA needs to ensure that all CCOs have encryption policies that apply to transportation and storage of all protected health information.

Provider directories

Overall, the CCOs struggled to provide integrated and accessible directories that included practitioner-level detail for all CCO services.

- OHA should work with CCOs to make it easier for members to search for providers and to ensure that provider directories include the required information for all types of service providers.

For additional details, see pages 47–55.

CCO Performance Improvement Projects (PIPs)

The OHA contract requires the 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 CCOs must conduct three PIPs and one focus project targeting improvements in care.

Statewide PIP

This PIP, conducted as a statewide collaborative, addresses the integration of primary and behavioral health care. Initiated in 2013, the Statewide PIP focuses on diabetes monitoring (delivery of HbA1c and LDL-C tests) for OHP members with diabetes and schizophrenia or bipolar disorder. Acumentra Health is responsible for facilitating and documenting the overall PIP, while CCOs are responsible for developing their own interventions and documenting their progress in quarterly reports to OHA. In turn, OHA collects, calculates, and reports the aggregated statewide study indicator data for the study measurement periods.

Since improvement in the study indicator is being measured on a statewide basis, rather than for individual CCOs, Acumentra Health evaluated only the CCOs' fulfillment of the criteria for Standard 8 (Improvement Strategies). The full Statewide PIP report for 2014 appears in Appendix B.

Standard 8 validation results

At the end of the first remeasurement period, Acumentra Health evaluated each CCO's July 2014 quarterly report according to the degree of completeness of each Standard 8 criterion, and assigned an overall score for Standard 8 documentation.

Three CCOs fully met all of the Standard 8 criteria and received an overall score of 100 out of 100 points. Overall, CCOs performed well in describing their individual interventions and the barriers encountered during implementation. The area most in need of improvement was in developing and reporting the results of tracking and monitoring plans.

Study indicator results

Statistical tests showed no significant increase in the percentage of enrollees with co-occurring diabetes and schizophrenia or bipolar disorder who received at least one HbA1c test *and* at least one LDL-C test between the baseline and first remeasurement periods. However, interpretation of the aggregated study results is confounded by inconsistences between baseline and remeasurement data collection

methodologies, large differences among CCO study populations, and the validity of the study indicator as a proxy for system integration.

CCO profiles in Appendix A report the topics of the CCOs' additional PIPs.

INTRODUCTION

The Balanced Budget Act of 1997 (BBA) requires an annual EQR in states that use a managed care approach to provide Medicaid services. In 2014 OHA contracted with 16 CCOs, and with GOBHI and CareOregon, to deliver services to OHP members through managed care. The CCOs contract with physical and mental health, addiction treatment, and dental providers, and with pharmacy management companies and hospitals, to deliver care. The CCO is responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory obligations to provide effective care.

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 of PIPs, a required element of health plans' QI programs
- annual validation of performance measures reported by plans or calculated by the state, including an ISCA

Since 2013 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. Acumentra Health reviewed the CCOs'

- current delegation processes as they related to compliance reviews
- readiness for the 2014 ISCA
- selected PIP topics and the status of their work on the Statewide PIP

In 2014, Acumentra Health reviewed all CCOs' compliance with standards for Enrollee Rights, Grievance Systems, and Certification and Program Integrity; conducted PMV-related activities, including full ISCAs; and reviewed and scored work that the CCOs had completed for the Statewide PIP. Acumentra Health also conducted compliance reviews and PIP validations for GOBHI and CareOregon, in addition to an ISCA for CareOregon and an ISCA follow-up for GOBHI.

In 2015, Acumentra Health will conduct a compliance review, covering Quality Assessment and Performance Improvement of all the CCOs and GOBHI; review

PIPs; and conduct PMV-related activities, including following up on the 2014 CCO ISCAs. Acumentra Health will also conduct a full ISCA of GOBHI.

The review activities in this report address the following questions:

1. Does the CCO meet CMS regulatory requirements?
2. Does the CCO meet the requirements of its contract with OHA?
3. Does the CCO monitor and oversee contracted providers in their performance of any delegated activities to ensure regulatory and contractual compliance?
4. Does the CCO conduct effective interventions for the statewide PIP?
5. Do the CCOs' information systems and data processing and reporting procedures support the production of valid and reliable state performance measures and the capacity to manage the health care of enrollees?

Each section of this report describes the procedures used to assess the CCO's compliance with CMS standards related to the specific EQR activity. Procedures were adapted from the following CMS protocols and approved by OHA:

- *EQR Protocol 1: Assessment of Compliance with Managed Care Regulations,* Version 2.0, September 2012
- *Appendix V: Information Systems Capabilities Assessment,* September 2012
- *EQR Protocol 3: Validating Performance Improvement Projects (PIPs),* Version 2.0, September 2012

General procedures, adapted from the CMS protocols, consisted of these steps:

1. The CCO received a written copy of all interview questions and documentation requirements prior to onsite interviews.
2. The CCO used a secure file transfer site to submit requested documentation to Acumentra Health for review.
3. Acumentra Health staff visited the CCO to conduct onsite interviews and provided each CCO with an exit interview summarizing the results of the review.
4. Acumentra Health weighted the oral and written responses to each question and compiled results.

The scoring plan for each activity was adapted from CMS guidelines. The oral and written answers to the interview questions were scored by the degree to which they met regulatory- and contract-based criteria, and then weighted according to a system developed by Acumentra Health and approved by OHA.

Oregon's Coordinated Care Organizations

Table 1 lists the CCOs and their enrollment totals as of December 2014.

Table 1. CCOs' OHP Enrollment, December 2014.

CCO	Total enrollees
AllCare Health Plan, Inc.	48,568
Cascade Health Alliance (CHA)	17,002
Columbia Pacific Coordinated Care Organization (CPCCO)	28,068
Eastern Oregon Coordinated Care Organization (EOCCO)	44,801
FamilyCare CCO	114,893
Health Share of Oregon (HSO)	233,802
Intercommunity Health Network (IHN)	55,498
Jackson Care Connect (JCC)	30,022
*PacificSource Community Solutions (PSCS) – Central Oregon	50,876
PacificSource Community Solutions – Columbia Gorge	12,244
PrimaryHealth of Josephine County (PHJC)	11,054
Trillium Community Health Plan (TCHP)	89,237
Umpqua Health Alliance (UHA)	25,195
Western Oregon Advanced Health, LLC (WOAH)	20,606
Willamette Valley Community Health, LLC (WVCH)	101,726
Yamhill County Care Organization (YCCO)	23,950
Total	**907,542**

Source: Oregon Health Plan: Coordinated Care, Managed Care and Fee for Service Enrollment for December 15, 2014.

*As of January 1, 2014, PacificSource Community Solutions – Columbia Gorge became a separate CCO. Acumentra Health reviewed PacificSource as a single CCO in 2014 except for the PIP review.

OHA's Quality Improvement Activities

OHA requires the CCOs to participate in monthly meetings of the Quality and Health Outcomes Committee (QHOC). Medical directors and quality staff members from each CCO attend the meetings.

OHA's Transformation Center coordinates statewide learning collaboratives, which have dedicated time at the monthly QHOC meetings. Since July 2013, monthly sessions have covered topics such as Screening, Brief Intervention and Referral to Treatment; prenatal care; pain management; depression screening; and colorectal cancer screening. The Transformation Center issues quarterly progress reports on the CCOs' performance on key performance measures.

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 before approval of the 1115 Medicaid waiver. The waiver described key principles of Oregon's 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 would face 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.
- OHA submits quarterly reports to CMS regarding the indicators in the waiver.

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.

In November 2014, OHA published its 2015–2018 Behavioral Health Strategic Plan, developed through input from stakeholders across Oregon and from state mental health advisory committees. The plan identifies six strategic initiatives with corresponding goals, aimed at building and expanding an integrated, coordinated, and culturally competent behavioral health system. Key principles include health equity, access to care, behavioral health promotion and prevention, and supporting successful recovery in the community.[1]

Wraparound services for children

OHA's Addictions and Mental Health Division (AMH) conducts the Statewide Children's Wraparound Initiative, providing services and supports for children with behavioral and emotional challenges. The wraparound approach builds on each child's and family's strengths and needs to develop an individualized plan for services and care coordination. AMH reports that this program has served more than 800 children since July 2010. State lawmakers approved funding to expand the initiative in 2013; currently, 13 CCOs are participating.[2]

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 2014, 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 AMH.[3] AMH added questions to each survey to collect additional data to help evaluate the

[1] Oregon Health Authority. 2015–2018 Behavioral Health Strategic Plan. November 2014. Available online: www.oregon.gov/oha/amh/Pages/strategic.aspx.

[2] Oregon Department of Human Services and Oregon Health Authority. Statewide Children's Wraparound Initiative: 2015 Biennial Legislative Report. Salem, OR, December 4, 2014. Available online: www.oregon.gov/oha/amh/wraparound/Report%20-%202014.pdf.

[3] 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.

progress of ongoing programs. Survey participants had the option to complete the survey online or on paper.

Adult survey results: Acumentra Health distributed a survey to adults who had received outpatient services through OHP and to adults in residential treatment programs or foster care. Acumentra Health mailed surveys to 6,467 adults who had received mental health services during July–December 2013, including 5,066 adults receiving outpatient services and 1,401 adults in either residential or foster care. In all, 1,560 adults returned surveys, for a response rate of 24.1%.[4]

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. After two years of falling scores, the proportion of adults reporting satisfaction in the Social Connectedness, Outcomes, Functioning, and Quality domains increased in 2014. The increase in the Outcomes domain was statistically significant.

Youth survey results: The Youth Services Survey for Families (YSS-F) asked about 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 24% (up from 17% in 2013), with 2,285 responses from 9,506 caregivers with valid addresses.[5]

The Youth Services Survey (YSS) asked 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 727 responses from 3,224 young people with valid addresses, for a response rate of 23%, up from 20.6% in 2013.

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

[4] Acumentra Health. 2014 Oregon Mental Health Statistics Improvement Project Survey for Adults–Outpatient and Residential. January 2015.

[5] Acumentra Health. 2014 Oregon Youth Services Survey for Families, and Youth Services Survey Report. January 2015.

with positive scores increased significantly in the social connectedness and participation domains in 2014.

RESULTS

Federal regulations identify *access* to care and the *quality* and *timeliness* of care as the cornerstones of EQR analysis (42 CFR §438.320). However, no standard definitions or measurement methods exist for access, timeliness, and quality. Acumentra Health used contract language, definitions of reliable and valid quality measures, and research literature to guide the analytical approach.

Access to care is the process of obtaining needed health care; thus, measures of access address the enrollee's experience *before* care is delivered. Access depends on many factors, including availability of appointments, the enrollee's ability to see a specialist, adequacy of the healthcare network, and availability of transportation and translation services.[6,7,8] Access to care affects an enrollee's experience as well as health outcomes.

Timeliness of care can affect service utilization, including both the appropriateness of care and over- or underutilization of services. Presumably, the earlier an enrollee sees a healthcare professional, the sooner he or she can receive needed services. Postponing needed care may result in increased hospitalization and utilization of crisis services.

Quality of care encompasses access and timeliness as well as the *process* of care delivery (e.g., use of evidence-based practices) and the *experience* of receiving care. Although enrollee outcomes also can serve as an indicator of quality of care, outcomes depend on numerous variables that may fall outside the provider's control, such as enrollees' adherence to treatment.

Access

Strengths

- All CCOs experienced large increases in enrollment in 2014 due to Medicaid expansion. Many were able to expand their networks to accommodate the expansion, using strategies that ranged from increasing practitioner caseloads to adding new clinics and providers. Some CCOs extended their customer service hours to provide evening and weekend availability. One

[6] Berk ML, Schur CL. Measuring access to care: improving information for policymakers. *Health Aff*. 1998; 17(1):180–186.

[7] Institute of Medicine. Coverage Matters: Insurance and Health Care. Washington, DC: National Academy Press, 2001.

[8] Sinay T. Access to quality health services: determinants of access. *J Health Care Finance*. 2002; 28(4):58–68.

CCO developed a four-point plan to improve access and aimed to assign all members to a primary care provider by mid-October 2014.

- CCOs' innovative programs to improve access to care include:
  - mobile crisis teams operating 24 hours a day/seven days per week
  - peer-staffed facilitation of post-hospitalization services
  - 24-hour nurse help line
  - extended hours and development of after-hours clinic
- One CCO has a pilot project with a minority service provider to provide culturally and linguistically appropriate system navigation and wraparound services for the CCO's minority enrollees.
- Managed care benefits were expanded in 2014 to include dental services (all CCOs) and non-emergency transportation (NEMT) services (some CCOs).

Areas for improvement

- Although all CCOs contract with certified interpreters, many CCOs reported lack of access to certified health care interpreters who can interpret medical terminology for enrollees in a way they can understand.
- Many of the rural CCOs struggle to provide access to dental care. These CCOs used strategies that ranged from hiring a dental coordinator to facilitate access to contracting directly with a dentist rather than with a dental care organization.
- Most CCOs needed to provide more details about individual practitioners through their websites and provider directories, to enable enrollees to make fully informed choices of providers. Many websites lacked the required information about all practitioners, and some were difficult to navigate. The majority of the provider directories provided the required information about physical health practitioners, but provided limited information about vision, oral health, and behavioral health providers.
- One CCO was closed to new enrollment for an extended period during 2014 and unable to accommodate new members.
- Few CCOs have policies and procedures related to providing access to specialists in all service areas. The policies typically address physical health, but rarely address access to oral or behavioral health specialists.

Timeliness

Strengths

- Several CCOs reported that they expedite grievances and appeals whenever an enrollee or provider requests an expedited process.

- The CCOs typically distributed their handbooks to members within the required time frames.

Areas for improvement

- Most CCOs did not provide all required information to enrollees annually.
- Most CCOs did not screen staff, governing board, providers, and facilities on a monthly basis to ensure that none were excluded from participating in federal health care programs.
- Several CCOs lacked policies and procedures to address the required time frames for informing enrollees of service authorization decisions.
- Several CCOs failed to meet the timelines for resolving grievances.

Quality

The CCOs have implemented many initiatives to transform care at the provider level. This year's annual report omits discussion of initiatives that do not relate to compliance with standards for enrollee rights, grievance systems, or certifications and program integrity. Since the 2015 compliance review will address quality and appropriateness of care, among the standards in the Quality Assessment and Performance Improvement section of the federal EQR protocol, the 2015 annual report will discuss quality initiatives in greater detail.

Strengths

- One CCO partners with community organizations to provide health care services such as Living Well with Chronic Conditions, an Obesity Project, and Better Breathers Club.
- One CCO meets with the local health and human services agency to perform community planning to identify gaps in care coordination. The CCO has facilitated the integration of a community care managers program to better address community issues involving people with complex care needs, diabetes, and timely care for foster children. The enhanced case management program includes co-location of services at a local clinic, with plans to expand over time.

Areas for improvement

- OHA's most recent quarterly report to CMS identified the following types and numbers of grievances addressed by the CCOs: provider's rude or inappropriate comments or behavior (179); billing OHP clients without a signed agreement to pay (179); concern about prescriber or medication or

medication management issues (162); provider explanation/instruction inadequate/incomplete (132); clients not involved with treatment plan or disagreeing with treatment plan (99).[9] The CCOs resolved all of these grievances and took actions to prevent recurrence in all but two categories (concern about prescriber or medication or medication management issues and billing OHP clients without a signed agreement to pay).

- Most CCOs refer quality-of-care grievances to a peer review process that often extends beyond the required time frames for grievance resolution. Some CCOs close a grievance when it is referred to medical management. In almost all such cases, the enrollee receives a generic letter with little or no information about what action was taken as a result of the grievance.
- Reporting on integrated care is difficult or not possible in some cases due to the lack of data integration. Most CCOs handle data for physical, behavioral, and dental health services separately. They have not integrated data from all their partner organizations and contracted entities, which has hindered the efficiency of reporting.

PIP topics and focus areas

The Statewide PIP focuses on the integration of primary and behavioral health care. The CCOs are 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. Because the CCOs differ significantly in terms of geography, provider networks, patient mix, level of integration, and population size, the CCOs were advised to develop strategies for this PIP in a manner that best meets the needs of their local communities. Most Statewide PIP interventions are addressing care access and quality (see Appendix B for detailed descriptions of CCO interventions).

- Sixteen CCOs are seeking to improve care coordination through use of interdisciplinary teams, facilitating communication between mental and physical health care providers, and using traditional health workers and peer wellness specialists.
- Eight CCOs are using existing co-located or integrated clinical settings, or are developing those settings.

[9] Oregon Health Authority. Oregon Health Plan Section 1115 Quarterly Report, Federal Fiscal Year 2014, Quarter 4. Available online: www.oregon.gov/oha/healthplan/DataReportsDocs/Fourth%20Quarter%202014.pdf.

- Eight CCOs are providing education on quality issues for physical and mental health care providers and staff.
- Seven CCOs are educating enrollees either individually or by conducting classes.

CCOs' additional PIPs are addressing access, quality, and timeliness of care for different member populations.

- Seven CCOs are conducting projects aimed at improving perinatal and maternity care (including alcohol and drug screening).
- Six CCOs are seeking to increase the number of Patient-Centered Primary Care Home (PCPCH) clinics or the number of members assigned to PCPCH clinics.
- Four CCOs' projects are aimed at reducing preventable rehospitalizations.
- Three CCOs are targeting improvements in timeliness of prenatal care and behavioral health screening.

COMPLIANCE REVIEW

Acumentra Health reviewed the CCOs' compliance with regulatory and contractual standards governing the delivery of managed health care services. This review sought to answer the following questions.

1. Does the CCO meet CMS regulatory requirements?
2. Does the CCO meet the requirements of its contract with OHA?
3. Does the CCO monitor and oversee contracted providers in their performance of any delegated activities to ensure regulatory and contractual compliance?

Review Sections

Acumentra Health reviewed the CCOs' compliance with federal and state standards in three categories:

Section 1: Enrollee Rights

Section 2: Grievance Systems

Section 3: Certifications and Program Integrity

Each section contains the specific review elements and the corresponding sections of 42 CFR §438, OHA's contract with the CCOs, Oregon Administrative Rules, and other state regulations where applicable. Acumentra Health will review the CCOs in additional compliance sections in 2015.

Acumentra Health's review tool and scoring plan were adapted from CMS guidelines and approved by OHA. Acumentra Health used each CCO's written documentation and responses to interview questions to score the CCO's performance on each review element on a scale from 1 to 4 (see Table 2).

Table 2. Scoring Scheme for Elements in the Compliance Review.

Rating	Score
Fully met	4
Substantially met	3
Partially met	2
Not met	1

Acumentra Health combined the scores for the individual elements and used a predetermined weighting system to calculate a weighted average score for each section of the compliance review, rated according to this scale:

3.5 to 4.0	=	Fully met
2.75 to 3.4	=	Substantially met
1.75 to 2.74	=	Partially met
< 1.75	=	Not met

In scoring each section, Acumentra Health assigned "findings" for areas in which the CCO did not comply with federal and/or state requirements. The individual CCO reports included recommendations on how to address any findings, as well as recommendations for improvement in areas for which the CCO did not clearly or comprehensively meet the requirements.

Summary of CCO Review Results

Acumentra Health worked with OHA before the 2014 reviews began. OHA took several steps to prepare the CCOs for the 2014 EQR:

- During 2013–2014, OHA convened a workgroup to improve grievance system processes. OHA's QI staff provided extensive training to the CCOs on how to define a grievance and how to log a grievance and appeal.
- OHA encourages all CCOs to provide input about the EQR process. In October 2014, many CCOs attended an OHA-hosted meeting that addressed the intent of each standard in the Quality Assessment and Performance Improvement section of the compliance protocol. OHA solicited input from the CCOs before revising the protocol.
- OHA facilitated three EQR trainings for OHA staff, CCO CEOs, and the Transformation Center, including the innovator agents, to clarify the federal requirements that apply to the CCOs.
- OHA convened a meeting with the Office of Equity and Inclusion and Acumentra Health EQR staff to ensure that diversity and cultural awareness are woven into the EQR protocol and review process.

Acumentra Health's 2014 review did not use an extended look-back period since the CCOs did not form until 2012. Instead, the reviews evaluated the status of each CCO's compliance as of the review date. Since the CCOs are still transitioning to systems that fully coordinate members' care, the results for the CCOs reviewed

later in the year may have reflected several additional months of development when compared to their peers that were reviewed earlier in the year.

All CCOs had developed an integrated member handbook. Most CCOs rely on their websites to inform enrollees of their benefits, rights, responsibilities, and available providers. However, some CCOs did not have fully functioning websites that could provide all the needed member and provider information. In some cases, the website was the former fully capitated health plan's website.

Provider directories on the websites often did not present all required information. This was particularly the case with mental and dental health services. Often an enrollee was directed to contact a mental health agency or dental plan to select a practitioner. The websites often presented no information about the specialties and language capabilities of individual mental or dental health practitioners, or about whether a practitioner was accepting new patients.

Initially, many CCOs held face-to-face meetings with community partners to plan for health care integration. Some CCOs formalized the integration process by performing pre-assessments of potential partners and delegates. A few initiated action plans to bring partners and delegates into compliance with the CCO contract expectations. A few CCOs had established mechanisms to conduct oversight of partners and delegates. However, most plans had not progressed to developing monitoring mechanisms for all service areas.

While all CCOs have developed a governance structure, more work is needed to fully integrate all service areas. At the time of review, many lacked sufficient documentation to demonstrate an integrated structure. Most CCOs lacked integrated policies and procedures defining the fundamental processes that occur within the CCO and its partners and delegates. Many CCOs' physical and mental health services were guided by separate policies and procedures, while a few CCOs had begun to integrate policies and procedures. Most CCOs were in the early stages of reviewing the dental plans' policies and procedures.

All CCOs had compliance programs, though some were still in draft form. All conducted annual compliance training for employees, including for the boards of directors. Many CCOs did not require providers and subcontractors to have a compliance program, comply with conflict-of-interest disclosure requirements, and/or perform monthly screening for excluded providers. Only a few CCOs performed proactive internal and external audits or conducted risk assessments.

Overall, the lack of standardization and integration across physical, dental, and mental health services limits the CCOs' ability to address compliance issues and

may impede the effectiveness of the CCOs' quality improvement, utilization management, and care coordination efforts.

Many CCOs are becoming aware of the cultural differences between physical, dental, and mental health care delivery systems as they begin working together more closely. In addition to cultural differences in service delivery, clientele, and training, each delivery system may have a different version of member rights and access standards. In 2014, this was particularly apparent when reviewing the individual grievance systems. Most CCOs were not receiving many grievances from mental health providers. More work is needed to ensure that all expressions of dissatisfaction are being captured and tracked. Credentialing also varies significantly between mental health and physical health.

Most CCOs have initiated conversations or workgroups with mental health providers to begin to understand the differences between the two delivery systems, facilitate communication, and negotiate expectations.

Meeting member needs for access to care was a major challenge for the CCOs in 2014 due to the influx of new OHP members from Medicaid expansion. One CCO was closed to new enrollment for eight months.

The following pages describe overall strengths and improvement needs related to Enrollee Rights, Grievance Systems, and Certifications and Program Integrity. Table 3 shows the average CCO score for each review section. Compliance scores and other review results for individual CCOs appear in Appendix A.

Table 3. Average CCO Compliance Scores.

Section	Score	Rating
Enrollee Rights	2.9	Substantially met
Grievance Systems	3.5	Fully met
Certifications and Program Integrity	2.8	Substantially met

Section 1: Enrollee Rights

This section of the compliance protocol assesses the degree to which the CCO had written policies in place on enrollee rights, communicated annually with enrollees about those rights, and made that information available in accessible formats and language that enrollees could understand.

As shown in Figure 1, most CCOs substantially met the requirements for Enrollee Rights.

Figure 1. CCO Compliance Scores: Enrollee Rights.

Major strengths

Member information: All CCOs had an integrated enrollee handbook. Many handbooks were well-designed and visually appealing. Most of the CCOs' websites contained member handbooks in both English and Spanish. Some websites posted the CCO's policies and procedures, grievance process and forms, provider manuals, and educational materials. A few CCOs issued member newsletters with information about enrollee rights.

The CCOs used a variety of methods to inform enrollees of their rights, including "welcome" calls to new members, employing health navigators to help members with complex needs to obtain the care they need, and member newsletters.

Provider communication: All CCOs worked with providers to ensure that they were aware of and honored enrollee rights. Many CCOs conducted provider

orientations, newsletters, and trainings related to enrollee rights. Some CCOs held frequent meetings with providers, hospital discharge planners, and provider office staff, at which enrollee rights were reviewed. Some CCOs visited provider offices to assess access to appointments, access to medical records, and privacy. One CCO distributed the results of member/patient satisfaction surveys to providers.

Customer service: Many CCOs provided training for customer service representatives and other CCO staff regarding enrollee rights. All CCOs monitored grievances related to enrollee rights. Most CCOs monitored customer service calls to determine whether the calls were handled in an appropriate and timely manner. Some CCOs had expanded customer service hours to include evening availability.

Information about member satisfaction: The CCOs used a variety of methods to gather input from members about their satisfaction with services and to identify service gaps. A few CCOs and community advisory committees had conducted focus groups or surveys related to engagement and self-directed care. The CCOs closely monitored CAHPS survey scores on overall customers' satisfaction with care quality and access.

Cultural diversity and competency: Several CCOs had initiated cultural diversity and competency strategies. One CCO convened a cultural competency workgroup that explored health equity. Other CCOs had established diversity and equity committees that provided quarterly "Lunch and Learn" sessions about diversity for providers, or conducted annual diversity training. Some CCOs had developed policies on cultural diversity and competency.

Major areas for improvement

In general, the CCOs lacked integrated processes for ensuring that enrollees were consistently informed of their rights, and lacked mechanisms to monitor across all service areas. More work is needed in the following areas.

Information about providers: Many provider directories lacked required information for all service areas, particularly mental health. Enrollees were not consistently informed annually of the availability of information about individual practitioners' names, addresses, specialties, language capacities, and whether practitioners were accepting new enrollees.

Many CCOs had provider directories on their websites. However, when tested, many websites provided incomplete and outdated information. In some cases, the hyperlinks did not function. This was particularly true for mental and dental health services. Most CCOs listed the mental health agencies without a mechanism to provide the required information for an individual practitioner upon member

request. Very few CCOs listed individual dentists. Often the enrollee was directed to call the dental organization or routed to the dental organization's website.

Lack of integrated policies and processes; lack of monitoring: Acumentra Health found a lack of integration of policies and procedures across all CCOs' service areas. Many of the CCOs' physical health policies and processes addressed enrollee rights requirements, but these policies often lacked references to mental or dental health. Mental health providers often were not incorporated into the CCOs' annual provider education efforts.

Monitoring of enrollee rights across all service areas was inadequate. Most CCOs had very limited processes for monitoring mental and dental health providers.

Since the majority of CCOs had the issues described above, Acumentra Health began citing a single overarching finding for enrollee rights, rather than issuing a finding for each right that was not addressed across the entire CCO network, after the first few individual CCO reports in 2014.

Table 4 lists the rights that were not being monitored on a consistent basis across the CCO networks.

Table 4. Enrollee Rights: Summary of Most Common Findings and Recommendations.	
Findings	**Recommendations**
The CCOs did not ensure that all providers consistently followed federal and state laws and regulations.	The CCOs need to develop mechanisms to ensure that all providers consistently follow federal and state laws pertaining to enrollee rights.
The CCOs lacked enrollee rights policies that applied to all service areas.	The CCOs need to integrate policies pertaining to enrollee rights to include physical, mental, and dental health providers and services.
The CCOs did not demonstrate monitoring of enrollee rights across all service areas.	The CCOs need to monitor enrollee rights for physical, mental, and dental health service delivery.
A few CCOs did not inform enrollees that a certified or qualified health care interpreter for non-English-speaking enrollees was available free of charge.	The CCOs need to inform members that certified or qualified health care interpreter services are free of charge and how to access this service.
Enrollees were not consistently informed about individual practitioners' names, locations, specialties, language capacity, and whether they were accepting new members.	The CCO needs to ensure that enrollees can easily access the required information annually.
The CCOs' provider directories did not include all the required information for individual practitioners across all service areas.	The CCO needs to make information available, upon request, about individual practitioners' names, locations, specialties, language capacity, and whether they are accepting new members. This requirement applies to behavioral and dental health practitioners. Enrollees need to be informed about how to obtain that information.
The CCOs lacked integrated policies addressing access to specialty care and other services not furnished by the member's primary care provider.	The CCOs need to develop policies on how to access specialists across all service areas, including mental and dental health specialty care.
Most CCOs' handbooks lacked information about the enrollee's right to be treated with respect, dignity, and consideration of their privacy.	CCO handbooks need to incorporate the enrollee's right to be treated with respect, dignity, and consideration for privacy.
Enrollees were not adequately informed of their right to refuse care.	An enrollee's right to refuse care needs to be distinguished from the right to be free of seclusion and restraint.
The CCOs rarely conducted community education about advance directives, including both physical health and mental health declarations.	The CCOs need to educate staff about policies and procedures on advance directives and provide community education on advance directives.

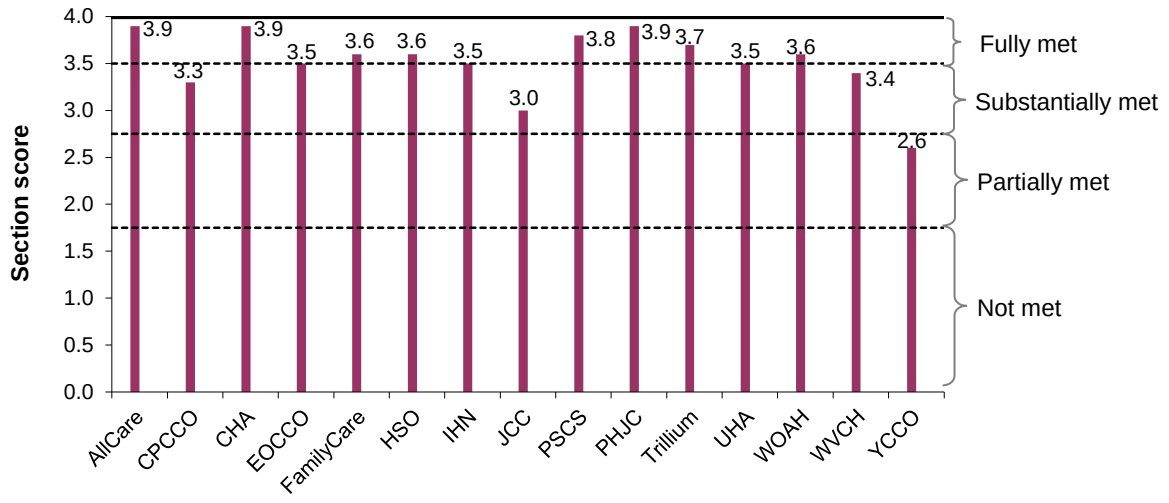
The CCOs' policies on advance directives often lacked reference to mental health declarations.	The CCOs need to integrate mental health declarations into their policies on advance directives.
The CCOs did not monitor compliance concerning documentation of advance directives in clinical records for all service areas.	The CCOs need to ensure that documentation of advance directives, including mental health declarations, are included in the clinical records of members with an executed advance directive. This should include monitoring mental health clinical records for the presence of a physical health advance directive or a mental health declaration.
Enrollees were not adequately informed of the right to be free from inappropriate seclusion and restraint.	The right to be free from inappropriate seclusion and restraint needs to be listed separately from the right to refuse care.
The CCOs did not ensure that all contracted providers and facilities had policies and procedures on the use of seclusion and restraint.	The CCOs need to ensure that all contracted providers and facilities have policies and procedures on the use of seclusion and restraint.
The CCOs did not monitor contractors' use of seclusion and restraint as part of credentialing or recredentialing.	The CCOs' credentialing and recredentialing processes need to include review of the use of seclusion and restraint. The CCOs need to monitor use of seclusion and restraint by mental and dental health providers.
The CCOs lacked processes to ensure that providers comply with the member's right to access and amend their medical records.	The CCOs need to establish mechanisms to ensure that providers, including mental and dental health practitioners, allow enrollees to access and amend their medical records.
Most CCOs lacked a policy on non-discrimination, required by the OHA contract.	Each CCO needs to develop a policy on non-discrimination and to inform providers of this policy.

Section 2: Grievance Systems

This review section evaluates the CCO's policies and procedures regarding grievances and appeals, state fair hearings, and the CCO's process for monitoring adherence to mandated timelines.

Figure 2 shows that most CCOs fully met the criteria for this section.

Figure 2. CCO Compliance Scores: Grievance Systems.



Major strengths

Most of the CCOs had robust grievance systems for physical health. Systems were in place to elevate grievances to the highest clinical or administrative level within the organization as necessary. Most CCOs investigated grievances thoroughly and conducted thorough analyses.

Grievance reporting: Grievance reports were routinely reviewed in QI committee meetings. When a trend was identified, the CCO might modify an internal process or coach a provider or the provider's office staff. A few CCOs followed up with enrollees to ensure that they were satisfied with the handling of their grievance.

Working with providers: Some CCOs had processes in place to send the information from grievances back to physical health practitioners. This sometimes took the form of an individual conversation or graphs comparing one provider with another. Most CCOs used a sequential process to address quality-of-care grievances. This process might begin with coaching the provider, or when

compliance issues arose, the CCO might require corrective action. Most CCOs incorporated quality-of-care concerns into recredentialing reviews.

Grievance system consistency: Most CCOs had identified a lack of consistency between the handling of physical health and mental health grievances (see more below under areas for improvement). Mental health providers reported very few grievances. Some CCOs convened workgroups with mental health providers to build consensus regarding the definition of a grievance and to clarify reporting expectations. Others implemented strategies to work with mental health providers to ensure that all expressions of enrollee dissatisfaction were documented and reported.

The CCOs were in the initial stages of working with dental organizations and non-emergent medical transportation vendors to ensure that grievance processes were in place that met state requirements and CCO expectations.

Delegation of grievances: A few CCOs handled all grievances rather than delegating grievances to the mental or dental health providers. Other CCOs met with delegated organizations to review issues related to grievances and appeals.

Monitoring: A few CCOs had established systems to monitor and oversee mental health delegates. Others were in the process of working with the mental health providers to develop monitoring systems.

Some CCOs had delegated the grievance system review and grievance acknowledgement and resolution letters. Most CCOs reviewed all or a sample of notice-of-action (NOA) letters issued to CCO enrollees. Most CCOs issued NOA letters on CCO letterhead.

Major areas for improvement

Lack of updated, integrated policies and procedures: In many instances the CCO's physical health policies and procedures related to grievances had not been updated to incorporate mental and dental health services.

Several CCOs lacked policies defining the timing of notices for termination, suspension, or reduction of previously authorized Medicaid-covered services. Most failed to define the exceptions for providing notice to members. Some also lacked policies and procedures on the time frames for authorization decisions and for expedited authorization decisions.

Discrepancies in handling grievances for physical health and mental health: Many CCOs did not demonstrate that their grievance systems were consistently implemented across all service areas. This was particularly true for mental health services. Most CCOs reported differences in the way grievances were handled

between physical and mental health providers. Very few mental health grievances were reported. More work is needed to bring the two systems into alignment regarding how expressions of dissatisfaction are handled.

A few CCOs closed grievances related to quality of care when the grievance was referred to medical management for a peer review process. In some instances, members did not receive a grievance resolution letter that detailed the concern and the CCO's response. Several CCOs routinely extended the time frame for resolving grievances without notifying the member. More work is needed to ensure that enrollees are appropriately informed about how the CCO handles their quality-of-care concerns.

In most instances, mental health providers issued few NOA letters. Mental health providers reported routinely negotiating treatment with members; as a result, providers rarely denied services. The providers' position is that if care is not denied in the amount, duration, or scope requested, no NOA is required. More work is needed to determine whether this reflects differences between the two service sectors in terms of practice patterns, culture, or the definitions of denial, termination, suspension, or reduction in service.

Language in NOA letters: Almost all CCOs continued to struggle to ensure that NOA letters were written in easy-to-understand language. The NOA letters often contained medical jargon, abbreviations, and/or vague denial reasons such as: "not medically appropriate," procedure "above the line," or "you are not likely to benefit from the procedure." A few CCOs had enlisted their citizen advisory boards to help in this effort. More work is needed to make sure that members understand the reason why a certain procedure is denied.

Lack of monitoring: Many CCOs lacked mechanisms to monitor their grievance system in all service areas. Some CCOs lacked processes to monitor the resolution and disposition of grievances and appeals. They lacked mechanisms to track and monitor the timeliness of notifications that were delegated to mental and dental health providers. In some instances, the CCO might not know whether a delegate had acknowledged grievances in writing. Some CCOs lacked processes to ensure that NOA letters issued by delegates were written in easy-to-understand language. The CCOs need to continue to work with their partners and delegates to ensure that the grievance system is consistently implemented across all service areas.

Adjudication of final appeals: Some CCOs had delegated adjudication of final appeals, though this is not allowed under the CCO contract with OHA. This situation improved after the delegation training in 2014. However, dental care grievances and appeals continued to be delegated to the dental care organizations. The CCOs reported lacking expertise in determining the medical necessity of

dental care and, therefore, relied on dental care organizations to handle denials and appeals. More work is needed to establish the clinical expertise to handle dental care-related grievances and appeals within the CCOs.

Table 5 shows the most common areas for improvement and corresponding recommendations found in the 2014 review of grievance systems.

Table 5. Grievance Systems: Summary of Most Common Findings and Recommendations.

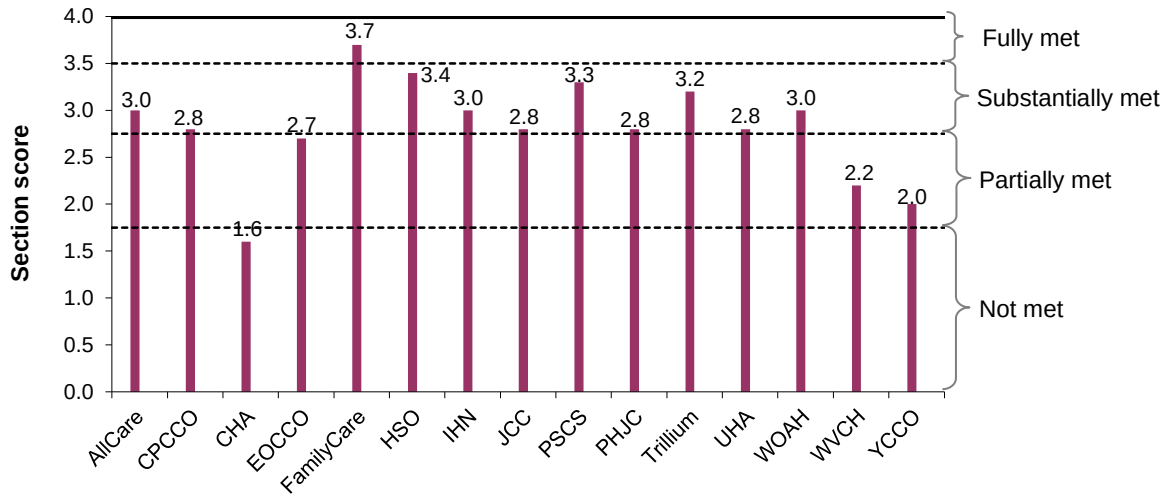
Findings	Recommendations
Many CCOs did not demonstrate that their grievance system was consistently implemented across all service areas.	The CCOs need to continue to work with mental and dental health providers to ensure that grievance systems meet contract requirements.
Some CCOs did not ensure that grievance policies and procedures were consistent across all service areas.	The CCOs need to continue to work with mental health providers to establish common definitions of grievances, processes to collect and handle grievances, and grievance reporting requirements.
Most CCOs were not able to demonstrate that NOA letters were easily understood by enrollees.	The CCOs need to continue to work on ensuring that NOA letters are written in language that is easily understood by enrollees.
Many CCOs lacked mechanisms to monitor the grievance system in all service areas.	The CCOs need to ensure that mechanisms are in place to monitor all components of the grievance system, including components that are delegated to mental health providers and dental organizations.
Some CCOs lacked mechanisms to ensure that NOA letters were issued within the required time frames across all service areas.	The CCOs need to ensure that NOA letters, including those issued by delegates, are issued within the required time frames.
The CCOs reported lacking the clinical expertise to adjudicate final appeals of dental service denials.	The CCOs need to continue to work with the dental organizations to ensure that adjudication of final appeals is performed by the CCO, as required in the CCO contract.

Section 3: Certifications and Program Integrity

This section of the review protocol is designed to assess whether the CCO has systems in place to avoid conflicts of interest; mechanisms to verify that persons and entities are not excluded from participating in Medicaid programs; and administrative and management arrangements or procedures, including a compliance plan, designed to guard against fraud and abuse.

Figure 3 shows that most CCOs substantially met the criteria for this section.

Figure 3. CCO Compliance Scores: Certifications and Program Integrity.



All of the CCOs had compliance programs, though some were still in draft form and some had not been approved by the governing boards at the time of the EQR.

Major strengths

The CCOs' compliance programs had many strengths. Several CCOs had mature compliance programs that not only included policies and procedures and management practices to guard against fraud, waste, and abuse, but applied to all areas of compliance.

Compliance training: All CCOs conducted annual compliance training for employees. Some CCOs also held training for providers, and many CCOs provided training for the boards of directors. Many CCOs required board members to complete conflict-of-interest attestations, and some extended that requirement to

staff. A few CCOs included constraints against vendor gifts and gratuities in their codes of conduct.

Screening for exclusion: Most CCOs incorporated screening for exclusion from participating in federal health care programs into credentialing and recredentialing of licensed providers. Some conducted screening on a monthly basis. A few screened non-contractor providers for exclusion before paying those providers' claims.

Compliance officers: All CCOs had a compliance officer with direct access to the governing board. A few of the compliance officers were certified in health care compliance or held other compliance-related certifications.

Audits and evaluations: Most CCOs conducted external audits as part of their compliance program, and some CCOs conducted internal audits of all departments as well. A few CCOs conducted an annual evaluation of their compliance programs.

Major areas for improvement

Conflict-of-interest disclosures: Although all CCOs had compliance policies and procedures, many policies lacked at least one required disclosure. Often conflict-of-interest disclosures were applied to governing board members, but not to CCO staff or delegates. Many CCOs addressed vendor gifts and gratuities on some level, while others lacked guidelines for staff and governing board members. More work is needed to ensure that providers, subcontractors, staff, and governing board members disclose conflicts of interest.

Inadequate monitoring: Some CCOs did not monitor governing board members or non-licensed staff and providers for exclusion from participation in federal health care programs. Some CCOs screened for exclusion upon hire or at recredentialing, rather than monthly. More work is needed to ensure that no Medicaid funds are used to pay for services provided by persons or facilities on the exclusion list.

Incomplete compliance programs: A few CCOs did not have an approved compliance program at the time of EQR. In general, these CCOs' draft program descriptions addressed the required elements. However, in most cases, the CCOs did not have a compliance plan that was based on a CCO-wide risk assessment. Only a few CCOs' compliance programs had evolved to monitor and audit internal processes. Therefore, only a few CCOs were able to conduct an annual evaluation of the effectiveness of their compliance programs. More work is needed to ensure

that the CCOs' compliance programs are effective in preventing, detecting, and addressing compliance issues.

Lack of integrated compliance programs: Most CCOs' compliance programs included all the required elements. The compliance programs routinely focused on physical health providers and on enrollee fraud and abuse. Few CCOs had fully integrated mental and dental health into compliance activities. As the year progressed, more conversations had occurred with dental organizations and non-emergent transportation vendors.

Table 6 shows the most common areas for improvement and recommendations for this section.

Table 6. Certifications and Program Integrity: Summary of Most Common Findings and Recommendations.

Findings	Recommendations
Some CCOs lacked processes to ensure that providers and subcontractors complied with conflict-of-interest disclosure requirements.	The CCOs need to ensure that all certification and disclosure requirements are applied to the governing board, staff, providers, and subcontractors.
Many CCOs did not demonstrate that all staff, governing board, licensed and non-licensed CCO and provider staff had been screened for exclusion from participation in federal Medicaid programs.	The CCOs need to expand screening for exclusion to include the governing board and non-licensed staff at both the CCO and provider offices.
Some CCOs did not screen for exclusion on a monthly basis.	The CCOs need to establish mechanisms to screen for exclusion from participation in federal Medicaid programs on a monthly basis. This requirement must apply to delegates and other downstream entities.
Some CCOs did not have an approved compliance program at the time of the site visit.	The CCOs need to ensure that the organization's compliance program is approved by the governing board.
Most CCOs lacked processes to conduct internal audits.	The CCOs need to conduct internal audits to ensure compliance with federal and state regulations, and the CCO contract, and to prevent, detect, and respond to fraud, waste, and abuse.
Some CCOs had not applied the organization's compliance program to all service areas.	The CCOs need to ensure that all partners and delegates have compliance programs that protect Medicaid program integrity.

Recommendations for OHA

The areas for improvement that the CCOs need OHA's guidance and clarification on are described below.

Policies and procedures

Acumentra Health found a lack of integration of policies and procedures across all CCOs' service areas.

- OHA should provide guidance to the CCOs in developing integrated policies and procedures that apply to all their service areas.

Enrollee Rights

Acumentra Health found that mental health, physical health, substance abuse, and dental health organizations have their own versions of enrollee rights.

- OHA should define a single set of enrollee rights for the CCOs across all service areas.

Member handbooks: OHA approves each CCO's member handbook, but the handbooks did not contain all information needed to fulfill federal requirements. Most handbooks contained separate definitions of an emergency, for physical, mental, and dental health. Many handbooks advised members to call their primary dentist before visiting the emergency room. This could be construed as a preauthorization requirement and a barrier to care, in conflict with the federal requirements. OHA should:

- ensure that the member handbook template includes federally required language
- develop a single definition for emergency services and include examples appropriate for physical, mental, and dental services

Most CCOs described the member handbook approval process as time-consuming and labor-intensive.

- It would be helpful for OHA to provide a template that includes all the required elements for the CCOs to follow.

Provider directories: OHA approved CCOs' websites to serve in lieu of hard-copy provider directories. However, many CCO websites lacked the necessary information to fully inform members of available practitioners and nearest locations.

- OHA should define the minimum standard web information requirements.

Centralizing CCO contact for members: Upon enrollment, new CCO members may be given a variety of phone numbers for contacting the CCO. In other cases, a member may call the CCO to file a grievance and be directed to call the dental or mental health organization.

- OHA should encourage centralization of CCO customer service, with the CCO performing "warm transfers" to its providers/delegates when indicated (i.e., the customer service employee contacts the provider directly, often while the enrollee is on the phone, to schedule an appointment).

Seclusion and restraint monitoring: Most CCOs were not certain about how to monitor the use of seclusion and restraint or the frequency of the monitoring.

- OHA should clarify to the CCOs what is required to monitor the use of seclusion and restraint, including by the dental entities.

Grievance Systems

Some CCOs are uncertain how to define a mental health grievance, and as a result, those CCOs report very few mental health grievances. Other CCOs may delay investigating a grievance until the member has repeated the grievance in writing and/or has given written permission to proceed with the investigation. In some CCOs, the resolution letter typically cited peer confidentiality and contained no information about what was discovered and/or what would change as a result of the CCO's investigation. OHA should:

- provide additional training for CCOs on the grievance process
- clarify for the CCOs when it is necessary to obtain a release of information when investigating a grievance

NOA letters: Although most CCOs have conducted additional staff training, the NOA letters are not written in easy-to-understand language. Developing user-friendly language in the NOA letters is particularly challenging for the CCOs that are looking for greater efficiencies by eliminating customized letters and developing automated processes. A number of CCOs said they needed more guidance from OHA, especially in developing templates for the more common reasons for NOAs. Once developed, the letter templates could be made available to all CCOs.

- OHA should facilitate additional training for CCOs to ensure that NOA letters are written in easy-to-understand language.

Appeal acknowledgement: Acknowledgment of member appeals varied among CCOs. The CCO contract requires an acknowledgement, but many CCOs

considered the resolution notification to be the acknowledgement. Other CCOs sent an acknowledgement in the same time frame as the grievance/complaint, meaning at five days if not resolved.

- OHA should clarify for the CCOs the requirements for an appeal acknowledgement.

Monitoring: Most CCOs rely heavily on grievance data as a proxy for monitoring compliance with enrollee rights. Many CCOs' delegates process the grievances (complaints) and submit them to the CCO quarterly on a log sheet. However, the categories generally do not provide enough detail to fully understand the issues. Also, there is variation among the CCOs regarding how grievances are used as a QI process. For example, many CCOs identified "rude providers or staff" as one of the more common reasons a member filed a grievance, but limited information was available to describe CCO follow-up and action taken. OHA should:

- specify in more detail the monitoring methods the CCOs and their downstream entities should use to monitor enrollee rights
- more actively promote the use of grievances in process improvement and in the development of the CCO's overall quality strategies

Interpretation: The OHA member handbook and the contract state that the member has the right to a certified or qualified health care interpreter. The OHA contract does not define qualified health care interpreter; however, most CCOs believed that they met the minimum requirement by contracting with large national companies that staff medical/health care interpreters. Many CCOs had limited access to certified health care interpreters, especially in the rural areas.

- OHA should facilitate more training opportunities for people interested in becoming certified health care interpreters.

Adjudication of final appeals: Through early 2014, most CCOs were uncertain about how to interpret the language in the CCO contract about adjudication of final appeals. Many CCOs had delegated that activity to their subcontractors.

In May 2014, OHA and Acumentra Health held a day-long delegation training to help the CCOs meet contractual and regulatory requirements. The training focused on the CCOs' oversight responsibilities regarding activities that cannot be delegated: oversight of QI activities, certification of encounter data, and adjudication of final appeals. Since the training, most of the remaining CCOs have modified their processes to meet the OHA requirements.

- It is recommended that OHA continue to guide the CCOs in developing the necessary infrastructure to fully meet this OHA requirement.

Certifications and Program Integrity

Standards of certifications and program integrity varied considerably among CCOs. At the time of the review, many CCOs were still developing their compliance plans, compliance committees, and reporting structures. Most CCOs did not fully define the expectations of the downstream entities, or fully understand the CCO's accountability regarding the performance of these entities.

Disclosure requirements regarding conflict of interest and excluded providers were inadequately addressed. Many CCOs had not performed a risk assessment or completed a compliance program evaluation. Most CCOs did not routinely perform internal and external monitoring and/or auditing regarding compliance performance.

- OHA should guide the CCOs in developing effective compliance programs, including monitoring of downstream entities.

PERFORMANCE MEASURE VALIDATION

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.

As part of Oregon's 1115 Medicaid waiver agreement with CMS, OHA's Metrics and Scoring Committee developed 17 CCO Incentive Measures for 2013 and 2014. These metrics are used to evaluate Oregon's performance on health care quality and access, and to hold CCOs accountable for improved outcomes.

CCOs receive funds from a quality pool based on their annual performance on these 17 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 as an alternative to paying for service utilization. The 17 measures are listed below.

- 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

Scope of the Review

Ten of the 17 measures are calculated using encounter data that OHA collects and maintains. Per OHA's instruction, Acumentra Health validated only those 10 measures, including Timeliness of Prenatal Care, which was calculated using both encounter data and clinical chart review data. The remaining seven measures are calculated exclusively with clinical data collected by chart review (3 measures), with data from the CAHPS survey, administered by a contractor (2 measures), or with non-encounter data from other OHA systems (2 measures).

Acumentra Health did not review the "Test" measures for which OHA is accountable to CMS. These measures include 16 of the incentive measures plus additional measures of well-child visits, child immunization status, diabetes care, and hospital admission and readmission, among others.

Measures calculated with clinical data

The three incentive measures calculated exclusively with clinical data are (1) Screening for clinical depression and follow-up, (2) Controlling high blood pressure, and (3) Diabetes: HbA1c poor control. Beginning in 2014, each CCO was required to submit a technology plan describing how the CCO would pull a representative sample of data from its EHR to calculate these three measures. After OHA approved the technology plans, the CCOs had to submit proof-of-concept data, or a small sample of data from their EHRs that could be used to calculate the three measures. In 2014, incentive payments for these measures were not based on performance, but on the CCO's ability to produce an acceptable technology plan and proof-of-concept data.

OHA contracted with Acumentra Health to perform a statewide chart review to collect the data used to calculate the statewide baseline for these three measures. In all, 10 reviewers examined 1,385 medical records in 88 cities over 7 weeks. The review results are summarized in "Oregon Performance Measure Calculation: Summary Report of 2013 Measures," submitted to OHA in June 2014.

Validation Results

OHA enlisted the Oregon Health Care Quality Corporation (Q Corp) to validate the code used to calculate the 10 performance measures that use encounter data. Q Corp staff reviewed the code for 9 of the 10 eligible incentive measures, and compared the code written by OHA to the performance measure specifications to ensure that the numerator and denominator of each measure were accurately identified. Q Corp then provided feedback to OHA regarding coding errors, and OHA incorporated the recommended corrections into the code.

While the code review and measure calculation process for these 10 measures was adequate, 9 measures received a "partially met" compliance rating because Acumentra Health has concerns about the validity of the data used to calculate the measures. The Timeliness of Prenatal Care measure received a "not met" rating because no code review was conducted for this measure.

OHA has no system in place to determine the volume of encounter data that is not submitted or that is submitted but rejected by the EDI Translator. In addition, the CCOs' data submission processes vary widely. While some CCOs review their encounter data before submitting the data to the state, other CCOs and their partner organizations transmit the data directly to the state without review. Conducting a data review enables a CCO to identify and correct any anomalies before sending data to the state, and to identify encounters that were rejected. Performance measure calculations based on incomplete data will not yield valid results.

It is unclear how OHA ensures that it has received all encounters before calculating the measures. Because CCOs are subject to financial withholds for late encounter submissions, CCOs seem to be incentivized to not submit encounters if they are late. This creates a risk of calculating performance measures on the basis of incomplete data (in addition to lower capitation payments to the CCO).

Table 7 shows the validation ratings for each of the 10 performance measures reviewed in 2014.

Table 7. Performance Measure Validation Ratings, 2014.		
Measure	**Status**	**Compliance Rating**
Alcohol or other substance misuse (SBIRT)	Code review completed by Q Corp	Partially met
Follow-up after hospitalization for mental illness	Code review completed by Q Corp	Partially met
Follow-up care for children prescribed ADHD medications	Code review completed by Q Corp	Partially met
Prenatal and postpartum care: Timeliness of Prenatal Care	No code review	Not met
PC-01: Elective delivery before 39 weeks	Code review completed by Q Corp	Partially met
Ambulatory care: Outpatient and emergency department utilization	Code review completed by Q Corp	Partially met
Colorectal cancer screening	Code review completed by Q Corp	Partially met
Developmental screening in the first 36 months of life	Code review completed by Q Corp	Partially met
Adolescent well-care visits	Code review completed by Q Corp	Partially met
Mental and physical health assessment within 60 days for children in DHS custody	Code review completed by Q Corp	Partially met

Recommendations

OHA should document processes, policies, and procedures specific to each performance measure. This documentation should specify steps to ensure that:

- OHA receives complete encounter data from all CCOs in a timely manner
- the data flow between and within OHA systems is documented and understood
- OHA communication with CCOs and provider agencies is documented and consistent
- code review is conducted on all performance measure calculations that use encounter data

Information Systems Capabilities Assessment

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 health care for the organization's enrollees.

42 CFR §438.242 requires states to ensure that each managed care plan "maintains a health information system that collects, analyzes, integrates, and reports data" to meet objectives related to quality assessment and performance improvement:

> "The State must require, at a minimum, that each MCO and PIHP comply with the following:
>
> (1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.
>
> (2) Ensure that data received from providers is accurate and complete by—
>
> (i) Verifying the accuracy and timeliness of reported data;
>
> (ii) Screening the data for completeness, logic, and consistency; and
>
> (iii) Collecting service information in standardized formats to the extent feasible and appropriate.
>
> (3) Make all collected data available to the State and upon request to CMS, as required in this subpart."

In 2014, Acumentra Health conducted a full ISCA review of both OHA's data management and reporting systems and those of the individual CCOs. The results of those reviews are summarized below.

ISCA scoring

Acumentra Health organized the ISCA in two main sections: (1) Data Processing Procedures and Personnel and (2) Data Acquisition Capabilities, with 10 subsections, listed below. Each subsection contains review elements corresponding to relevant federal standards.

- Information Systems
- Staffing
- Hardware Systems
- Security
- Administrative Data

- Enrollment Systems
- Vendor Data Integration
- Report Production and Integration and Control of Data for Performance Measure Reporting
- Provider Data
- Electronic Health Records

To score each organization's performance, Acumentra Health drew on information that OHA or the CCO provided in the ISCA tool; responses to interviews with the organization's staff, partners, and providers; and the results of a security walkthrough. Within each section, Acumentra Health scored each element on a scale from 1 to 3 (see Table 8).

Table 8. Scoring Scheme for ISCA Elements.

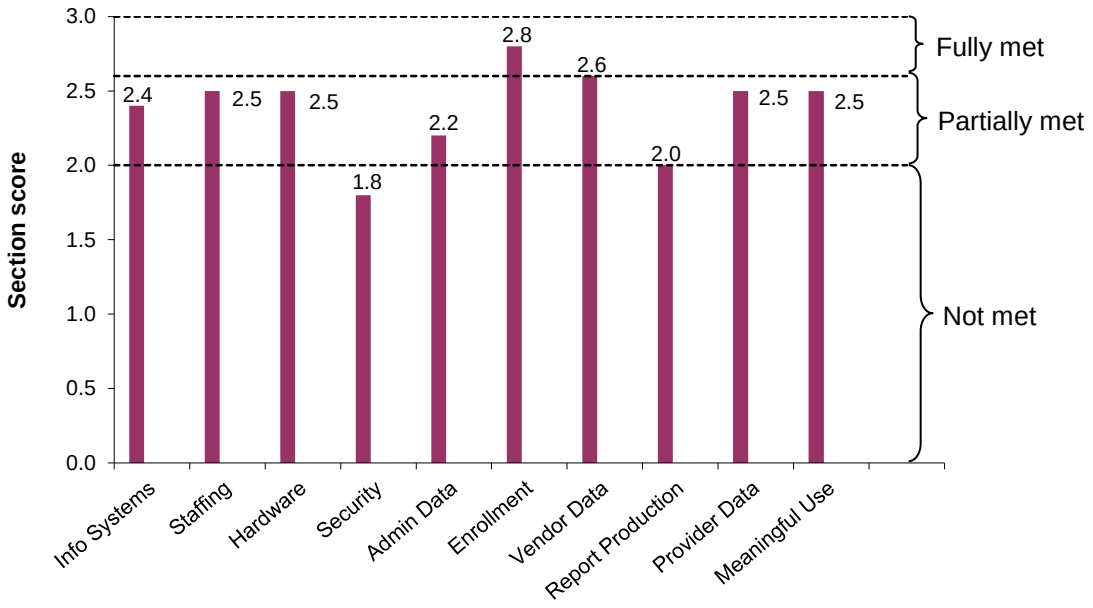
Score	Rating	Definition
2.6–3.0	Fully met (pass)	Met or exceeded the element requirements
2.0–2.5	Partially met (pass)	Met essential requirements of the element, but is deficient in some areas
< 2.0	Not met (fail)	Did not met essential requirements of the element
–	N/A	Not applicable

After scoring the individual elements, Acumentra Health combined the scores and used a predetermined weighting system to calculate a weighted average score for each section and subsection. The detailed criteria for identifying and evaluating these sections are available from Acumentra Health upon request.

State-level ISCA summary

Acumentra Health scored the performance of OHA's information systems on the various subsections of the 2014 ISCA review as shown in Figure 4. OHA *fully met* the criteria for two subsections (Enrollment Systems and Vendor Data Integration), *partially met* the criteria for seven sections, and *did not meet* the criteria for Security. Appendix C presents a brief description of OHA's data systems, along with the detailed ISCA results.

Figure 4. State-Level ISCA Scores.



Results and recommendations

OHA's data systems exhibit several high-level strengths. OHA updates its data warehouse weekly, performs daily backups of Medicaid data, and replicates the backups to an offsite location. OHA has added databases and production servers to accommodate the increased workload due to Medicaid expansion. In addition, CCOs reported that the accuracy of member eligibility files received from the state has improved significantly.

Moving forward, OHA needs to address deficiencies related to:

- in-house knowledge of MMIS support, maintenance, and design, currently outsourced to Hewlett Packard
- lack of clarity regarding IT staff roles and responsibilities
- inconsistencies in data submission by the CCOs
- maintenance and ongoing support for MMIS hardware and software
- data security issues (outdated policies and procedures, absence of a business continuity/disaster recovery plan, data encryption and media destruction/ disposal practices)

See Appendix C for additional details.

CCO-level ISCA summary

In 2013, Acumentra Health conducted ISCA readiness reviews of each CCO in preparation for the full ISCA in 2014. No scoring was associated with the 2013 readiness reviews. The 2014 ISCA involved a more detailed review of the CCOs' information systems, including interviews with relevant staff and CCO partners. Acumentra Health summarized the CCOs' IT infrastructures, and those of their delegates, in individual CCO reports. Acumentra Health also identified strengths, improvement needs, and corresponding scores with recommendations or findings in each of the 10 ISCA review sections.

In 2014, CCOs were required to begin offering dental services, and in some cases, NEMT services to members. Most CCOs had not implemented NEMT services at the time of the ISCA reviews. Implementation of these additional services may require significant planning and resources over a longer period of time.

In 2015, Acumentra Health will follow up on the 2014 recommendations and findings and will report progress made with these issues. The next full ISCA review will occur in 2016.

Results and recommendations

Major themes and recommendations for improvement resulting from the CCO ISCA reviews are summarized briefly below. Table 9 presents specific findings and additional details. For a summary of individual CCOs' ISCA results, including review section scores, see the CCO profiles in Appendix A.

IT systems integration: Overall, the CCOs have not performed strategic planning to integrate all required services (mental health, addiction, dental, and NEMT) into their IT systems. This has hindered the efficiency of CCO reporting as workloads have expanded during service integration. Many CCOs have collaborative relationships with multiple partner organizations, adding complexity to this task. CCOs need to improve their understanding of service authorization, eligibility, data flow, and data validation for all services in order to perform appropriate monitoring and oversight of in-house and outsourced services.

Most CCOs are still struggling to integrate their data processes so that all CCO services are administered with similar processes and procedures. Most CCOs' physical, mental, and dental health services remain segregated. For example, encounter data for most dental services are processed by the dental organization or by a third-party administrator (TPA). As a result, reporting on integrated care is difficult, and in some cases, impossible.

OHA needs to:

- work with CCOs to develop and implement IT activities, communication, policies, and procedures across all CCO services
- encourage the CCOs to continue efforts to integrate their administration of physical, mental, and dental health services
- encourage the CCOs to continue integrating all service data into a single data repository for each CCO, to enable better reporting on integrated care
- encourage CCOs to develop internal reporting capabilities so that the CCOs rely less on state data for quality assessment and performance improvement
- encourage CCOs to continue to reduce the number of paper claims received

Encounter data certification: The OHA contract prohibits CCOs from delegating the 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).

Many CCOs are combining encounter/claims data from multiple sources without a process to validate the completeness and accuracy of data. Many CCOs lack adequate understanding or documentation of the different sources of encounter data. Some CCOs had difficulty developing a process resulting in meaningful verification rather than simply an automatic signature.

OHA needs to:

- ensure that the CCOs implement a certification process to ensure the completeness, accuracy, and truthfulness of all data submitted by providers, and a process to verify all data before submission to OHA
- ensure that CCOs have appropriate documentation (such as a data flow diagram) to understand the sources of all types of encounter data

Delegated activities and responsibilities: Although CCOs may subcontract numerous activities to outside entities, the CCO is responsible for all duties and responsibilities included in its contract with OHA, and must monitor contractors' and subcontractors' performance.

OHA needs to:

- continue to work with the CCOs to ensure that they define the roles and responsibilities of the CCO and all delegates in monitoring the quality, completeness, and accuracy of encounter data
- encourage the CCOs to develop processes for monitoring their providers to enforce contractual requirements for timely data submission, IT security, and business continuity planning

Security policies/procedures and disaster recovery plans: OHA needs to

- ensure that the CCOs review and update their data security policies and procedures and those of their delegates at least every two years
- ensure that the CCOs' business continuity/disaster recovery (BC/DR) plans address all CCO activities and that the plans are tested annually and updated when significant changes occur
- ensure that all CCOs have encryption policies that apply to transportation and storage of all protected health information (PHI)
- work with the CCOs to implement appropriate strategies for upgrading and replacing critical hardware, and enforcing similar practices for partner organizations

Provider directories: Overall, the CCOs struggled to provide integrated and accessible directories that included practitioner-level detail for all CCO services.

OHA should work with CCOs to:

- make it easier for members to search for providers
- ensure that provider directories include information for all types of service providers, including individual practitioners' specialties, gender, languages spoken, and provider type
- develop and implement formal processes for updating provider directories
- ensure that individual practitioners' national provider identifier (NPI) numbers are used for billing

Table 9. CCO-Level ISCA: Major Areas for Improvement.
Information Systems (data flow)
Finding #1 – Encounter data certification *Exhibit B, Part 8, 7.e. See also Exhibit B, Part 4, 11.d, and Exhibit B, Part 8, 7.c (1)(2); OHP 410-141-3180 (10 A)(B)* Most CCOs do not maintain a process to validate data before sending to OHA. It was unclear if the CCO would identify and appropriately investigate any variance in encounters. CCOs do not appear to have processes in place to determine if a file was not submitted on time, or omitted. Many CCOs are combining encounter/claims data from multiple sources without a process to validate the completeness and accuracy of data. Many CCOs lack adequate understanding or documentation of the different sources of encounter data. Some CCOs had difficulty developing a process leading to meaningful verification rather than simply an automatic signature. • The CCOs need to ensure, through a verification and certification process, the completeness, accuracy, and truthfulness of encounter/claims data before submitting the data to OHA. • The CCOs should ensure that signing the attestation is meaningful and not the result of an automatic signature process. The attestation signing must not be delegated. • The CCOs need to develop and implement processes to verify that all encounters provided by the CCO are received, verified, and submitted to OHA, especially those encounters submitted directly to OHA by a delegated or partner organization.
Finding #2 – Lack of integrated policies and procedures *Exhibit B, Part 8, 1.d.1; OHP 410-141-0180 (1)* Most CCOs lack policies, processes, and employees to bridge the gap between IT systems of previously separate organizations that provide CCO services. • CCOs need to develop integrated IT policies and procedures for all CCO activities.
TPAs and other partner organizations collect data on behalf of the CCOs. Most CCOs did not maintain data flow diagrams that account for all CCO data. The ISCA review team received little documentation of how different types of CCO data are received, processed, and submitted. • CCOs need to develop an integrated data flow diagram that includes all CCO services. • CCOs need to develop and implement monitoring processes to ensure that all CCO service data are received and submitted to OHA in a timely manner.
Data warehouses varied across the CCOs. Some data warehouses contained all CCO data, while other CCOs maintained separate data warehouses for different services. Some CCOs lacked a process to store and report data on some CCO services (e.g., mental health, dental, vision, and pharmacy data). • Each CCO should implement a single data repository for all physical health, mental health, addiction, vision, pharmacy, and dental encounters to enable reporting on integrated care. • CCOs should clearly document an integrated reporting strategy.

Some CCOs did not have a formal system development practice, but used informal version control and peer review processes for computer programming and data report production.

- Each CCO needs to adopt and thoroughly document a system development life cycle.
- CCOs need to develop a formal process for peer review of report production.
- CCOs need to ensure that delegates and partner organizations maintain similar formal peer review and system development practices.
- CCOs should consider implementing a formal version control process or software for Medicaid reporting, and requiring that delegates have similar processes in place.

Staffing (service authorization)

Many CCOs delegate to partner organizations the provision of mental health and addiction services. CCOs' authorization processes, training for authorization staff, and staff turnover rates were unclear. At least one delegated entity was making authorization decisions after the related claims had occurred. Some delegates appeared not to understand which services required preauthorization and how that information was tracked during claims payment.

- CCOs need to improve their knowledge of authorization processes for all CCO services.
- CCOs should develop, implement, and distribute formal processes for authorization of mental health, addiction, and dental services. These processes should clearly define the role and responsibilities of the CCO, delegates, and other partner organizations.
- CCOs should maintain clear documentation of staff training and turnover.

Hardware Systems

Some CCOs operate with hardware that is at or approaching the end of life, and thus are beginning to be at risk for hardware failure. Some CCOs have deferred hardware maintenance and lack a strategy for planned hardware replacement.

- CCOs should develop a process to review and implement planned upgrade strategies for critical hardware.
- CCOs should determine hardware replacement standards for their contracted and/or partner organizations, and monitor the hardware replacement practices of those organizations (e.g., dental service providers).

Security (incident management, risk management)

Finding #3 – Monitoring

OHP 410-141-0180 (1)

Most CCOs did not provide evidence of monitoring and oversight of their contracted or partner organizations' security practices. This should include monitoring for TPAs, delegates, partners, and provider organizations.

- CCOs should maintain written policies and procedures that describe maintaining the security of records as required by HIPAA and other federal regulations.
- CCOs should communicate these policies and procedures to their partners.
- CCOs should regularly monitor compliance with these policies and procedures and take corrective action, where necessary.

Finding #4 – Lack of business continuity/disaster recovery (BC/DR) plan

Many CCOs had BC/DR plans that had not been updated to address all CCO activities. Many plans had not been updated since the CCO's inception. Most CCOs did not maintain a comprehensive CCO-level BC/DR plan.

- CCOs should ensure that their BC/DR plans apply to all CCO activities. CCOs need to determine which BC/DR plans (internal or delegated) are sufficient in order to effectively recover systems.
- CCOs need to determine the level of detail necessary to enable a skilled IT person to recover or assist with resuming operations in a timely manner.
- CCOs should test their BC/DR plans at least every two years and update the plans when significant changes occur.

OAR 943-120-0170 (2)

Most CCOs need to address security issues related to:

- Implementing formal processes to update and review policies and procedures
- formalizing the process for encrypting protected health information (PHI)
- updating and regularly testing BC/DR plans
- monitoring provider agencies and other partner organizations with regard to:
  - data breach reporting strategies
  - updating and regularly testing BC/DR plans
  - password complexity standards, forced-change practices, and a multifactor authentication process in accordance with business standards
  - encrypting PHI and/or portable media
  - hardware destruction and disposal processes

Administrative Data (claims and encounter data)

While some CCOs have worked hard to reduce the number of paper claims received, other CCOs continue to record more than 50% of their encounters on paper. All CCOs received paper claims for both mental and physical health, though the percentage of paper claims varied widely among CCOs and claim types. Significant variation existed even for CCOs with the same or similar service area.

- The CCOs should identify ways to reduce the number of paper claims received.

Most CCOs do not conduct encounter data validation (EDV) to verify the accuracy and completeness of data against the clinical records. EDV processes can uncover services that should have been encountered and were not reported, or can provide additional information on how encounters are being captured and reported.

- CCOs should work with provider agencies to ensure that all data submitted to OHA are accurately processed and included in the state data set.
- CCOs should develop and implement a process to regularly validate a sample of the state's encounter data against clinical records for all service types (e.g., dental) in order to assess the completeness and accuracy of encounter data.

Enrollment Systems (Medicaid eligibility)

Finding #5 – Enrollment verification on a per-service basis

OHP 410-141-0420 (4)

Some partner organizations and provider agencies reported that they do not verify Medicaid eligibility on a per-service basis, but verify eligibility periodically (e.g., at first service, then monthly or randomly). At least one delegated entity was performing enrollment verification after the service had been provided.

- CCOs need to work with their partner organizations and provider agencies to ensure that enrollment is verified for each service for all service types.

Many provider agencies reported that few or no reports were available to identify CCO members, limiting their ability to perform outreach related to the service population. It was unclear how a capitated provider would know which members they are serving without looking up each individual separately.

- CCOs should develop a process to reconcile and verify capitated encounters.
- CCOs should develop and implement a reporting strategy for each capitated provider agency to ensure that the agencies can easily access member-level information regarding their capitated members.

Vendor Data Integration and Ancillary Systems

Finding #6 – Encounter data submission

OHP Rule 410-141-3430

OHA is not receiving some encounter data, such as vision or dental service data, from some CCOs. At the time of the ISCA reviews, the CCOs and/or their partner organizations had not developed appropriate practices to send this data to OHA.

- CCOs need to submit data to OHA in accordance with contract requirements.
- CCOs need to integrate all required services and encounter processes within current CCO processes.

Some CCOs had an informal process to monitor the timeliness of vendor data submissions.

- CCOs should verify the turnaround time for vendor data submissions (e.g., submissions by pharmacy benefit managers).

Some partner organizations passed encounter data directly to OHA.

- CCOs should implement a process to verify encounter data before submission to OHA.

One CCO determined that its partner organization and other clearinghouses were not submitting zero-dollar claims to the CCO. At least two provider agencies reported that they did not report encounters for dually enrolled (Medicare and Medicaid) members. It was unclear whether system configuration issues prevented zero-dollar claims from being sent forward.

- CCOs should work with their partner organizations and provider agencies to ensure that all Medicaid encounters are submitted to OHA, regardless of dual enrollment or the dollar amount associated with the claim.

- CCOs should develop monitoring processes to ensure that zero-dollar claims are appropriately received and submitted to OHA.

Report Production and Integration and Control of Data for Performance Measure Reporting

Most CCOs' data warehouses were incomplete or excluded some CCO activities and, therefore, did not meet the CCO's data reporting needs.

- Each CCO needs to develop and implement an integrated data storage and reporting structure that addresses all CCO activities.

Some CCOs reported that they rely solely on state data to monitor their performance measures. Some CCOs had internal mechanisms to verify and report data, but CCO staff lacked training and did not follow software development life cycle standards related to performance measure reporting. One CCO reported a manual process to verify performance measure results.

- CCOs need to develop and implement processes to internally monitor performance measure results rather than relying on state data for strategic planning.
- CCOs need to develop and implement a formal software development life cycle.
- CCOs need to formalize their processes for peer review of reporting and software production.

Provider Data (compensation and profiles)

Finding #7 – Provider directory

OHP 410-141-3300

Most CCOs' provider directories focused on physical health. Many directories included some details about individual practitioners but omitted some CCO services (mental health, dental, or vision service providers).

CCOs used various strategies to inform their members about CCO service providers. Some CCOs' websites provided links to their mental health partners' provider directories; others did not refer to mental health, addiction, dental, or vision services. It was unclear how members were expected to find those services.

Many CCOs' processes for updating their provider directories were unclear, especially for services other than physical health.

- CCOs should make it easier for members to search for providers.
- CCO's provider directories should present information about all types of providers—physical and mental health, addiction, vision, pharmacy, and dental.
- CCOs' provider directory information should include individual practitioners' specialties, gender, languages spoken, and provider type.
- CCOs should develop and implement formal processes for updating provider directories for all provider types.

Many CCOs allow their mental health practitioners to use agency-level NPIs for encounters. In these cases, it is unclear how OHA could validate that the individual provider meets the required education, certification, or training for the services provided. It is also unclear whether the state is meeting its required documentation standards by accepting encounter data in

aggregate, in lieu of encounter data activity at the individual provider level.

- CCOs should clarify their expectations of who is required to report individual provider NPI numbers on encounters, and of the provider types or services for which agency-level NPI numbers are appropriate.
- CCOs should ensure that all eligible providers report provider-level NPI numbers on encounters.
- CCOs should develop and implement edits to identify inaccurate NPI reporting to ensure accurate reporting of individual rendering providers.

Meaningful Use of Electronic Health Records (EHR)

Most CCOs did not maintain policies or procedures related to partners or delegates that may implement, upgrade, or change their EHR implementation.

- CCOs should develop EHR policies and procedures prior to implementation, addressing 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.
- During EHR implementation at provider agencies, CCOs should work with providers on testing to ensure that the data are accurate and complete.
- CCOs should consider monitoring data for quality, completeness, and accuracy throughout EHR implementation, including a post-implementation review.

PERFORMANCE IMPROVEMENT PROJECTS

The purpose of PIPs is to assess areas of need and develop interventions intended to improve health outcomes. OHA's 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."

CCOs are required to conduct three PIPs and one focus study that target 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 is being conducted as a statewide collaborative and addresses the integration of primary care and behavioral health. 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.

Statewide PIP

Overview

The current Statewide PIP, focused on the integration of primary and behavioral health care, was initiated in 2013. The project monitors 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.

The Statewide PIP is being conducted in accordance with the 2012 CMS PIP protocol. Table 10 presents the federal standards for PIP validation. Acumentra Health is responsible for facilitating and documenting the PIP. The CCOs are responsible for developing interventions that meet the needs of their local communities (Standard 8 of the PIP protocol) and for documenting the development and implementation of their interventions in quarterly reports submitted to OHA. OHA provides each CCO with quarterly reports that include study indicator data (the composite of both HbA1c and LDL-C tests) for the entire CCO as well as a member list with patient ID, the date of the most current HbA1c and LDL-C tests, the performing provider's name, and the billing provider's name. OHA also collects, calculates, and reports aggregated statewide study indicator data for the study measurement periods.

Appendix B presents the full Statewide PIP report.

Table 10. 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

Technical assistance

From the inception of the Statewide PIP, Acumentra Health has provided support and technical assistance to the CCOs. At monthly meetings of the state Quality and Health Outcomes Committee (QHOC), 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 Plan-Do-Study-Act (PDSA) methodology, monitoring improvement by using run charts, building an effective project team, diabetes management of the population with severe and persistent mental illness (SPMI), how to address the Standard 8 criteria in quarterly report documentation, Standard 8 criteria scoring, 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 on the upcoming Statewide PIP quarterly report submissions (due at the end of October 2013). Since then, Acumentra Health has offered these individualized technical assistance meetings on a quarterly basis or by request. Acumentra Health has met with representatives from all CCOs at least once, and most CCOs have participated in several technical assistance meetings. Feedback solicited at these meetings has indicated that CCOs found the technical assistance meetings very helpful and appreciated the opportunity to report on their PIP progress, clarify how best to meet the Standard 8 criteria, and troubleshoot problem areas.

Standard 8 validation and scoring

CCOs were advised to complete their quarterly reports on the development and progress of their Statewide PIP interventions according to the Standard 8 criteria (see Appendix B, Attachment G). Acumentra Health provided the CCOs with information about the Standard 8 validation criteria and scoring matrix, and offered ongoing assistance throughout much of the first remeasurement year (June 30, 2013–July 1, 2014).

Following the first remeasurement period, Acumentra Health scored each CCO's July 2014 quarterly report submission. Each CCO received a score (on a 100-point scale) for the degree of completeness of each of the Standard 8 criteria, and an overall score for documenting their work. CCOs had the option of either accepting their initial score or resubmitting their Standard 8 documentation for rescoring. Fourteen of the 16 CCOs asked to be rescored on their October 2014 quarterly reports. CCOs that elected to resubmit their Standard 8 documentation generally responded to feedback and recommendations made by Acumentra Health following their initial PIP submissions.

Following is a brief review of high-level themes drawn from the October 2014 CCO quarterly reports. Details of individual CCO interventions, barriers, and next steps can be found in Appendix B, Attachment I.

- The **main barriers/factors** identified in root cause analyses of gaps in performance included:
  - lack of communication between mental health and physical health systems
  - characteristics and needs specific to the SPMI population
  - mental health and physical health providers are uncomfortable with and lack knowledge about working with members with SPMI who also have chronic illnesses
- **Interventions:** Many CCOs analyzed the study population according to members' primary care providers (mental health vs. physical health) and then focused interventions on improving communication with those providers. An increasing number of CCOs are focusing on co-location of services, mostly incorporating behavioral and mental providers in primary care settings. CCOs also implemented other interventions: using community health workers, peer support specialists, and case managers to work with study members; training mental health and physical health providers; and developing integrated clinics. Most CCO interventions addressed the cultural characteristics and needs of the SPMI population.
- **Barriers:** All CCOs identified barriers affecting some aspect of data entry or data collection, including discrepancies between internal and OHA member lists, difficulty accounting for dual-eligible members, inability to integrate different data systems, and incomplete provider data. Organizational factors such as competing priorities, staff turnover, and absence of prior processes and procedures for integration also presented significant barriers to intervention implementation.

The CCOs' average total score on Standard 8 was 90.7 points out of 100 possible points, with scores ranging from 70 to 100. (Standard 8 scores for each CCO appear in the CCO profiles in Appendix A.) Generally, CCOs did a good job of describing their interventions, the barriers encountered during the implementation of those interventions, and next steps.

Three CCOs (EOCCO, Health Share, and PHJC) fully met all of the Standard 8 criteria and received an overall score of 100 out of 100 points. These high-scoring CCOs did an excellent job of conducting data and barrier analyses, and clearly linked the analyses to expected improvement in the study indicator, development of their interventions, and the cultural and linguistic appropriateness of the interventions. The three CCOs thoroughly described barriers encountered and how they were addressed, and reported detailed data on the study indicator, intervention

implementation results during the entire measurement period, and the next steps for this PIP.

The remaining CCOs could best improve their scores by providing updated study indicator data and results of their intervention tracking and monitoring plans.

Statewide PIP results

Table 11 shows the aggregated Statewide PIP results.

Table 11. Aggregated Results of Statewide PIP (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* July 1, 2011–June 30, 2012	First remeasurement July 1, 2013–June 30, 2014
Numerator	1,407	1,090
Denominator	2,137	1,637
Calculated indicator	65.8%	66.6%

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

Acumentra Health conducted a Fisher's Exact chi-square test (appropriate for categorical data) with a probability of $p \leq .05$ to determine if there was a statistically significant difference between the percentage of enrollees with co-occurring diabetes and schizophrenia or bipolar disorder who received *both* at least one HbA1c test and at least one LDL-C test at baseline and at first remeasurement. Although there was a slight increase in the study indicator, the statistical test yielded a result of $p=.6519$, indicating no statistically significant difference between baseline and first remeasurement.

The interpretation of these results is not straightforward. A number of factors must be taken into account when discussing the study results, including: discrepancies between the state and CCO study indicator data, differences among CCOs in terms of study population, level of physical and behavioral health system integration at baseline and interventions, validity of the study indicator as a proxy for system integration, and an unexpectedly large expansion of the Medicaid population in January 2014.

In terms of clinical improvements and lessons learned as a result of this PIP, CCOs made several observations:

- The interventions promoted increased communication between physical and mental health providers, who reported feeling more connected. The increased communication resulted in better outcomes for members.
- It is important to involve all team members in the integration process.
- Team members need to be frequently reminded to focus on the "big picture" (integration) as opposed to the immediate goal (improving testing rates).

Recommendations

Based on the quarterly reports submitted by CCOs and technical assistance meetings to date, Acumentra Health offers the following recommendations.

- OHA needs 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.
- CCOs need to:
  1. develop their own systems and processes for tracking their data for projects, including the Statewide PIP study indicator data
  2. consistently track and monitor the effective implementation of their Statewide PIP intervention strategies
  3. adequately document their Statewide PIP activities in accordance with Standard 8 criteria

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. See the CCO profiles in Appendix A for CCO-specific PIP and focus study topics.

SUMMARY OF CAREOREGON AND GOBHI REVIEWS

During 2014, OHA contracted with CareOregon, a managed care organization (MCO), and with GOBHI, a managed mental health organization (MHO), to deliver care for OHP enrollees.

As with the CCOs, Acumentra Health reviewed both organizations' compliance with federal and state regulations and contract provisions related to Enrollee Rights, Grievance Systems, and Certifications and Program Integrity. Each section contains the specific review elements and the corresponding sections of 42 CFR §438, OHA's contracts, Oregon Administrative Rules, and other state regulations where applicable.

The review tool and scoring plan used were adapted from CMS guidelines and approved by OHA. Acumentra Health used written documentation and responses to interview questions to score the plans' performance on each review element on a scale from 1 to 4 (see Table 2). Acumentra Health combined the scores for the individual elements and used a predetermined weighting system to calculate a weighted average score for each section of the compliance review, rated according to this scale:

3.5 to 4.0	=	Fully met
2.75 to 3.4	=	Substantially met
1.75 to 2.74	=	Partially met
< 1.75	=	Not met

Acumentra Health also evaluated CareOregon's and GOBHI's clinical and nonclinical PIPs required by the OHA contract, conducted a full ISCA review of CareOregon, and followed up on GOBHI's response to recommendations arising from its full ISCA review in 2013.

Reports detailing the review results for each plan were submitted to OHA in 2014. High-level summaries of the EQR results appear below. See the organizational profiles in Appendix A for additional details.

CareOregon Review Results

Compliance review summary

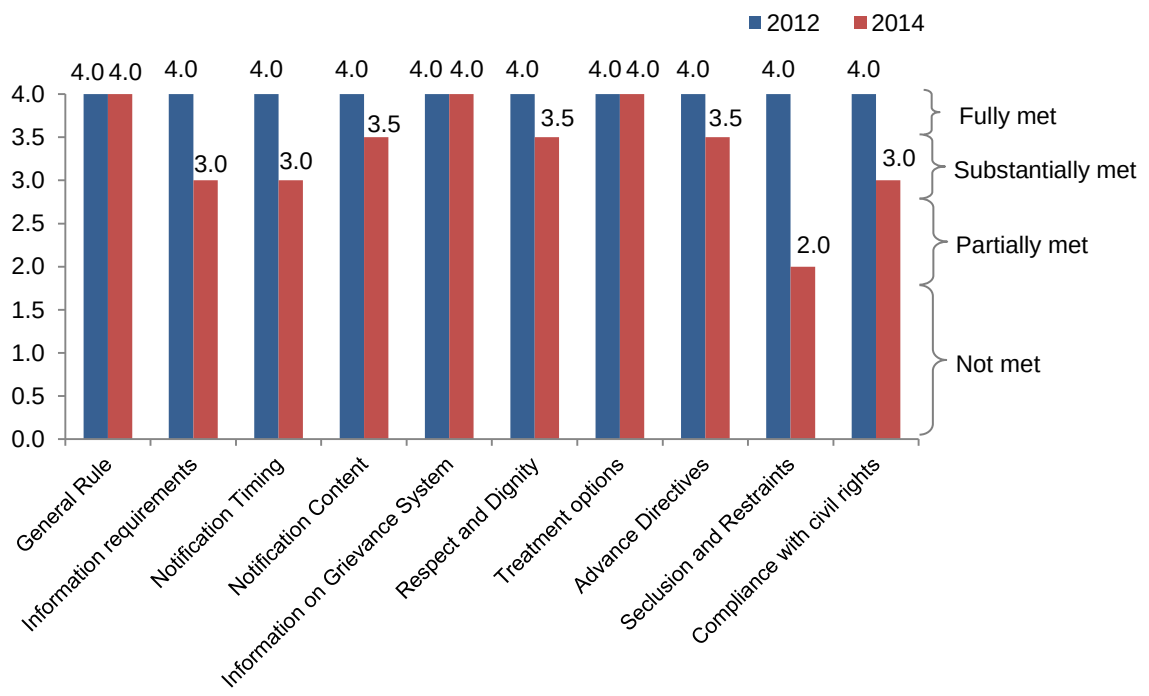
The 2014 review found that CareOregon *fully met* the Grievance Systems standard and *substantially met* Enrollee Rights and Certifications and Program Integrity standards. Table 12 shows the weighted average scores assigned for each section.

Table 12. CareOregon's Weighted Average Scores and Ratings on Compliance Review Sections.		
Review section	**2012 scores**	**2014 scores**
Enrollee Rights	4.0 (Fully met)	3.3 (Substantially met)
Grievance Systems	3.9 (Fully met)	3.9 (Fully met)
Certifications and Program Integrity	4.0 (Fully met)	2.9 (Substantially met)

Enrollee Rights

Figure 5 compares CareOregon's compliance with individual Enrollee Rights provisions in 2014 vs. the MCO's compliance in 2012, the previous review year.

Figure 5. CareOregon Compliance Scores: Enrollee Rights.



Strengths: CareOregon has systems in place to ensure that enrollee rights are honored. For example, customer service calls are monitored and complaints about providers are incorporated into the provider recredentialing process. The MCO monitors respect, dignity, and privacy through routine provider site visits.

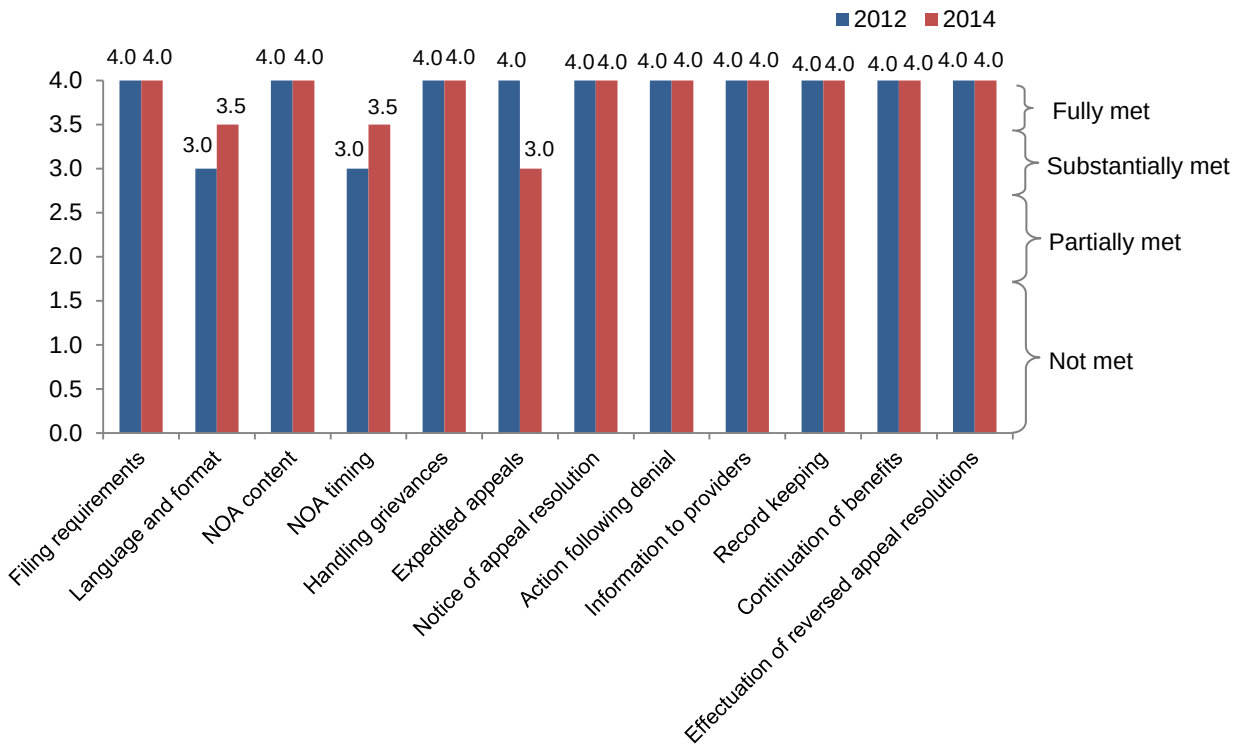
Major areas for improvement: CareOregon did not submit some of the required documentation to demonstrate that it followed its policies and procedures related to enrollee rights. At the time of the review, the MCO's website and provider directory omitted some required information, such as whether a provider was accepting new enrollees. Interpretation services were not covered for scheduling appointments, relaying test results, or communicating with the enrollee's provider by phone.

CareOregon did not demonstrate that it reviewed the use of seclusion and restraint by contracted providers and facilities as part of its credentialing and recredentialing process. The MCO did not demonstrate that it had a process in place to ensure that enrollees had access to their medical records.

Grievance Systems

Figure 6 compares CareOregon's 2012 and 2014 scores for the individual review sections related to Grievance Systems.

Figure 6. CareOregon Compliance Scores: Grievance Systems.



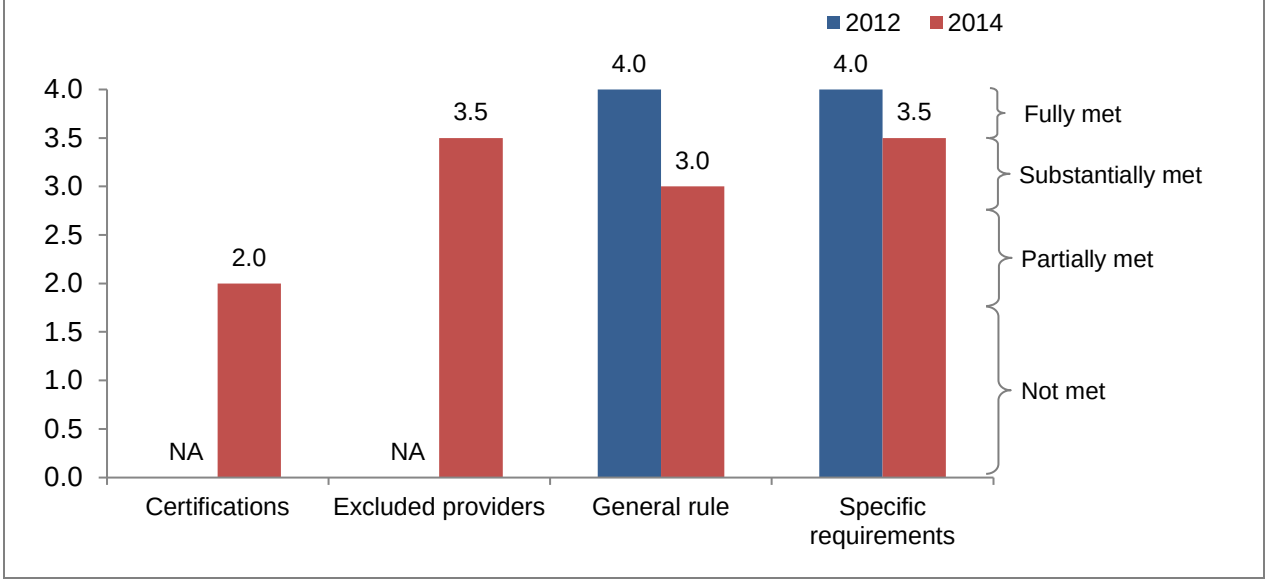
Strengths: CareOregon has an electronic system for collecting, monitoring, and analyzing information pertaining to the grievance system. Staff can monitor correspondence daily to ensure that required response times are met. The MCO's QI work plan includes ensuring that enrollees can understand NOA letters.

Major areas for improvement: CareOregon routinely extended the timelines for resolving grievances without informing enrollees. As mentioned previously, CareOregon had identified the need to improve its NOA letters so that enrollees can easily understand them.

Certifications and Program Integrity

Figure 7 shows CareOregon's compliance with the Certifications and Program Integrity review sections.

Figure 7. CareOregon Compliance Scores: Certifications and Program Integrity.



Strengths: CareOregon's compliance plan included all the required items. The MCO's conflict-of-interest disclosure packet is completed annually by the board of directors, officers, and key employees. Its compliance program is guided by robust policies and procedures.

Major areas for improvement: CareOregon did not demonstrate that its conflict-of-interest policies applied to providers and delegates. Although several units of CareOregon conducted monthly checks for exclusion from participation in federal health care programs, the screening results were not forwarded to the MCO's compliance department. The MCO's current compliance work plan was based on an organization-wide risk assessment for its Medicare line of business, which did not evaluate the effectiveness of the compliance program. CareOregon's work plan needs to address Medicaid compliance risks.

PIP validation summary

Nonclinical PIP: Assuring Better Child Health and Development (ABCD) III

This PIP, in its first year, focused on implementing a standardized primary care developmental screening process for children up to age 3, in an effort to increase the screening rate. CareOregon reported that the screening rates achieved by a previous ABCD III PIP were lower than expected, but the MCO did not report that rate or a benchmark/target for comparison. CareOregon plans to offer training and assistance for its clinics in implementing a standardized developmental screening process. The MCO needed to provide more detailed information about the training model and the developmental screening tool it intended to use.

This PIP earned an overall weighted score of 63 on an 85-point scale, resulting in a compliance rating of Substantially Met.

Clinical PIP: Diabetes Monitoring for People with Diabetes and Schizophrenia or Bipolar Disorder

This first-year PIP focused on the topic chosen by CCOs for the Statewide PIP. Although CareOregon stated that it had enough study-eligible enrollees to justify selection of this topic, the MCO could produce no supporting data. Acumentra Health obtained first quarter 2014 data from OHA showing that CareOregon had 12 enrollees with diabetes and co-occurring schizophrenia or bipolar disorder, of whom 9 had received the HbA1c test and 9 had received the LDL-C test. After discussion with OHA, Acumentra Health accepted this PIP as meeting the MCO's contract requirement, but assigned no scores for the PIP. Instead, Acumentra Health recommended that CareOregon select a new PIP topic for 2015 that affects a significant number of MCO enrollees.

ISCA summary

Acumentra Health's assessment of CareOregon found that the MCO *fully met* standards for all but 3 of the 10 review sections.

Major areas for improvement included:

- lack of updated policies and procedures—many of CareOregon's policies and procedures had not been updated in the past two years
- security issues related to provider agencies
- lack of current BC/DR plan

GOBHI Review Results

Compliance review summary

The 2014 review found that GOBHI *fully met* the Certifications and Program Integrity standard and *partially met* the Enrollee Rights and Grievance Systems standards. Table 13 shows the weighted average scores for each section.

Table 13. GOBHI's Weighted Average Scores and Ratings on Compliance Review Sections.

Review section	2012 scores	2014 scores
Enrollee Rights	2.4 (Partially met)	2.6 (Partially met)
Grievance Systems	2.9 (Substantially met)	2.5 (Partially met)
Certifications and Program Integrity	4.0 (Fully met)	3.5 (Fully met)

Overall strengths

Since the previous compliance review in 2012, GOBHI has updated many of its policies and procedures and has reinstated provider site visits. The MHO has resolved several findings of the 2012 review.

- GOBHI was able to demonstrate oversight of its contractors in many areas. Certification reviews with AMH have resumed. GOBHI interviews consumers as part of the site visits. GOBHI has performed additional oversight of the community mental health providers, as needed.
- GOBHI hired a member and diversity coordinator who has strengthened the MHO's cultural competency.
- GOBHI conducted a consumer survey, and its quality and utilization coordinator followed up on any negative comments by enrollees.

Major areas for improvement

Although GOBHI has made progress in certain areas since the 2012 review, the MHO remains less than fully compliant with federal and state requirements in other areas. More work is needed for GOBHI to reach full compliance with Medicaid managed care standards.

- GOBHI's English-language handbook in place for the 2014 site visit was first published in 2009 and had not been revised since the previous EQR to address deficiencies in information provided to enrollees.
- GOBHI's had updated its provider contract to address the 2012 findings, but had not executed the contract to implement changes in the information provided to or required from community mental health programs (CMHPs).
- GOBHI had delegated authorization of inpatient care to the CMHPs since the previous site visit. The CMHPs had issued no NOA letters since being delegated this duty. GOBHI submitted only one NOA letter for the 2014 review, issued for an enrollee of a CCO.

Figures 8–10 compare GOBHI's compliance with the individual provisions of Enrollee Rights, Grievance Systems, and Certifications and Program Integrity in 2014 vs. the MHO's compliance in 2012, the previous review year.

Figure 8. GOBHI Compliance Scores: Enrollee Rights.

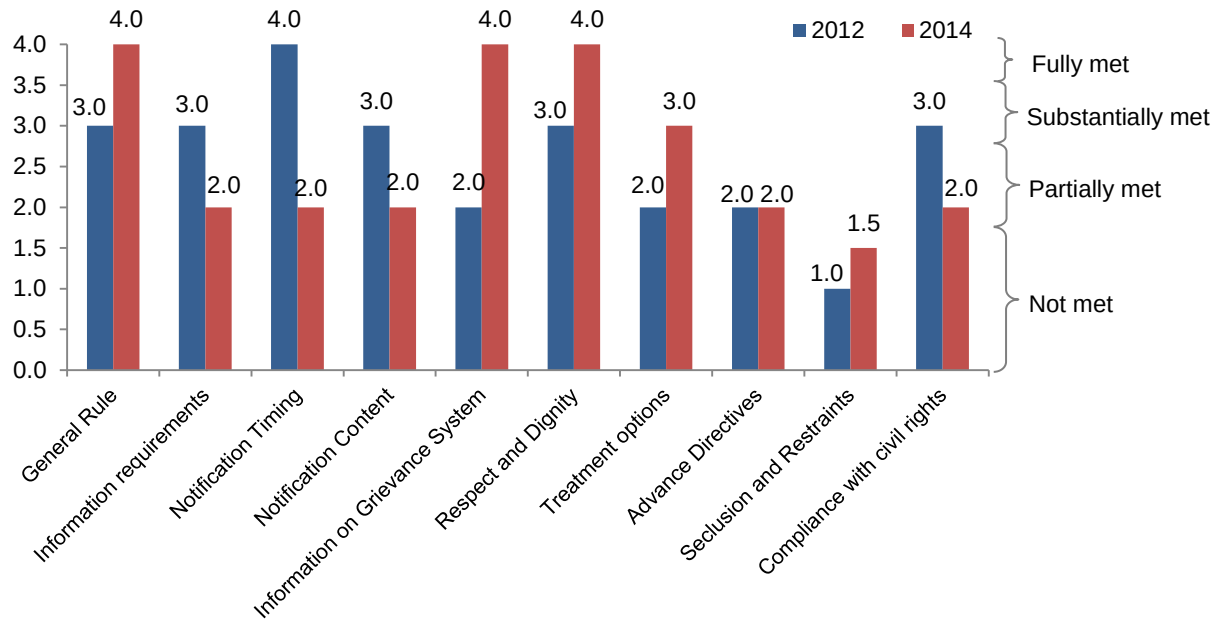


Figure 9. GOBHI Compliance Scores: Grievance Systems.

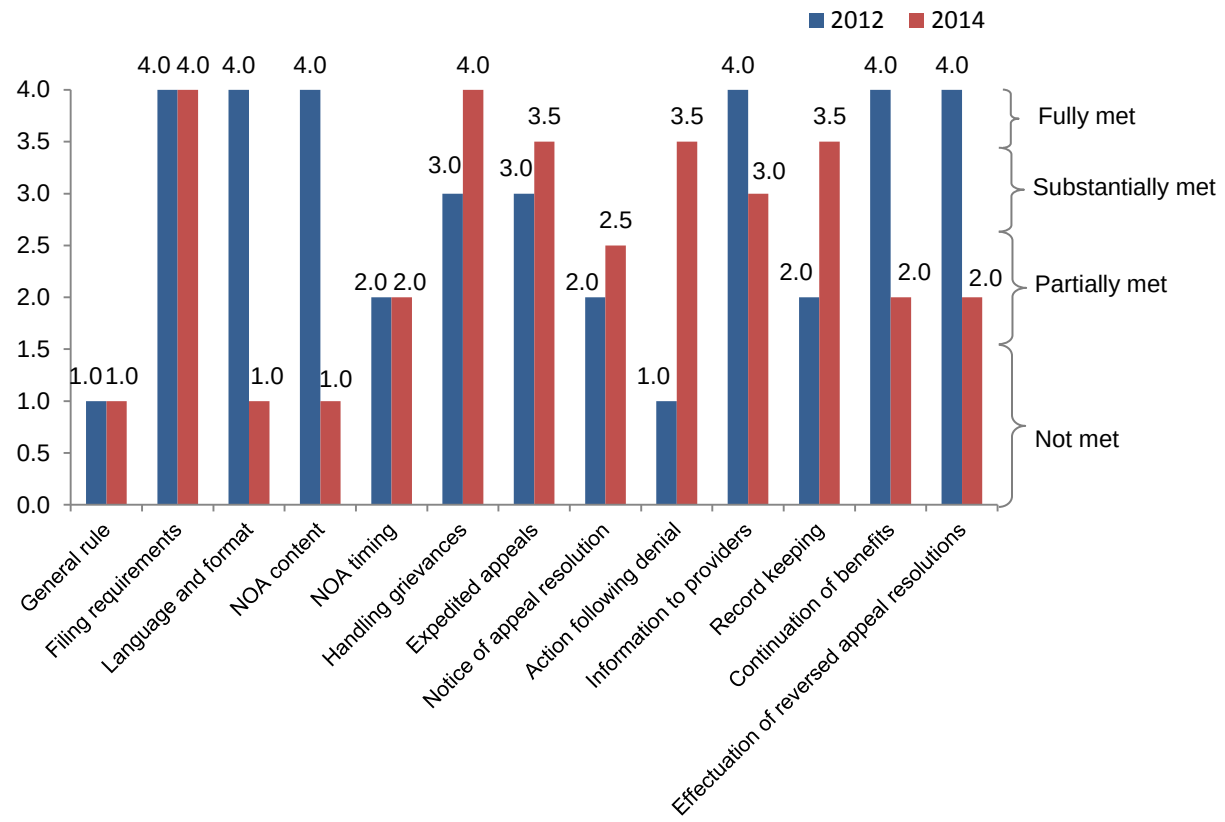


Figure 10. GOBHI Compliance Scores: Certifications and Program Integrity.

PIP validation summary

Nonclinical PIP: Mental Health First Aid

This PIP, initiated in 2013, sought to increase the percentage of children, age 6–18, who use mental health services (penetration rate). GOBHI reported that only 5% of its school-age member population used mental health services, indicating an opportunity for improvement. Multiple barriers contribute to the underutilization of mental health services. GOBHI observed that rural areas have historically been underserved and faced significant health disparities, and all 16 counties in the MHO's service area are designated as rural.

GOBHI planned to conduct workshops in Rural Mental Health First Aid, an evidence-based practice, for selected school staff and teachers. Implementation of this intervention was delayed due to the length and complexity of educating and preparing the GOBHI trainers and lack of availability of teachers and school staff. If GOBHI cannot implement the intervention in the second year of this PIP, the MHO should choose a more feasible intervention or consider a new study topic.

The overall weighted score for this PIP was 59 on an 85-point scale, resulting in a compliance rating of Substantially Met.

Clinical PIP: Early Childhood Assessment and Intervention Training

This PIP, in its fourth year, focused on increasing access to services (penetration rate) for members age 5 and younger. Local data from 2009 showed that of the 13,125 eligible GOBHI members in that age group, only 1.2% received mental health services, demonstrating "a distinct need for intervention."

As its initial intervention, GOBHI conducted training sessions for all clinicians on early childhood assessment from June to November 2010. First remeasurement results demonstrated a small but statistically significant improvement in the penetration rate, from 1.2% to 1.5%. After analyzing the intervention and remeasurement data, GOBHI concluded that the initial intervention did not "address the complexity of getting services to children in this age group." GOBHI modified its intervention to include staff training in child-parent psychotherapy and an outreach and education program aimed at "first observers" (primary care physicians, preschool teachers, and early childhood interventionists).

Second remeasurement data demonstrated a statistically significant increase in the penetration rate, to 2.0%. GOBHI conducted a third remeasurement to evaluate the outreach intervention. Partial data for the third remeasurement period demonstrated a penetration rate of 4.1%, exceeding GOBHI's target goal of 3%. However, a dramatic decrease in the study population in the third remeasurement period, due

to the transition to CCOs, confounded comparisons with the baseline and other remeasurement periods. GOBHI planned to discontinue this PIP.

ISCA summary

In 2014, Acumentra Health reviewed with GOBHI the areas for improvement and recommendations identified in 2013, and evaluated the MHO's documentation to assess the steps it had taken to address them. GOBHI was in the process of addressing 5 of the 36 recommendations from 2013.

As indicated in the 2013 review, GOBHI needs to continue addressing issues from the transition to PH Tech as its data administrator. This includes reported delays in submission of encounter data from providers to PH Tech, and clarifying PH Tech's roles and responsibilities for monitoring encounter data. GOBHI also needs to address data security issues, such as data encryption and backup storage, with its provider agencies to ensure that they meet industry standards.

DISCUSSION AND OVERALL RECOMMENDATIONS

The past year has been both transformative and challenging for the CCOs. Early in 2014, most CCOs experienced a very large increase in enrollment due to Medicaid expansion, which created challenges in meeting member needs for access to care. Also, dental care and NEMT services were brought under the CCOs during 2014 and 2015.

From the 2014 EQR, Acumentra Health identified major areas for improvement and those areas in which that the CCOs need OHA's guidance.

Lack of Integration

Acumentra Health found a lack of integration between physical, dental, and mental health services. The CCOs had different policies and procedures across all service areas.

- OHA should guide the CCOs in developing integrated policies and procedures that apply to all their service areas.

Enrollee rights

The CCOs often had a different set of enrollee rights for the different service areas.

- OHA should define a single set of enrollee rights for the CCOs across all service areas.

Provider directories

Contact information for members was disparate, with different contact phone numbers and sometimes confusing links on websites to different organizations. Overall, the CCOs struggled to provide integrated and accessible provider directories that included practitioner-level detail for all types of CCO services.

- OHA should encourage the CCOs to centralize their customer service phone numbers.
- OHA should work with CCOs to
    - make it easier for members to search for providers in all services areas
    - ensure that provider directories include the required information for all types of service providers

Data integration

Most CCOs' data systems for physical, behavioral, and dental health services remain segregated. For example, encounter data for most dental services are

processed by the dental organization or by a third-party administrator. As a result, reporting on integrated care is difficult, and in some cases, impossible.

OHA needs to:

- work with CCOs to develop and implement IT activities, communication, policies, and procedures across all CCO services
- encourage the CCOs to continue efforts to integrate their administration of physical, behavioral, and dental health service data
- encourage the CCOs to continue integrating all service data into a single data repository for each CCO to enable better reporting on integrated care

Monitoring Delegates

Although CCOs may subcontract numerous activities to outside entities, the CCO is responsible for all duties and responsibilities included in its contract with OHA, and must monitor contractors' and subcontractors' performance.

The CCOs generally had not established mechanisms to monitor the compliance of their partner organizations and subcontractors with managed care requirements.

- OHA should provide guidance to the CCOs on monitoring delegates and partners related to enrollee rights and grievances.
- OHA should continue to work with the CCOs to ensure that they define the roles and responsibilities of the CCO and all delegates in monitoring the quality, completeness, and accuracy of encounter data.
- OHA should encourage the CCOs to develop processes for monitoring their providers to enforce contractual requirements for timely data submission, IT security, and business continuity planning.

Most CCOs rely heavily on grievance data as a proxy for monitoring compliance with enrollee rights. Also, there is variation among the CCOs regarding how they use grievances to inform quality assurance and performance improvement.

OHA should

- specify in more detail the monitoring methods the CCOs and their downstream entities should use to monitor enrollee rights
- more actively promote the use of grievances in process improvement and in the development of the CCO's overall quality strategies

Many CCOs were still developing their compliance plans, compliance committees, and reporting structures at the time of the 2014 reviews. Most did not fully define the expectations for downstream entities, or fully understand the CCO's

accountability regarding the performance of these entities. Most CCOs did not perform routine internal and external monitoring and/or auditing regarding compliance performance.

- OHA should guide the CCOs in developing effective compliance programs, including monitoring of downstream entities.

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. Many CCOs lack adequate understanding or documentation of the different sources of encounter data. Some CCOs had difficulty developing a process resulting in meaningful verification rather than simply an automatic signature.

OHA needs to:

- ensure that the CCOs implement a certification process to ensure the completeness, accuracy, and truthfulness of all data submitted by providers, and a process to verify all data before submitting to OHA

Performance Measures

OHA should document processes, policies, and procedures specific to each performance measure. This documentation should specify steps to ensure that:

- OHA receives complete encounter data from all CCOs in a timely manner
- the data flow between and within OHA systems is documented and understood
- OHA communication with CCOs and provider agencies is documented and consistent
- code review is conducted on all performance measure calculations that use encounter data

APPENDIX A. PLAN PROFILES

These profiles briefly describe each CCO's organizational structure and summarize the CCO's performance in the review areas covered by the 2014 EQR:

- Statewide and CCO-specific performance improvement projects (PIPs)
- Information Systems Capabilities Assessment (ISCA)
- Compliance with regulatory and contractual standards

These high-level results are extracted from the reports of individual CCO reviews that Acumentra Health delivered to OHA throughout 2014. Acumentra Health calculated the CCO scores for these activities using methodology based on the Centers for Medicare & Medicaid Services review protocols and approved by OHA.

Profiles are presented for the 15 CCOs and 2 additional managed care entities (CareOregon and GOBHI) that served Oregon Health Plan enrollees during 2014.

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AllCare Health Plan

AllCare Health Plan has an agreement with Mid Rogue Management Services Organization to provide the staff needed to support CCO operational management and to administer claims management, customer service, credentialing, network management, contracting, compliance, and data management services. AllCare delegates mental health services to Jackson County Mental Health, Curry Community Health, and Options for Southern Oregon. The CCO delegates addiction and drug recovery to OnTrack; opioid treatment services to Allied Health Services; and dental care management to Advantage Dental, Capitol Dental Care, Willamette Dental Group, and Moda Health. The CCO directly manages quality improvement activities (overseen by the CCO's governing body) and final adjudication of appeals.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 92 out of 100)

Strengths: AllCare thoroughly described its root cause analysis, described why the interventions are expected to improve the study indicator, addressed the cultural and linguistic appropriateness of its interventions, and described the next steps for this PIP.	**Recommendations:** The CCO should provide more details about its tracking and monitoring of the interventions to demonstrate the effectiveness of implementation.
CCO-Specific PIPs: • Increase referrals to community substance abuse treatment programs for expectant mothers • Increase percentage of members age 50 and older who are disabled or dual-eligible with an advanced directive embedded in PCPCH EMR	**CCO Focus Area:** Increase the rate of primary care visits for members with severe and persistent mental illness

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.5)	Enrollment Systems	Fully Met (3.0)
Staffing	Fully Met (3.0)	Vendor Data Integration/Ancillary Systems	Fully Met (3.0)
Hardware Systems	Fully Met (2.7)	Report Production and PM Reports	Partially Met (2.4)
Security	Partially Met (2.3)	Provider Data	Partially Met (2.5)
Administrative Data	Fully Met (2.8)	Meaningful Use of EHRs	Fully Met (2.9)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: AllCare needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – Monitoring: AllCare needs to monitor all partner organizations and provider agencies to ensure that their IT policies and procedures are up-to-date and comply with CCO contract requirements. The CCO should monitor provider agencies' IT security, including backup processes, encryption and media destruction practices, and password security standards to ensure that they align with industry standards and HIPAA requirements.

Finding #3 – Lack of business continuity/disaster recovery (BC/DR) plan: AllCare needs to ensure that its BC/DR plan, and those of its provider agencies, address all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems. The BC/DR plans should be tested regularly and updated when significant changes occur.

Finding #4 – Provider directory: The CCO's provider directory should include information on all types of providers (physical health, mental health, and dental services), including practitioners' specialties, gender, languages spoken, and provider type.

AllCare needs to determine which IT policies and procedures the CCO needs to develop and which of Mid Rogue Management's policies and procedures the CCO can use.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Substantially Met (3.2)	**Grievance Systems – Fully Met (3.9)**
Enrollee rights: General – 4.0	Grievance system: General – 4.0
Information requirements – 3.5	General requirements and filing requirements – 4.0
Notification timing – 3.0	Language and format of notice of action – 4.0
Notification content – 3.0	Content of notice of action – 4.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 2.0
Respect and dignity – 4.0	Handling of grievances and appeals – 4.0
Treatment options – 4.0	Expedited resolution of appeals – 4.0
Advance directives – 2.0	Format and content of notice of appeal resolution – 4.0
Seclusion and restraint – 2.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 3.0	Information to providers and subcontractors – 4.0
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Substantially Met (3.0)	Continuation of benefits during appeal – 4.0
Certifications – 3.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 3.0	
General program integrity requirements – 2.0	
Specific program integrity requirements – 4.0	

Strengths	Key Findings
Enrollee Rights	
• The CCO's handbook is integrated, easy to read, and visually attractive. AllCare informs the member that the primary care team includes community health workers, personal navigators, and peer wellness specialists. • The CCO distributes information about interpretive services in provider newsletters, at manager meetings, and during face-to-face meetings at provider offices. Dental organizations received a reminder memo regarding the availability of interpreter services. • AllCare makes a live receptionist available from 8 a.m. to 8 p.m. seven days a week to answer member inquiries and arrange interpretive services.	• The CCO's member materials/website did not provide complete information about individual practitioners' specialties, language capabilities, and whether they are accepting new members for all service areas. • The CCO did not demonstrate that its processes were implemented consistently across all service areas.
Grievance Systems	
• Practitioners/subcontractors are informed about the grievance system during initial contracting, at provider meetings, by newsletters and face-to-face contact.	• The CCO lacks a policy for defining the timing of notices for termination, suspension, or reduction of previously authorized Medicaid-covered services.
Certification and Program Integrity	
• The CCO provides annual training to the board, shareholders, and office staff regarding conflict of interest. • The CCO screens non-contractor provider claims for exclusion before paying the claim.	• The CCO's policies and procedures did not require all providers and subcontractors to comply with disclosure requirements regarding conflict of interest and vendor relations, and other compensations.

CareOregon MCO

As a fully capitated health plan, CareOregon provides only physical health care services for about 3,500 OHP enrollees, primarily in Marion and Polk counties. Mental health services are available to the members through Willamette Valley Community Health CCO, which subdelegates to Mid-Valley Behavioral Care Network.

Performance Improvement Projects (PIPs)

Clinical PIP: Diabetes Monitoring for People with Diabetes and Schizophrenia or Bipolar Disorder: Not scored The MCO selected this topic to align with the Statewide PIP. However, data showed that the number of study-eligible members was too low to justify continuation of the project. This PIP was accepted as meeting the MCO's contract requirement, but was not scored.	**Nonclinical PIP: Assuring Better Child Health and Development (ABCD) III: Overall score: 63 out of 85 (Substantially Met)** The MCO provided a rationale for selecting the study topic and study indicator, formulated a study question, defined the numerator and denominator, described data collection procedures, and presented a data analysis plan. The MCO now needs to implement, track, and monitor the intervention, collect remeasurement data, and analyze the results.

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Fully Met (2.7)	Enrollment Systems	Fully Met (3.0)
Staffing	Fully Met (3.0)	Vendor Data Integration/Ancillary Systems	Fully Met (3.0)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Partially Met (2.0)
Security	Partially Met (2.1)	Provider Data	Fully Met (3.0)
Administrative Data	Fully Met (2.7)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Lack of updated policies and procedures: Many of CareOregon's policies and procedures had not been updated in the past two years. The MCO needs to update any policies and procedures that no longer meet OHA contract requirements.

Finding #2 – Lack of business continuity/disaster recovery (BC/DR) plan: CareOregon needs to ensure that its BC/DR plan addresses all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable a skilled IT person to recover or assist with resuming operations in a timely manner.

Finding #3 – Provider directory: At the time of review, CareOregon's provider directory had not been working for several months. The MCO needs to ensure that the directory is accessible to members and presents information on practitioners' specialties, gender, languages spoken, and provider type.

CareOregon needs to develop and implement a formal process for peer review of data report production.

CareOregon needs to develop and implement a process for monitoring provider agencies' IT security, data breach reporting strategies, password security requirements, data encryption practices, and BC/DR planning and testing.

CareOregon should regularly validate a sample of the state's encounter data against clinical records to assess the completeness and accuracy of the MCO's encounter data.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Substantially Met (3.3)	**Grievance Systems – Fully Met (3.9)**
Enrollee rights: General – 4.0	Grievance system: General – 4.0
Information requirements – 3.0	General requirements and filing requirements – 4.0
Notification timing – 3.0	Language and format of notice of action – 3.5
Notification content – 3.5	Content of notice of action – 4.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 3.5
Respect and dignity – 3.5	Handling of grievances and appeals – 4.0
Treatment options – 4.0	Expedited resolution of appeals – 3.0
Advance directives – 3.5	Format and content of notice of appeal resolution – 4.0
Seclusion and restraint – 2.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 3.0	Information to providers and subcontractors – 4.0
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Substantially Met (2.9)	Continuation of benefits during appeal – 4.0
Certifications – 2.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 3.5	
General program integrity requirements – 3.0	
Specific program integrity requirements – 3.5	

Strengths	Key Findings
Enrollee Rights	
• CareOregon routinely monitors customer service calls and incorporates the results into the customer service staff's annual performance appraisal. The MCO thoroughly analyzes appeals and grievances, and incorporates provider complaints and QI issues into the recredentialing process. • CareOregon's online information indicates that provider listings are "as of the previous day." This is helpful for determining which practitioners are accepting new members.	• CareOregon does not inform enrollees at least annually of their right to request and obtain names, locations, and telephone numbers of, and all non-English languages spoken by current network providers in the enrollee's service area. • CareOregon did not demonstrate that it reviews the use of seclusion and restraint by contracted providers and facilities as part of its credentialing and recredentialing process. • CareOregon did not demonstrate that it had a process in place to ensure that enrollees can request and receive their medical records and can request that they be amended or corrected.
Grievance Systems	
• CareOregon's notices of grievance resolution fully address each aspect of the complaint and are written in easily understood terms.	• CareOregon did not notify enrollees when grievance time frames were extended.
Certification and Program Integrity	
• CareOregon's comprehensive conflict-of-interest disclosure packet is completed annually by the board of directors, officers, and key employees.	• CareOregon did not demonstrate assurance that its conflict-of-interest policies apply to providers.

Cascade Health Alliance (CHA)

CHA is a wholly owned subsidiary of Cascade Comprehensive Care (CCC), a local physician-owned organization. CHA has no employees, but leases employees from CCC to perform the contractually required administrative and operational activities of the CCO on behalf of OHP members in Klamath County. CHA contracts with local agencies to provide mental health care services and substance use disorder prevention and treatment. CHA administers and manages behavioral health services, including credentialing, utilization management, grievance system, network management, quality improvement (QI), and customer service. CHA's governing board oversees QI activities, and the CCO's medical director adjudicates final appeals.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 91 out of 100)

Strengths: CHA did a good job of analyzing local data, conducting a root cause analysis, and using those analyses to develop its interventions.	**Recommendations:** CHA needs to clarify issues regarding cultural and linguistic appropriateness and implementation tracking/monitoring, and document how the CCO could address some of its identified barriers.
CCO-Specific PIPs: • Promote single evidence-based guideline for the treatment of chronic obstructive pulmonary disease • Improve access and quality of care for maternity and perinatal care	**CCO Focus Area:** Increase number of Medicaid members enrolled in a PCPCH, any tier

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Not Met (1.8)	Enrollment Systems	Fully Met (2.8)
Staffing	Partially Met (2.5)	Vendor Data Integration/Ancillary Systems	Fully Met (2.8)
Hardware Systems	Partially Met (2.5)	Report Production and PM Reports	Partially Met (2.4)
Security	Not Met (1.7)	Provider Data	Partially Met (2.5)
Administrative Data	Partially Met (2.2)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: CHA needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – Monitoring: CHA needs to develop and implement a process for monitoring providers' and partner organizations' adherence to IT policies, procedures, and CCO contract requirements.

Finding #3 – Lack of integrated policies and procedures: CHA needs to develop policies and procedures, identify roles and responsibilities, and define functions to integrate all CCO activities.

Finding #4 – Lack of integrated business continuity/disaster recovery (BC/DR) plan: CHA needs to ensure that its BC/DR plan addresses all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems.

Finding #5 – Provider directory: The CCO's provider directory should include information on all types of providers (physical health, mental health, and dental services), including practitioners' specialties, gender, languages spoken, and provider type.

CHA's strategic plan should define IT activities, roles, and responsibilities.

CHA should regularly validate a sample of the state's encounter data against clinical records for all service types (e.g., dental) to assess the completeness and accuracy of the CCO's encounter data.

CHA needs to adopt and thoroughly document a system development life cycle, formalize its process for peer review of computer programming, and implement planned upgrade strategies for critical hardware.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Substantially Met (3.0)	**Grievance Systems – Fully Met (3.9)**
Enrollee rights: General – 3.0	Grievance system: General – 4.0
Information requirements – 3.5	General requirements and filing requirements – 4.0
Notification timing – 4.0	Language and format of notice of action – 3.5
Notification content – 3.5	Content of notice of action – 4.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 4.0
Respect and dignity – 3.5	Handling of grievances and appeals – 4.0
Treatment options – 3.5	Expedited resolution of appeals – 4.0
Advance directives – 3.5	Format and content of notice of appeal resolution – 4.0
Seclusion and restraint – 0.5	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 2.0	Information to providers and subcontractors – 3.5
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Not Met (1.6)	Continuation of benefits during appeal – 4.0
Certifications – 2.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 1.0	
General program integrity requirements – 1.5	
Specific program integrity requirements – 2.0	

Strengths	Key Findings
Enrollee Rights	
• CHA's website displays all policies, procedures, and time frames related to the grievance, appeal, and fair hearing process. The grievance process is well defined in the member handbooks. • In the member handbooks and in multiple policies and procedures, CHA informs enrollees, or the family or surrogate if the enrollee is incapacitated, about advance directives.	• CHA did not ensure that providers consistently followed federal and state laws and regulations during the past calendar year. • The CCO lacks a process to ensure that enrollees are free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • CHA did not have nondiscrimination policies and procedures and lacked a monitoring process.
Grievance Systems	
• CHA fully met the criteria for this section.	• None.
Certification and Program Integrity	
• CHA conducts compliance training for staff annually and at hire. The training includes modules on fraud, waste, and abuse, standards of conduct, HIPAA, and the various oversight committees, including the board of directors. • CHA conducts internal audits of its departments. Annual audits of providers include an administrative audit. The CCO has mechanisms in place to identify anomalies in its claims processing and payment systems.	• CHA does not monitor staff, governing board, non-licensed employees, non-licensed subcontracted affiliates, and the Citizen's Advisory Committee for exclusion from participating in federal health care programs. • CHA did not have an approved compliance program nor a compliance committee at the time of the site visit. • CHA did not document an internal routine monitoring and auditing process for identifying fraud, waste, and abuse and lack of compliance.

Columbia Pacific CCO (CPCCO)

Based in Portland, CPCCO provides physical and behavioral health services to OHP members in Columbia, Clatsop, Tillamook, and western Douglas counties. CPCCO is a wholly owned subsidiary of CareOregon and has a management agreement with CareOregon to provide CCO support services (including administrative and risk-associated services). CareOregon delegates behavioral health services to Greater Oregon Behavioral Health, Inc. (GOBHI); pharmacy services to Catamaran; and disease management to Health Integrated. CPCCO's utilization management, care coordination, and case management activities are shared functions between CareOregon and GOBHI staff.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 70 out of 100)

Strengths: CPCCO consistently tracked the study indicator over time, and described the interventions and their progress (or lack thereof) at each quarterly update.	**Recommendations:** CPCCO should conduct additional analyses of the study population and the barriers preventing receipt of testing; document how the interventions address identified root causes; report tracking and monitoring results; and clarify whether previously documented barriers have remained unchanged over time.
CCO-Specific PIPs: • Addressing population health issues: Best practices in the prescribing of opioids for chronic pain • Improving perinatal and maternity care: Improve timeliness of prenatal care	**CCO Focus Area:** Increase rates of developmental screening for children up to 36 months

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Not Met (1.9)	Enrollment Systems	Fully Met (2.7)
Staffing	Fully Met (2.75)	Vendor Data Integration/Ancillary Systems	Fully Met (2.75)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Partially Met (2.2)
Security	Not Met (1.5)	Provider Data	Partially Met (2.5)
Administrative Data	Fully Met (2.6)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: CPCCO needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – Lack of integrated policies and procedures: CPCCO needs to develop policies and procedures, identify roles and responsibilities, and define functions to integrate all CCO activities.

Finding #3 – Monitoring: CPCCO needs to monitor provider agencies' IT security, data breach reporting strategies, password security requirements, data encryption practices, and BC/DR planning and testing.

Finding #4 – Lack of integrated business continuity/disaster recovery (BC/DR) plan: CPCCO needs to ensure that its BC/DR plan addresses all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems.

CPCCO needs to continue plans to implement a single data repository containing physical and behavioral health, vision, pharmacy, and ultimately dental service encounters to enable reporting on integrated care.

CPCCO should regularly validate a sample of the state's encounter data against clinical records to assess the completeness and accuracy of the CCO's encounter data.

CPCCO needs to create a provider directory with information on all types of providers, including physical health, mental health, and dental services, including practitioners' specialties, gender, and languages spoken.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Partially Met (2.3)	**Grievance Systems – Substantially Met (3.3)**
Enrollee rights: General – 2.5	Grievance system: General – 3.0
Information requirements – 3.0	General requirements and filing requirements – 4.0
Notification timing – 3.0	Language and format of notice of action – 3.0
Notification content – 3.0	Content of notice of action – 4.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 3.0
Respect and dignity – 2.0	Handling of grievances and appeals – 3.0
Treatment options – 2.0	Expedited resolution of appeals – 2.0
Advance directives – 2.0	Format and content of notice of appeal resolution – 3.0
Seclusion and restraint –1.0	Action after denial of request for expedited resolution – 3.0
Compliance with other state/federal laws – 3.0	Information to providers and subcontractors – 3.0
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Substantially Met (2.8)	Continuation of benefits during appeal – 4.0
Certifications – 3.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 3.0	
General program integrity requirements – 2.0	
Specific program integrity requirements – 3.0	

Strengths	Key Findings
Enrollee Rights	
• The CCO's provider agreement clearly states that the provider may, without constraint from the CCO, advise or advocate on behalf of members regarding treatment options. • The CCO's provider contracts define expectations of providers regarding advance directives.	• The CCO did not demonstrate monitoring of enrollee rights across all service areas. • The CCO did not provide information about which providers were not accepting new patients, or about non-English languages spoken by providers. • The CCO did not demonstrate integration of its policies and procedures across all service lines.
Grievance Systems	
• The CCO's comprehensive grievance policy and procedure provides staff with clear directions about investigating grievances.	• The CCO did not demonstrate that its grievance system was consistently implemented across all service areas. • The CCO did not notify enrollees when extending the time frame for resolving grievances.
Certification and Program Integrity	
• The CCO and its delegates have processes in place to report a compliance violation or fraud and abuse through a variety of methods.	• The CCO's policies and procedures did not require all providers and subcontractors to comply with disclosure requirements. • Contracts with partners and subcontractors did not specify the frequency with which individuals and facilities are monitored for exclusion. • The CCO's compliance activities were not integrated.

Eastern Oregon CCO (EOCCO)

EOCCO provides physical, behavioral, and dental health services to OHP members in Baker, Gilliam, Grant, Harney Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler counties. EOCCO is a limited liability corporation formed through a partnership of Moda Health, Greater Oregon Behavioral Health, Inc. (GOBHI), Good Shepherd Health Care System, Grand Ronde Hospital, Inc., Saint Alphonsus Health System, St. Anthony Hospital, Pendleton IPA, and Yakima Valley Farm Workers Clinic. Moda Health and GOBHI employees perform daily operational activities for the CCO, and the two organizations share responsibility for claims payment, credentialing, customer service, provider contracting, quality improvement, and utilization management. At the time of the site review, Moda Health and GOBHI maintained separate information systems.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 100 out of 100)

Strengths: EOCCO presented clear and thorough documentation to meet all criteria for Standard 8. The continually updated, detailed information about the study indicator and effective implementation of the interventions were particularly noteworthy.

CCO-Specific PIPs:	**CCO Focus Area:** Increase rates of developmental screening for children up to 36 months
• Improve maternity and child health outcomes • Increase early childhood mental health screening, referral to treatment and coordination of care	

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.2)	Enrollment Systems	Partially Met (2.4)
Staffing	Fully Met (3.0)	Vendor Data Integration/Ancillary Systems	Fully Met (2.8)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Partially Met (2.4)
Security	Not Met (1.7)	Provider Data	Partially Met (2.5)
Administrative Data	Fully Met (2.7)	Meaningful Use of EHRs	Partially Met (2.4)

Key Findings and Areas for Improvement

Finding #1 – Reporting: EOCCO needs to continue plans to implement a single data repository for all CCO services to enable reporting on integrated care.

Finding #2 – Encounter data certification: EOCCO needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #3 – Lack of integrated policies and procedures: EOCCO needs to develop policies and procedures, identify roles and responsibilities, and define functions to integrate all CCO activities.

Finding #4 – Monitoring: EOCCO needs to monitor all partner organizations to ensure that their IT policies and procedures are up-to-date and comply with CCO contract requirements.

Finding #5 – Lack of business continuity/disaster recovery (BC/DR) plan: EOCCO needs to ensure that its BC/DR plan addresses all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems.

Finding #6 – Eligibility: EOCCO needs to develop and implement a monitoring process to ensure that all providers, including mental health service providers, check member eligibility at every encounter.

Finding #7 – Provider directory: The CCO's provider directory should include information on all types of providers (physical and mental health, vision, pharmacy, and dental services), including practitioners' specialties, gender, languages spoken, and provider type.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Substantially Met (3.3)	**Grievance Systems – Fully Met (3.5)**
Enrollee rights: General – 4.0	Grievance system: General – 3.5
Information requirements – 3.5	General requirements and filing requirements – 3.0
Notification timing – 3.0	Language and format of notice of action – 3.0
Notification content – 3.0	Content of notice of action – 4.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 3.0
Respect and dignity – 4.0	Handling of grievances and appeals – 3.0
Treatment options – 4.0	Expedited resolution of appeals – 4.0
Advance directives – 2.5	Format and content of notice of appeal resolution – 3.5
Seclusion and restraint – 2.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 4.0	Information to providers and subcontractors – 3.0
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Partially Met (2.7)	Continuation of benefits during appeal – 4.0
Certifications – 2.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 3.0	
General program integrity requirements – 3.0	
Specific program integrity requirements – 3.0	

Strengths	Key Findings
Enrollee Rights	
• Orientation for EOCCO's customer service representatives includes an eight-week training program, and customer service monitoring includes monthly call audits. • EOCCO's integrated member handbook provides member education in easy-to-understand language. • EOCCO provides annual training to physical health providers in its service area regarding member rights. The CCO also provides one-on-one refresher training to new network providers.	• The CCO did not provide complete information about individual mental health practitioners' specialties, language capabilities, and whether they are accepting new members for all service areas. • The CCO did not demonstrate routine monitoring of documentation of advance directives in clinical records. The CCO did not provide community education about advance directives in 2013. • The CCO lacks a process to ensure that enrollees are free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
Grievance Systems	
• The CCO processes an appeal as expedited when a provider requests it on the member's behalf. • The CCO's notice-of-action letters inform members of the availability of other formats and languages.	• The CCO did not have uniform grievance policies and procedures in place for all service areas. • The CCO did not demonstrate that its grievance system was implemented consistently across all service areas.
Certification and Program Integrity	
• Moda and GOBHI employees receive annual training in fraud and abuse and HIPAA issues. • Moda uses claims software designed to detect unusual billing practices that may suggest fraud, waste, or abuse.	• The CCO's policy and procedure did not require all providers and subcontractors to comply with conflict-of-interest disclosure requirements. • The CCO did not have an approved compliance program at the time of the site visit.

FamilyCare Inc.

FamilyCare serves OHP members in Multnomah, Washington, and Clackamas counties and a portion of Marion County. Before becoming a CCO, FamilyCare was an integrated managed care organization with an established physical and mental health network. The CCO delegates pharmacy benefit management to CVS CareMark, claims administration to PH Tech, and some credentialing to Yakima Valley Farm Workers Clinic.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 90 out of 100)

Strengths: The CCO presented information about its root cause analysis, how the intervention can be expected to improve the study indicator, frequencies of tracking and monitoring activities, and barriers to implementation of the intervention.	**Recommendations:** FamilyCare should consider whether there is enough room for improvement at its selected clinic site before proceeding further. Also, the CCO needs to provide additional information about its interventions, including tracking and monitoring results, as well as how barriers have been or will be addressed.
CCO-Specific PIPs: • Improve primary care: Well-child visits • Improve primary care: Colorectal screening	**CCO Focus Area:** Increase the percentage of members assigned to a PCPCH

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.3)	Enrollment Systems	Fully Met (3.0)
Staffing	Fully Met (3.0)	Vendor Data Integration/Ancillary Systems	Fully Met (2.8)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Fully Met (2.8)
Security	Partially Met (2.0)	Provider Data	Partially Met (2.5)
Administrative Data	Partially Met (2.5)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Vision data: FamilyCare and its delegates need to submit vision service data to OHA per contract requirements. The CCO needs to continue plans to integrate vision claims and encounters into its processes.

Finding #2 – Encounter data certification: FamilyCare needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #3 – Monitoring: FamilyCare needs to monitor all partner organizations to ensure that their IT policies and procedures are up to date and comply with CCO contract requirements.

Finding #4 – Monitoring of partner organizations' business continuity/disaster recovery (BC/DR) plans: FamilyCare needs to monitor PH Tech and the provider agencies to ensure that their BC/DR plans are up to date, aligned with CCO contract requirements, and tested regularly.

Finding #5 – Provider directory: The CCO's provider directory should include information on all types of providers (physical and mental health, vision, pharmacy, and dental services), including practitioners' specialties, gender, languages spoken, and provider type.

FamilyCare should regularly validate a sample of the state's encounter data against clinical records to assess the completeness and accuracy of the CCO's encounter data.

FamilyCare needs to continue to work with PH Tech and provider agencies to reduce the volume of paper claims for both physical and mental health encounters.

FamilyCare and PH Tech should develop a process to periodically review access to CCO data and terminate users' access to external or client-hosted systems when access is no longer required or authorized.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Partially Met (2.6)	**Grievance Systems – Fully Met (3.6)**
Enrollee rights: General – 2.0	Grievance system: General – 4.0
Information requirements – 3.0	General requirements and filing requirements – 4.0
Notification timing – 3.0	Language and format of notice of action – 3.0
Notification content – 2.0	Content of notice of action – 4.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 2.0
Respect and dignity – 2.0	Handling of grievances and appeals – 3.5
Treatment options – 4.0	Expedited resolution of appeals – 4.0
Advance directives – 2.0	Format and content of notice of appeal resolution – 4.0
Seclusion and restraint – 2.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state federal laws – 2.0	Information to providers and subcontractors – 2.0
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Fully Met (3.7)	Continuation of benefits during appeal – 4.0
Certifications – 3.5	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 3.5	
General program integrity requirements – 4.0	
Specific program integrity requirements – 4.0	

Strengths	Key Findings
Enrollee Rights	
• FamilyCare conducts a “welcome call” to new members. The call includes an orientation to the member handbook, which contains information about member rights. • FamilyCare records phone calls to monitor the quality of translation or need for alternative formats at the CCO level. • FamilyCare has a pilot project with Asian Health Services that provides culturally and linguistically appropriate system navigation and wraparound services for the CCO’s Asian enrollees.	• The CCO did not monitor to ensure that providers were consistently following federal and state laws and regulations regarding enrollee rights in 2013. • The CCO’s provider directory and website lack necessary information to fully inform enrollees about available practitioners in the service area. • The CCO did not monitor compliance concerning advance directives and the right to be free from seclusion and restraint.
Grievance Systems	
• FamilyCare meets all criteria for the majority of grievance standards.	• The CCO lacked a policy and procedure on time frames for authorization decisions and for expedited authorization decisions.
Certification and Program Integrity	
• FamilyCare has a strong compliance program. The CCO conducted an audit of its compliance program in 2013 that covered the Medicare and Medicaid lines of business and addressed all required elements of a compliance program.	• The CCO did not run the excluded provider list monthly for its own staff and governing board members to ensure that they are not excluded from participating in federal health care programs.

Greater Oregon Behavioral Health, Inc. (GOBHI)

GOBHI is a mental health organization (MHO) that contracts with OHA to deliver managed mental health services to OHP enrollees. At the time of the site review, GOBHI was still operating as an MHO in multiple counties, while also providing its mental health expertise to some CCOs.

Performance Improvement Projects (PIPs)

Clinical PIP: Early Childhood Assessment and Intervention Training. Overall score = 92 out of 100 (Fully Met)

This PIP focused on increasing access to services (service penetration rate) for MHO members five years and younger through outreach and education programs aimed at "first observers." GOBHI reported statistically significant improvement in the study indicator over three remeasurement periods.

Nonclinical PIP: Mental Health First Aid. Overall score = 59 out of 85 (Substantially Met)

This PIP, initiated in 2013, aims to increase the percentage of GOBHI-enrolled children aged 6–18 who utilize mental health services. GOBHI's planned intervention, Mental Health First Aid workshops for school staff and teachers, had not been implemented due to inability to recruit a school district partner. The MHO needs to choose a more feasible intervention or a new study topic if the recruitment barrier cannot be addressed in a timely manner.

Information Systems Capabilities Assessment

Summary of ISCA Follow-Up: Acumentra Health conducted a full ISCA for GOBHI in 2013 and found that GOBHI *partially met* federal 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. Opportunities for improvement and recommendations appeared in GOBHI's 2013 EQR report.

In 2014, Acumentra Health reviewed with GOBHI the 2013 opportunities for improvement and recommendations, and evaluated GOBHI's documentation to assess the steps the MHO had taken to address them. GOBHI was in the process of addressing 5 of the 36 recommendations from 2013, but still needed to address the remaining 31.

As noted in the 2013 review, GOBHI needs to establish monitoring processes to ensure proper oversight of its third-party administrator, PH Tech. GOBHI needs to continue addressing issues from the transition to PH Tech. This includes reported delays in encounter data submission (from providers to PH Tech) and clarifying PH Tech's roles and responsibilities for monitoring encounter data. GOBHI also needs to address data security issues, such as data encryption and backup storage, with its provider agencies to ensure that they meet industry standards.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Partially Met (2.6)	**Grievance Systems – Partially Met (2.5)**
Enrollee rights: General – 4.0	Grievance system: General – 1.0
Information requirements – 2.0	General requirements and filing requirements – 4.0
Notification timing – 2.0	Language and format of notice of action – 1.0
Notification content – 2.0	Content of notice of action – 1.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 2.0
Respect and dignity – 4.0	Handling of grievances and appeals – 4.0
Treatment options – 3.0	Expedited resolution of appeals – 3.5
Advance directives – 2.0	Format and content of notice of appeal resolution – 2.5
Seclusion and restraint – 1.5	Action after denial of request for expedited resolution – 3.5
Compliance with other state/federal laws – 2.0	Information to providers and subcontractors – 3.0
	Record keeping and reporting requirements – 3.5
Certifications/Program Integrity – Fully Met (3.5)	Continuation of benefits during appeal – 2.0
Certifications – 3.0	Effectuation of reversed appeal resolutions – 2.0
Provider selection, excluded providers – 4.0	
General program integrity requirements – 4.0	
Specific program integrity requirements – 3.0	

Strengths	Key Findings
Enrollee Rights	
• GOBHI has made progress since the previous EQR, including by updating many of its policies and procedures and by reinstating provider site visits. • GOBHI hired a member and diversity coordinator who has strengthened GOBHI's cultural competency. • GOBHI conducted a consumer survey, and its staff followed up on negative comments from members.	• GOBHI lacks a process to monitor use of translation and interpreter services at the CMHPs, compliance with whether the member has executed an advance directive, and use of seclusion and restraint. • GOBHI does not inform enrollees who do not speak English or Spanish about how to obtain information in their primary language. • GOBHI's member handbook presents no information on how to obtain services not included in its MHO contract, and does not define "post stabilization." • GOBHI lacks a centralized provider directory with information about individual practitioner's specialties and language capabilities.
Grievance Systems	
• GOBHI's staff treated all negative comments from the consumer survey as grievances.	• GOBHI did not issue notices of action (NOAs) when services were denied, reduced, or terminated, and did not notify its enrollees that alternative formats are available for these notices. • GOBHI did not issue an NOA when an appeal resolution exceeded the specified time frame.
Certification and Program Integrity	
• GOBHI has a strong compliance program.	

Health Share of Oregon

Health Share, based in Portland, provides physical and behavioral health services to OHP members in Multnomah, Clackamas, and Washington counties. The CCO comprises 16 risk-accepting entities (RAEs) that are capitated to deliver physical, mental, and dental health services to enrollees. All Health Share employees are "leased" from CareOregon, which is both a RAE and a delegate. Health Share and CareOregon have a management services agreement for human resources, accounting, and a portion of IT functions. Health Share's many workgroups and committees are charged with fully integrating behavioral and physical health care.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 100 out of 100)

Strengths: Health Share did an excellent job of documenting their intervention efforts and addressing the Standard 8 criteria. In particular, the CCO thoroughly analyzed its initial data, clearly delineated its process for selecting an intervention strategy and provided details on its tracking and monitoring activities.	**Recommendations:** Acumentra Health looks forward to hearing from Health Share whether the model at Cascadia is successful and whether it will be utilized in other locations.
CCO-Specific PIPs: • Deploying care teams to improve care and reduce utilization for high-utilizing members • Reducing preventable rehospitalizations	**CCO Focus Area:** Increase developmental screening for children 0-3 years

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.0)	Enrollment Systems	Partially Met (2.5)
Staffing	Fully Met (2.8)	Vendor Data Integration/Ancillary Systems	Fully Met (2.6)
Hardware Systems	Partially Met (2.5)	Report Production and PM Reports	Fully Met (2.6)
Security	Not Met (1.7)	Provider Data	Partially Met (2.3)
Administrative Data	Partially Met (2.2)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: Health Share needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA. The CCO needs to develop a process to certify data submitted to OHA, and ensure that signing the attestation is not delegated.

Finding #2 – Non-supported operating systems: Health Share needs to ensure that RAEs are running supported operating systems and database platforms.

Finding #3 – Lack of encounter data submission from DCO: Health Share needs to ensure that Kaiser Dental complies with CCO contract requirements for submission of encounter data.

Finding #4 – Lack of integrated policies and procedures: Health Share needs to determine what IT policies and procedures should not be delegated to RAEs but kept at the CCO level; determine the necessary elements or standards to be present in the RAEs' policies for consistency across the CCO's services area; and monitor the RAEs' policy updates and compliance with contract requirements.

Finding #5 – Monitoring: Health Share needs to monitor all partner organizations to ensure that their IT security policies and procedures are up-to-date and comply with CCO contract requirements.

Finding #6 – Lack of business continuity/disaster recovery (BC/DR) plan: Health Share needs to develop a CCO-level BC/DR plan that addresses all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems. The CCO's BC/DR plans and those of the RAEs should be tested regularly and updated when significant changes occur.

Finding #7 – Provider directory: Health Share should work with the RAEs to establish uniform standards for the information that should appear in their provider directories.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Fully Met (3.7)	**Grievance Systems – Fully Met (3.6)**
Enrollee rights: General – 4.0	Grievance system: General – 3.5
Information requirements – 4.0	General requirements and filing requirements – 4.0
Notification timing – 3.5	Language and format of notice of action – 3.5
Notification content – 3.0	Content of notice of action – 3.5
Information on grievance process and time frames – 4.0	Timing of notice of action – 3.0
Respect and dignity – 4.0	Handling of grievances and appeals – 3.5
Treatment options – 4.0	Expedited resolution of appeals – 3.5
Advance directives – 4.0	Format and content of notice of appeal resolution – 3.5
Seclusion and restraint – 3.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 4.0	Information to providers and subcontractors – 3.0
	Record keeping and reporting requirements – 3.5
Certifications/Program Integrity – Substantially Met (3.4)	Continuation of benefits during appeal – 4.0
Certifications – 3.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 4.0	
General program integrity requirements – 3.0	
Specific program integrity requirements – 3.5	

Strengths	Key Findings
Enrollee Rights	
• Health Share convened a cultural competency workgroup that explores health equity topics. The CCO's cultural competency work plan includes increasing the availability of qualified interpreters. • Health Share's compliance review of the RAEs covers policies and procedures regarding advance directives, mental health declarations, and seclusion and restraint. • Health Share has a robust process to ensure that its RAEs comply with federal and state laws.	• Health Share did not monitor all RAEs to ensure that they are meeting enrollee rights requirements. • Health Share did not provide all the required information to enrollees for all RAEs, such as emergency settings and locations for emergency and post-stabilization services. • Health Share did not provide a policy and procedure as to how enrollees can access specialty care and other services not furnished by the enrollee's PCP for all service areas. • Health Share did not review use of seclusion and restraint as part of its credentialing/recredentialing process.
Grievance Systems	
• Health Share has a comprehensive tool for monitoring the grievance system. The CCO provides ongoing coaching when issues are first identified.	
Certification and Program Integrity	
• The CCO has identified gaps among the RAEs and has taken steps to educate the RAEs about the need for a compliance program, practices, and plan.	• Health Share needs to ensure that all RAEs have policies and procedures on disclosure of conflicts of interest.

Intercommunity Health Network (IHN)

IHN, a wholly owned subsidiary of Samaritan Health Services, serves OHP enrollees in Benton, Lincoln, and Linn counties. The CCO is managed by Samaritan Health Plan Operations (SHPO), and all CCO staff members are SHPO employees. The CCO's governing board, representing diverse local stakeholders, meets quarterly and reports to Samaritan Health Services. IHN contracts with Envision Rx Options as the pharmacy benefit manager, with four dental care organizations, and with Cascade West Ride Line for non-emergent medical transportation. SHPO contracts directly with Benton, Linn, and Lincoln counties for mental health services.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 86 out of 100)

Strengths: IHN did a nice job of directly addressing many of the recommendations made by Acumentra Health, including providing additional information about the root cause analysis, reasons why the intervention can be expected to improve the study indicator and details about the intervention time frames.	**Recommendations:** IHN should indicate how many individuals have been reached by its intervention and describe tracking and monitoring of the non-data aspects of its intervention (involvement of the health psychologist and activities of the provider after receiving the master list).
CCO-Specific PIPs: • Reducing preventable rehospitalizations • Improving initial screening and identification of members with cardiovascular risk factors	**CCO Focus Area:** Improve alcohol, drug and mental health screening and referral for pregnant women

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.3)	Enrollment Systems	Fully Met (3.0)
Staffing	Fully Met (3.0)	Vendor Data Integration/Ancillary Systems	Fully Met (3.0)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Fully Met (2.8)
Security	Partially Met (2.3)	Provider Data	Fully Met (2.8)
Administrative Data	Fully Met (2.9)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: IHN needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – Monitoring: IHN needs to monitor all mental health and dental service providers to ensure that their IT policies and procedures are up to date and comply with CCO contract requirements.

Finding #3 – Lack of business continuity/disaster recovery (BC/DR) plan: IHN needs to ensure that its BC/DR plan addresses all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems. IHN should test the plan regularly and update it as necessary.

IHN needs to continue plans to integrate dental claims and encounter processes with current SHPO processes.

IHN should continue plans to implement a single data repository for all CCO services for the CCO's entire history, to enable reporting on integrated care.

IHN needs to determine which IT policies and procedures the CCO needs to establish and which policies and procedures of SHPO the CCO can use. IHN also needs to develop a process to update all IT policies at least every two years to align with contract requirements.

IHN should review provider agencies' data encryption practices to ensure that they are aligned with current industry standards and HIPAA requirements. The CCO should discourage manual processes for properly identifying protected health information and should encourage automated processes.

The CCO's provider directory should include information on all types of providers (physical and mental health, vision, pharmacy, and dental services), including practitioners' specialties, gender, and languages spoken.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Substantially Met (3.1)	**Grievance Systems – Fully Met (3.5)**
Enrollee rights: General – 3.0	Grievance system: General – 2.5
Information requirements – 4.0	General requirements and filing requirements – 3.5
Notification timing – 3.5	Language and format of notice of action – 4.0
Notification content – 3.0	Content of notice of action – 4.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 3.0
Respect and dignity – 3.5	Handling of grievances and appeals – 3.5
Treatment options – 4.0	Expedited resolution of appeals – 3.0
Advance directives – 2.0	Format and content of notice of appeal resolution – 3.0
Seclusion and restraint – 2.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 2.5	Information to providers and subcontractors – 3.0
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Substantially Met (3.0)	Continuation of benefits during appeal – 4.0
Certifications – 3.5	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 3.0	
General program integrity requirements – 3.0	
Specific program integrity requirements – 3.0	

Strengths	Key Findings
Enrollee Rights	
• IHN customer service is available 8 a.m. to 8 p.m. Monday–Friday. • The CCO contracts with primary care providers that maintain evening hours. • SHPO disseminates a brochure on advance directives.	• The CCO lacked a policy on referral for specialty care and on other benefits not furnished by the enrollee's primary care provider. • The CCO did not demonstrate integration of all service areas into its policies, or how it monitors documentation in the clinical record. • The CCO did not ensure that its contracted providers and agencies have policies/procedures on the use of seclusion and restraint, and did not monitor contractors' use of seclusion and restraint through the credentialing/recredentialing process.
Grievance Systems	
• IHN processes all requests made by the attending practitioner as expedited requests. • IHN uses an appeal "checklist" to ensure that it performs all required elements when processing expedited and standard appeals.	• IHN did not demonstrate monitoring of grievance systems in all service areas. • IHN did not monitor the resolution and disposition of grievances and appeals to ensure that they met the required time frames.
Certification and Program Integrity	
• IHN's CEO conducts periodic reviews that include compensation arrangements and benefits, joint venture and partnership arrangements, and ensuring compliance with conflict-of-interest policies.	• The CCO did not ensure that all dental providers, staff, governing board members, and volunteers are screened monthly for exclusion from participation in federal health care programs.

Jackson Care Connect (JCC)

JCC, based in Medford, is a wholly owned subsidiary of CareOregon providing physical and behavioral health services to OHP members in Jackson County. JCC has a management agreement with CareOregon to fulfill many contractual obligations as a CCO, including administrative, medical management, and physical health risk-associated services. JCC has a delegation agreement with Jackson County Mental Health (JCMH) to provide mental health services, and contracts with four dental care organizations to provide dental services. Greater Oregon Behavioral Health, Inc. provides residential addiction treatment for JCC members. Utilization management, care coordination, and case management activities are shared functions between CareOregon and JCMH staff.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 89 out of 100)

Strengths: JCC submitted a detailed and informative Driver Diagram that illuminated some ways in which the intervention can be expected to improve the study indicator. Most notably, the CCO applied tracking and monitoring results to its improvement strategies and next steps.	**Recommendations:** JCC may want to consider specifying potential root causes related to the statewide PIP and indicate if the intervention can be expected to improve the study indicator because it addresses those root causes. JCC also needs to document the cultural aspects of some of its new or planned interventions.
CCO-Specific PIPs: • 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	**CCO Focus Area:** Deploying community care teams

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Not Met (1.8)	Enrollment Systems	Fully Met (2.8)
Staffing	Partially Met (2.5)	Vendor Data Integration/Ancillary Systems	Fully Met (2.7)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Partially Met (2.2)
Security	Not Met (1.5)	Provider Data	Partially Met (2.5)
Administrative Data	Fully Met (2.6)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: JCC needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – Lack of integrated policies and procedures: JCC needs to develop policies and procedures, identify roles and responsibilities, and define functions to integrate all CCO activities.

Finding #3 – Monitoring: JCC needs to monitor all partner organizations and provider agencies to ensure that their IT policies and procedures are up-to-date and comply with CCO contract requirements. The CCO needs to monitor provider agencies' IT security, data breach reporting strategies, password security requirements, data encryption practices, and BC/DR planning and testing.

Finding #4 – Lack of business continuity/disaster recovery (BC/DR) plan: JCC needs to ensure that its BC/DR plan addresses all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems. JCC should test the plan regularly and update it as necessary.

Finding #5 – Provider directory: The CCO's provider directory should include information on all types of providers (physical health, mental health, and dental services), including practitioners' specialties, gender, languages spoken, and provider type.

JCC needs to continue plans to implement a single data repository containing physical and behavioral health, vision, pharmacy, and dental service encounters, to enable reporting on integrated care.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Partially Met (2.5)	**Grievance Systems – Substantially Met (3.0)**
Enrollee rights: General – 2.5	Grievance system: General – 3.0
Information requirements – 3.0	General requirements and filing requirements – 3.0
Notification timing – 3.0	Language and format of notice of action – 3.0
Notification content – 3.0	Content of notice of action – 2.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 3.0
Respect and dignity – 2.0	Handling of grievances and appeals – 3.0
Treatment options – 2.0	Expedited resolution of appeals – 2.0
Advance directives – 2.0	Format and content of notice of appeal resolution – 3.0
Seclusion and restraint – 1.0	Action after denial of request for expedited resolution – 2.0
Compliance with other state/federal laws – 3.0	Information to providers and subcontractors – 3.0
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Substantially Met (2.8)	Continuation of benefits during appeal – 4.0
Certifications – 3.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 3.0	
General program integrity requirements – 2.0	
Specific program integrity requirements – 3.0	

Strengths	Key Findings
Enrollee Rights	
• JCC's contracts stipulate that providers must comply with ADA regulations. • JCC's medical provider agreement clearly states that the provider may, without constraint, advise or advocate on behalf of the enrollee regarding treatment options. • Medical provider contracts define expectations of the provider regarding advance directives.	• JCC did not demonstrate monitoring of enrollee rights across all service areas. • JCC did not make information about accessing all services available to all enrollees. • JCC did not demonstrate integration of mental health and dental services into its policies and procedures. • JCC did not demonstrate that it provides community education on advance directives. • JCC did not ensure that its contracted providers and facilities have policies and procedures addressing seclusion and restraint and non-discrimination.
Grievance Systems	
• CareOregon provides annual training to staff regarding the purpose of advance directives.	• JCC did not demonstrate consistent implementation and monitoring of its grievance system across all service areas.
Certification and Program Integrity	
• JCC and its delegates have processes in place to report a compliance violation or potential fraud and abuse through a variety of methods. • Through CareOregon, JCC has access to many policies and procedures related to program integrity.	• JCC's policies and procedures did not require all providers and subcontractors to comply with disclosure requirements. • JCC's contracts with partners and subcontractors did not specify the frequency of monitoring for exclusion from federal health care programs.

PacificSource Community Solutions (PSCS)

PSCS, an affiliate of PacificSource Health Plans, now serves OHP members through two CCOs: Central Oregon CCO (PSCS–CO, serving Deschutes, Jefferson, and Crook counties) and Columbia Gorge CCO (PSCS–CG, serving Hood River and Wasco counties). As of the site review, the CCO had not yet transitioned into two CCOs. PacificSource Health Plans provides corporate oversight of the CCOs. PSCS contracts with Central Oregon IPA (COIPA) to provide medical services, and delegates credentialing to COIPA. PSCS delegates behavioral health services, including service authorization, care coordination, monitoring for excluded providers, credentialing, and utilization management activities, to Mid-Columbia Center for Living and to the Central Oregon Health Board, which contracts directly with mental health provider agencies. PSCS also contracts with PH Tech to provide claims processing and management, and data analysis and reporting for members and providers.

Performance Improvement Projects (PIPs)

Statewide PIP:

Strengths:	Recommendations:
PSCS–CO: (Standard 8 score = 94 out of 100) PSCS-CO presented a well-organized table of study enrollees according to clinic assignment, and reported on the presence of a behavioral health or case manager at each clinic. **PSCS–CG: (Standard 8 score = 97 out of 100)** The CCO did a good job of updating the Standard 8 criteria according to the needs and circumstances of the new region.	**PSCS–CO:** Once the barriers around Mosaic Clinic are addressed, the CCO should present tracking and monitoring results in its next report. Also, PSCO-CO should follow up on its plan to collect data on clinic adoption of non-fasting LDL testing. **PSCS–CG:** The CCO needs to clarify the nature of the interventions at all of its clinic sites. Also, PSCS–CG should follow up on its plan to collect data on clinics' adoption of non-fasting LDL testing.

CCO-Specific PIPs for PSCS–CO and PSCS–CG:	CCO Focus Area for PSCS–CO and PSCS–CG:
• Improving post-partum care • Integrating chronic pain management into primary care	Increase preventive care to members with severe and persistent mental illness

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.5)	Enrollment Systems	Fully Met (2.9)
Staffing	Fully Met (2.8)	Vendor Data Integration/Ancillary Systems	Fully Met (2.9)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Fully Met (2.8)
Security	Partially Met (2.1)	Provider Data	Partially Met (2.5)
Administrative Data	Fully Met (2.8)	Meaningful Use of EHRs	Fully Met (2.6)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: PSCS needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – IT policies: PSCS needs to ensure that PH Tech's IT policies are up to date and aligned with CCO contract requirements.

Finding #3 – Monitoring: PSCS needs to monitor all partner organizations and provider agencies to ensure that their IT policies and procedures are up to date and comply with CCO contract requirements.

Finding #4 – Provider directory: PSCS needs to continue its plan to update the provider directory to present information on all types of providers (physical health, mental health, and dental services), including practitioners' specialties, gender, languages spoken, and provider type.

PSCS needs to ensure that its BC/DR plan addresses all CCO activities, and determine the level of detail needed to enable a skilled IT person to recover or assist with resuming operations in a timely manner.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Substantially Met (3.3)	**Grievance Systems – Fully Met (3.8)**
Enrollee rights: General – 3.0	Grievance system: General – 3.5
Information requirements – 3.0	General requirements and filing requirements – 4.0
Notification timing – 3.5	Language and format of notice of action – 4.0
Notification content – 3.5	Content of notice of action – 3.5
Information on grievance process and time frames – 4.0	Timing of notice of action – 4.0
Respect and dignity – 3.5	Handling of grievances and appeals – 4.0
Treatment options – 3.5	Expedited resolution of appeals – 3.0
Advance directives – 2.5	Format and content of notice of appeal resolution – 4.0
Seclusion and restraint – 3.0	Action after denial of request for expedited resolution – 3.5
Compliance with other state/federal laws – 3.0	Information to providers and subcontractors – 4.0
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Substantially Met (3.3)	Continuation of benefits during appeal – 4.0
Certifications – 3.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 3.0	
General program integrity requirements – 4.0	
Specific program integrity requirements – 4.0	
Strengths	**Key Findings**
Enrollee Rights	
• The CCO's customer service phone line is open from 8 a.m. to 8 p.m. Monday–Friday. • The CCO administers a quarterly customer service survey ("mini-CAHPS") to solicit customer feedback. Follow-up calls are made as appropriate. • The CCO educates staff and community by posting information about advance directives on the CCO website, in newsletters, and through annual training.	• The CCO lacked a policy/procedure pertaining to enrollee rights. • The CCO did not demonstrate routine monitoring of documentation of advance directives, including declaration of mental health treatment, in clinical records.
Grievance Systems	
• After a member has filed a grievance, the CCO conducts a post-completion survey to ensure member satisfaction. • The CCO's compliance team reviewed the notice-of-action letters to ensure that they met sixth-grade reading level. The Appeal and Grievance Unit sends samples of denial letters to customer service to review and provide feedback.	
Certification and Program Integrity	
• The CCO's comprehensive compliance program addresses standards of conduct, descriptions of applicable federal and state laws and regulations, and many policies and procedures.	

Primary Health of Josephine County (PHJC)

At the time of this review, PHJC provided behavioral, physical, and dental health care for OHP members in Josephine County and in other counties with the same ZIP code (Jackson, Douglas, and Curry). During 2013, PHJC was solely owned by CareOregon and had a delegation agreement with Oregon Health Management Services (OHMS) to carry out most contractually required CCO operations and services. As of January 2014, ownership shifted to OHMS, which supplies staff for PHJC. OHMS contracts with Options for Southern Oregon to provide mental health services, with MedImpact for pharmacy benefits management, and with four dental care organizations. Chemical dependency services are provided by Choices Counseling Center, owned by OHMS. OHMS continues to delegate credentialing of physical health practitioners to CareOregon. PHJC, Options, and the dental organizations share service authorization and grievance system activities. PHJC's governing board oversees all quality improvement activities, and the Quality and Compliance Committee oversees the adjudication of final appeals and grievances.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 100 out of 100)

Strengths: PHJC did a good job of updating information on the study indicator, interventions, barriers encountered, and next steps, as well as addressing Acumentra Health's recommendations on documenting the results of tracking and monitoring.	**Recommendations**: PHJC should continue updating its tracking and monitoring results, including any results from its quarterly discussions that have resulted in modifications to the interventions.
CCO-Specific PIPs: • Design and implement local maternal medical home • Design and implement community outreach program for members who are "super utilizers"	**CCO Focus Area:** Addressing population health: Develop training program for medical support staff to increase their knowledge and awareness of effective strategies for assisting clients with mental health conditions and chronic disease

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.0)	Enrollment Systems	Fully Met (3.0)
Staffing	Partially Met (2.5)	Vendor Data Integration/Ancillary Systems	Fully Met (3.0)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Fully Met (2.6)
Security	Not Met (1.8)	Provider Data	Partially Met (2.3)
Administrative Data	Fully Met (2.9)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: PHJC needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – Lack of integrated policies and procedures: PHJC needs to develop policies and procedures, identify roles and responsibilities, and define functions to integrate all CCO activities.

Finding #3 – Monitoring: PHJC needs to monitor all partner organizations and provider agencies to ensure that their IT policies and procedures are up-to-date and comply with CCO contract requirements.

Finding #4 – Lack of integrated business continuity/disaster recovery (BC/DR) plan: PHJC needs to ensure that its BC/DR plan, and those of its partner organizations, address all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems. The BC/DR plans should be tested regularly and updated when significant changes occur.

Finding #5 – Security of protected health information (PHI): PHJC needs to determine whether the security of its main report production system meets industry standards to protect against vulnerabilities.

Finding #6 – Provider directory: PHJC should continue with its plan to implement a single website to enable members to obtain CCO information. The CCO's provider directory should include complete information on all types of providers (physical health, mental health, and dental services).

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Partially Met (2.7)	**Grievance Systems – Fully Met (3.9)**
Enrollee rights: General – 3.5	Grievance system: General – 4.0
Information requirements – 3.5	General requirements and filing requirements – 4.0
Notification timing – 2.0	Language and format of notice of action – 4.0
Notification content – 3.0	Content of notice of action – 4.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 3.5
Respect and dignity – 3.5	Handling of grievances and appeals – 3.5
Treatment options – 4.0	Expedited resolution of appeals – 4.0
Advance directives – 2.0	Format and content of notice of appeal resolution – 4.0
Seclusion and restraint – 0.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 3.0	Information to providers and subcontractors – 4.0
	Record keeping and reporting requirements – 3.0
Certifications/Program Integrity – Substantially Met (2.8)	Continuation of benefits during appeal – 4.0
Certifications – 3.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 2.0	
General program integrity requirements – 3.0	
Specific program integrity requirements – 3.5	
Strengths	**Key Findings**
Enrollee Rights	
• PHJC interacts frequently with providers through meetings with individual providers, onsite or teleconference meetings with hospital discharge planners, and monthly office manager meetings. • PHJC's 2014 work plan includes behavioral health cross-training to promote integration between physical health staff and individuals with mental health conditions. • PHJC's member handbook fully explains physical, mental, and dental services and is written in easy-to-understand language.	• PHJC lacks processes to ensure the enrollee's right to request updated provider information, to ensure that enrollees are free from restraint or seclusion, and to ensure that providers comply with the enrollees' rights to review their medical records. • PHJC's provider directory lacks necessary information to fully inform enrollees about available practitioners in the service area. • The CCO lacked a policy/procedure on advance directives, a process to monitor documentation in the clinical record, and a mechanism for providing community education.
Grievance Systems	
• PHJC routinely performs internal audits to ensure that notice-of-action timelines are met. Current results indicate that timelines are met 100% of the time.	• The CCO did not demonstrate that its grievance system was implemented consistently across all service areas.
Certification and Program Integrity	
• PHJC performs internal monitoring by a quarterly sampling of claims.	• PHJC's contracts do not inform all providers and subcontractors of the need to comply with disclosure requirements regarding conflict of interest. • PHJC did not monitor for excluded providers monthly.

Trillium Community Health Plan (TCHP)

At the time of this review, TCHP was owned by Agate Resources, Inc., which leased employees to the CCO to support claims processing, network management, credentialing, contracting, and other services required to fulfill OHA contract obligations. Agate owned Independent Professional Services, LLC, which performed credentialing of medical health providers for the CCO. Lane County provided behavioral health services for TCHP members as Trillium Behavioral Health (TBH). TBH established and maintained the provider network, and reviewed the initial appeals and grievances processes, with TCHP performing final adjudication of appeals. TCHP processed claims for physical and mental health services through an internally developed claims management system. TCHP delegated care coordination and prior authorizations for mental health services to TBH.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 72 out of 100)

Strengths: TCHP did a good job of describing its interventions. The CCO provided information about a tracking plan, barriers encountered during intervention implementation, and next steps.	**Recommendations:** TCHP needs to report information related to root causes that are specific to its local population and describe how its selected interventions can be expected to improve the study indicator. The CCO should also determine the ethnic and racial make-up of the study population (and how that is reflected in its interventions), report tracking and monitoring results, and discuss how it addressed barriers.
CCO-Specific PIPs: • Reducing preventable hospital readmissions • Developing guidelines for screening and treatment of depression	**CCO Focus Area:** Reducing tobacco use by pregnant women

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.5)	Enrollment Systems	Fully Met (2.7)
Staffing	Fully Met (3.0)	Vendor Data Integration/Ancillary Systems	Fully Met (3.0)
Hardware Systems	Fully Met (2.9)	Report Production and PM Reports	Partially Met (2.4)
Security	Not Met (1.9)	Provider Data	Fully Met (2.8)
Administrative Data	Partially Met (2.5)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding – Encounter data certification: TCHP needs to develop and implement a process to reconcile that data for all services provided by the CCO are received, verified, and submitted to OHA.

TCHP should work with its provider agencies to reduce the volume of paper claims submitted. (Currently, TCHP receives up to 24% of some claim types on paper.)

TCHP should develop and implement a process to regularly compare a sample of the state's encounter data with the clinical records in order to validate the completeness and accuracy of its encounter data.

TCHP needs to address security issues related to:

- updating policies and procedures
- updating and testing the BC/DR plan
- encryption of patient health information
- monitoring of provider agencies

TCHP should continue its plans to integrate member-level dental service data with existing administrative data sets in order to report on integrated care.

The CCO's provider directory needs to present required information on all providers.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Substantially Met (3.2)	**Grievance Systems – Fully Met (3.7)**
Enrollee rights: General – 3.5	Grievance system: General – 4.0
Information requirements – 3.5	General requirements and filing requirements – 4.0
Notification timing – 3.5	Language and format of notice of action – 3.5
Notification content – 3.0	Content of notice of action – 3.5
Information on grievance process and time frames – 4.0	Timing of notice of action – 3.0
Respect and dignity – 3.5	Handling of grievances and appeals – 3.5
Treatment options – 4.0	Expedited resolution of appeals – 4.0
Advance directives – 2.5	Format and content of notice of appeal resolution – 4.0
Seclusion and restraint – 2.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 3.5	Information to providers and subcontractors – 3.0
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Substantially Met (3.2)	Continuation of benefits during appeal – 4.0
Certifications – 3.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 3.0	
General program integrity requirements – 3.5	
Specific program integrity requirements – 3.5	
Strengths	**Key Findings**
Enrollee Rights	
• TCHP's member handbook is well designed and visually appealing. • The customer service unit monitors incoming and outgoing calls to ensure that staff members treat enrollees with respect, dignity, and privacy. • TCHP sends new enrollees advance directive forms with the enrollment package, annually and upon request. • New care specialists undergo extensive benefit and program training.	• TCHP did not demonstrate that processes were implemented consistently across its service area. • Member materials/website lacked information about practitioners' language capabilities and whether they are accepting new members for all service areas. • TCHP lacked a process to ensure that enrollees are free from restraint of seclusion used as a means of coercion, discipline, convenience, or retaliation.
Grievance Systems	
• The CCO provided good examples of action taken on key issues identified with member grievances (e.g., access to care and rude providers/staff).	
Certification and Program Integrity	
• The CCO sends providers a compliance packet explaining the compliance program; how to contact the compliance officer; policies/procedures pertaining to fraud and abuse, privacy, coordination of benefits, and whistleblower protection; and the process for filing a grievance. • The CCO has a robust and well-defined compliance program.	• TCHP's policies and procedures do not require all providers and subcontractors to comply with disclosure requirements regarding conflict of interest, vendor relations, and gifts and other compensations. • TCHP lacked a mechanism for routine external monitoring.

Umpqua Health Alliance (UHA)

Douglas County Individual Practice Association, LLC (DCIPA), doing business as UHA, is the CCO providing physical and behavioral health services to OHP members in Douglas County. Architrave Health, LLC, DCIPA's parent company, holds the contracts with individual health care providers to serve the OHP population. UHA is staffed by employees leased from DCIPA Management, LLC. Until June 30, 2014, UHA contracted with Greater Oregon Behavioral Health, Inc. (GOBHI) to provide mental health services for UHA enrollees. As of July 1, shortly before the EQR site review, UHA transferred management of mental health services to Community Health Alliance, a local nonprofit agency. GOBHI continues to manage access to inpatient psychiatric hospitalization.

Performance Improvement Projects (PIPs)

Statewide PIP: (Standard 8 score = 91 out of 100)

Strengths: UHA did a good job of discussing how the intervention can be expected to improve the study indicator, describing the interventions and their cultural and linguistic appropriateness, and providing details on barriers encountered.	**Recommendations:** UHA should present the results of its tracking and monitoring plan, determine how many study members have been reached by the interventions, and analyze whether the interventions are having the intended effect.
CCO-Specific PIPs: • Identifying addiction issues in pregnancy • Decreasing emergency room utilization in the Douglas County Medicaid population	**CCO Focus Area:** Increase the number of local medical homes to become certified PCPCHs

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.4)	Enrollment Systems	Fully Met (3.0)
Staffing	Fully Met (3.0)	Vendor Data Integration/Ancillary Systems	Fully Met (3.0)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Fully Met (3.0)
Security	Partially Met (2.4)	Provider Data	Fully Met (2.8)
Administrative Data	Fully Met (2.8)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: UHA needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – Monitoring: UHA needs to develop processes to monitor all partner organizations to ensure that their IT policies and procedures are up-to-date and comply with CCO contract requirements.

Finding #3 – Lack of business continuity/disaster recovery (BC/DR) plan: UHA needs to ensure that its BC/DR plan addresses all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems. UHA should test the plan regularly and update it as necessary.

Finding #4 – Provider directory: The CCO's provider directory should include information on all types of providers (physical and mental health, vision, pharmacy, and dental services), including practitioners' specialties, gender, languages spoken, and provider type.

UHA needs to determine which IT policies and procedures the CCO needs to develop and which policies and procedures of partner organizations the CCO can use. UHA should develop a process to update IT policies at least every two years to align with contract requirements.

UHA should monitor partner organizations' IT security, including backup processes, encryption strategies for mobile devices, BC/DR planning, hardware destruction policies, and data submission trends.

UHA should explore options to enhance the physical security of its data center.

UHA needs to continue plans to integrate dental service claims and encounters into its reporting systems.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Substantially Met (2.9)	**Grievance Systems – Fully Met (3.5)**
Enrollee rights: General – 3.0	Grievance system: General – 2.0
Information requirements – 3.5	General requirements and filing requirements – 3.5
Notification timing – 4.0	Language and format of notice of action – 3.5
Notification content – 2.0	Content of notice of action – 3.5
Information on grievance process and time frames – 4.0	Timing of notice of action – 3.0
Respect and dignity – 3.0	Handling of grievances and appeals – 3.5
Treatment options – 4.0	Expedited resolution of appeals – 4.0
Advance directives – 2.0	Format and content of notice of appeal resolution – 3.0
Seclusion and restraint – 2.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 2.0	Information to providers and subcontractors – 4.0
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Substantially Met (2.8)	Continuation of benefits during appeal – 4.0
Certifications – 3.0	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 2.0	
General program integrity requirements – 3.0	
Specific program integrity requirements – 4.0	

Strengths	Key Findings
Enrollee Rights	
• Advantage Dental is collaborating with UHA to reduce inappropriate use of emergency services. • UHA's contract requires PCPs to protect enrollees from improper use of restraint or seclusion. • UHA's member handbook is easy to understand and visually attractive. The handbook and linked web page present information about prevention programs and how to obtain other health care resources.	• UHA's policies and procedures and provider handbook were out of date. Some policies did not address all service areas. • UHA did not demonstrate routine monitoring of enrollee rights in all service areas. • UHA did not distribute complete information about enrollee rights for all service areas.
Grievance Systems	
• UHA's member handbook informs the enrollee about how to contact OHA's Ombudsman for assistance. • UHA monitors the timeliness of notices of action biweekly. • UHA's Clinical Advisory Panel routinely reviews grievance and appeal reports.	• UHA did not demonstrate monitoring of the delegated enrollee notification process. • During 2013, authorization decisions resulting in a denial were not consistently made by a person with clinical expertise in treating the enrollee's condition.
Certification and Program Integrity	
• UHA's compliance program has demonstrated its value by recouping overpayments and third-party reimbursement. • UHA provides general and targeted training on fraud, waste, and abuse for providers, and follows up to ensure that problems are resolved.	• UHA's policies and procedures did not require all providers and subcontractors to comply with disclosure requirements. • UHA did not demonstrate that the CCO and its providers are not employing or contracting with individuals who are excluded from participating in federal health care programs.

Western Oregon Advanced Health (WOAH)

WOAH provides physical, behavioral, and dental health services to OHP members in Coos and Curry counties. WOAH is a wholly owned subsidiary of Southwest Oregon Independent Practice Association, doing business as Doctors of the Oregon Coast South (DOCS). WOAH has assigned many administrative functions to DOCS through a service agreement. WOAH's utilization management, care coordination, and case management activities are shared between Coos County Mental Health and DOCS staff. Behavioral health services are delegated to Coos County Health and Human Services (CCHHS) and to Curry Community Health. CCHHS subdelegates claims management to PH Tech. Dental services are delegated to Advantage Dental.

Performance Improvement Projects (PIPs)

Statewide PIP: (Standard 8 score = 90 out of 100)

Strengths: WOAH clearly explained how its intervention addresses identified root causes; explained the cultural and linguistic appropriateness of the intervention; and documented the next steps for the project.	**Recommendations:** WOAH may want to consider including the sources for identifying root causes. The CCO should report the frequency of tracking and monitoring activities and discuss how some of the barriers have been or will be addressed.
CCO-Specific PIPs: • Risk screening to reduce the number of inappropriate prescriptions for opioids • Reducing rehospitalizations for members with congestive heart failure, pneumonia, and COPD	**CCO Focus Area:** Increase the percentage of members assigned to a PCPCH

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.1)	Enrollment Systems	Partially Met (2.5)
Staffing	Partially Met (2.4)	Vendor Data Integration/Ancillary Systems	Fully Met (3.0)
Hardware Systems	Partially Met (2.4)	Report Production and PM Reports	Partially Met (2.5)
Security	Not Met (1.5)	Provider Data	Partially Met (2.5)
Administrative Data	Partially Met (2.4)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: WOAH needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – Lack of integrated policies and procedures: WOAH needs to develop policies and procedures, identify roles and responsibilities, and define functions to integrate all CCO activities.

Finding #3 – System integrity: WOAH needs to ensure that all partner organizations and provider agencies have appropriate and current IT policies and procedures that align with CCO contract requirements.

Finding #4 – Lack of integrated policies and procedures: WOAH should review its policies at least every two years and update them when necessary.

Finding #5 – System security: WOAH needs to upgrade its IT systems to current security standards and ensure that the CCO is using supported software (i.e., current operating systems).

Finding #6 – Monitoring: WOAH needs to monitor all partner organizations and provider agencies to ensure that their IT policies and procedures are up-to-date and comply with CCO contract requirements.

Finding #7 – Lack of integrated business continuity/disaster recovery (BC/DR) plan: WOAH needs to ensure that its BC/DR plan, and those of its partner organizations, address all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems.

Finding #8 – Provider directory: The CCO's provider directory should include information on all types of providers (physical health, mental health, and dental), including practitioners' specialties, gender, and languages spoken.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Substantially Met (3.0)	**Grievance Systems – Fully Met (3.6)**
Enrollee rights: General – 3.0	Grievance system: General – 3.0
Information requirements – 3.0	General requirements and filing requirements – 3.5
Notification timing – 3.0	Language and format of notice of action – 3.0
Notification content – 3.0	Content of notice of action – 3.5
Information on grievance process and time frames – 4.0	Timing of notice of action – 4.0
Respect and dignity – 3.0	Handling of grievances and appeals – 3.0
Treatment options – 4.0	Expedited resolution of appeals – 4.0
Advance directives – 2.0	Format and content of notice of appeal resolution – 3.5
Seclusion and restraint – 2.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 3.0	Information to providers and subcontractors – 3.5
	Record keeping and reporting requirements – 4.0
Certifications/Program Integrity – Substantially Met (3.0)	Continuation of benefits during appeal – 4.0
Certifications – 3.5	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 3.0	
General program integrity requirements – 2.0	
Specific program integrity requirements – 3.0	

Strengths	Key Findings
Enrollee Rights	
• WOAH's weekly new-member orientation class presents information about advance directives. • The member handbook clearly explains enrollees' right to obtain their medical records and request amendments, and whom to call with questions. • WOAH has a comprehensive Code of Business Ethics that refers to non-discrimination and the federal Civil Rights Act. • The CCO has a comprehensive opioid management program modeled on national best practices.	• WOAH did not demonstrate monitoring of enrollee rights across all service areas. • WOAH did not make information about accessing all services available to enrollees. • The CCO did not demonstrate integration of policies and procedures across all service areas. • The CCO did not demonstrate routine monitoring of documentation of advance directives and use of seclusion and restraint in all service areas.
Grievance Systems	
• WOAH solicited input from its Consumer Advisory Committee to develop notice-of-action letters that are written in easy-to-understand language.	• WOAH's grievance system is not implemented consistently across all service areas.
Certification and Program Integrity	
• WOAH's program document refers to many state and federal resources, as well as the CCO contract. The document also includes the seven elements of the Federal Sentencing Guidelines and the recommendations of CMS EQR protocols. • WOAH has a well-defined schedule of compliance requirements to ensure that the CCO meets OHA's contractual and regulatory requirements.	• WOAH lacked documentation to demonstrate that contracts with subcontractors specify expectations for compliance with program integrity, including the frequency with which individuals and facilities are to monitor for exclusion. • WOAH lacked documentation to support routine internal and external monitoring and auditing.

Willamette Valley Community Health (WVCH)

WVCH, based in Salem, provides services to OHP members in Marion and Polk counties. The CCO has no employees, and delegates all contracted activities to Willamette Valley Providers Health Authority. In turn, WVP Health Authority subdelegates behavioral health services to Mid-Valley Behavioral Care Network (MVBCN); information systems, claims processing, customer service, data analysis and reporting, and print material preparation to PH Tech; and some medical management activities to Salem Clinic. MVBCN further subdelegates activities to providers, such as medical management, monitoring for excluded providers, credentialing, and utilization management. Dental health services are contracted through ODS Community Health, Capitol Dental Care, and Willamette Dental Group.

Performance Improvement Projects (PIPs)

Statewide PIP: (Standard 8 score = 94 out of 100)

Strengths: WVCH addressed EQR recommendations by updating and providing more details on its root cause analysis, reasons why the interventions could be expected to improve the study indicator, progress on the interventions, barriers encountered, and next steps.	**Recommendations:** WVCH needs to provide current results of the tracking and monitoring results of both the study indicator and the intervention implementation.
CCO-Specific PIPs: • Improving perinatal and maternity care (discontinued 11/20/14; next topic will be tobacco prevention and cessation) • Deploying care teams to improve care and reduce preventable or unnecessary utilization by "super-users"	**CCO Focus Area:** Increase the percentage of members assigned to a PCPCH

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.1)	Enrollment Systems	Fully Met (2.8)
Staffing	Fully Met (2.8)	Vendor Data Integration/Ancillary Systems	Fully Met (2.75)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Fully Met (2.6)
Security	Not Met (1.7)	Provider Data	Fully Met (2.6)
Administrative Data	Partially Met (2.5)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: WVCH needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – Lack of integrated policies and procedures: WVP Health Authority needs to develop policies and procedures, identify roles and responsibilities, and define functions to integrate all CCO activities.

Finding #3 – Monitoring: WVCH needs to monitor all partner organizations and provider agencies to ensure that their IT policies and procedures are up-to-date and comply with CCO contract requirements. The CCO should monitor provider agencies' IT security, including backup processes, encryption strategies for mobile devices, business continuity planning, hardware destruction policies, and data submission trends.

Finding #4 – Lack of business continuity/disaster recovery (BC/DR) plan: WVCH needs to ensure that its BC/DR plan, and those of its partner organizations, address all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable effective recovery of information systems. The BC/DR plans should be tested regularly and updated when significant changes occur.

Finding #5 – Provider directory: The CCO's provider directory should include information on all types of providers (physical health, mental health, and dental services), including practitioners' specialties, gender, languages spoken, and provider type.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Substantially Met (2.8)	**Grievance Systems – Substantially Met (3.4)**
Enrollee rights: General – 2.0	Grievance system: General – 3.0
Information requirements – 3.0	General requirements and filing requirements – 3.0
Notification timing – 2.0	Language and format of notice of action – 4.0
Notification content – 2.0	Content of notice of action – 4.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 2.0
Respect and dignity – 3.0	Handling of grievances and appeals – 4.0
Treatment options – 4.0	Expedited resolution of appeals – 3.0
Advance directives – 3.0	Format and content of notice of appeal resolution – 4.0
Seclusion and restraint – 2.0	Action after denial of request for expedited resolution – 4.0
Compliance with other state/federal laws – 3.0	Information to providers and subcontractors – 3.0
	Record keeping and reporting requirements – 3.0
Certifications/Program Integrity – Partially Met (2.2)	Continuation of benefits during appeal – 3.0
Certifications – 2.5	Effectuation of reversed appeal resolutions – 4.0
Provider selection, excluded providers – 2.0	
General program integrity requirements – 2.0	
Specific program integrity requirements – 2.0	

Strengths	Key Findings
Enrollee Rights	
• WVCH's handbook is visually attractive and presents useful information, such as a picture of the member ID card and sample letters about type of coverage. • WVCH's provider contracts specify that the CCO will not prohibit or limit advising or advocating on behalf of a member regarding treatment options, including the right to refuse treatment.	• WVCH did not have an integrated process to ensure that all contracted providers in all service areas had policies and procedures regarding seclusion and restraint. The CCO did not monitor providers through the credentialing process. • WVCH lacked a method to notify enrollees of their right to request and obtain names, locations, telephone numbers of, and non-English languages spoken by network providers, including information about providers that are not accepting new patients. • The CCO did not demonstrate monitoring of enrollee rights across all services areas and delegates. • The CCO did not have policies that integrate processes across all service areas.
Grievance Systems	
• WVP Health Authority's medical management has an internal quality control process in place to ensure that notice-of-action letters are generated and sent in timely manner.	• The CCO lacked a policy/procedure defining the timing of notices for suspension or reduction of previously authorized Medicaid-covered services. • The CCO does not adjudicate final appeals.
Certification and Program Integrity	
• WVP Health Authority has a robust internal monitoring and audit process.	• WVCH did not have an approved compliance program at the time of the site visit.

Yamhill Community Care Organization (YCCO)

YCCO serves enrollees in Yamhill County and adjoining areas of Tillamook, Polk, Lincoln, Marion, Clackamas, and Washington counties. YCCO has an agreement with CareOregon to administer physical health services and to provide administrative and management support for YCCO operations. YCCO contracts with Mid-Valley Behavioral Care Network (MVBCN) to manage chemical dependency and mental health care services. MVBCN delegates activities to Yamhill County Health and Human Services, provider agencies, and PH Tech (data administration). YCCO contracts with Advantage Dental Services, Capitol Dental Care, and ODS Community Health for dental care. These entities share responsibilities for service authorization and the grievance system.

Performance Improvement Projects (PIPs)

Statewide PIP (Standard 8 score = 95 out of 100)

Strengths: YCCO did a good job of describing its root cause analysis, discussing why the intervention could be expected to improve the study indicator, reporting on the progress of the interventions and identifying the cultural and appropriateness of the interventions.	**Recommendations:** Once it receives and analyzes the data from OHA and/or implements its new integrated data system, YCCO should update reporting on the study indicator and tracking of the effective implementation of its interventions.
CCO-Specific PIPs: • Improving timeliness of prenatal care and behavioral health screening • Increasing the number of PCPCH clinics and member assignment to PCPCH clinics	**CCO Focus Area:** Ensuring that children receive comprehensive screening and appropriate referral from their primary care providers

Information Systems Capabilities Assessment

Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Not Met (1.8)	Enrollment Systems	Fully Met (2.8)
Staffing	Partially Met (2.4)	Vendor Data Integration/Ancillary Systems	Partially Met (2.5)
Hardware Systems	Fully Met (3.0)	Report Production and PM Reports	Partially Met (2.2)
Security	Not Met (1.3)	Provider Data	Partially Met (2.5)
Administrative Data	Partially Met (2.4)	Meaningful Use of EHRs	Partially Met (2.5)

Key Findings and Areas for Improvement

Finding #1 – Encounter data certification: The CCO needs to develop and implement a process to reconcile that all encounters provided by the CCO are received, verified, and submitted to OHA.

Finding #2 – Lack of integrated policies and procedures: YCCO needs to develop policies and procedures, identify roles and responsibilities, and define functions to integrate all CCO activities.

Finding #3 – Monitoring: YCCO needs to develop and implement a process for monitoring the IT services of providers and partners.

Finding #4 – Lack of business continuity/disaster recovery (BC/DR) plan: YCCO needs to ensure that its BC/DR plan addresses all CCO activities, and determine which BC/DR plans (internal or delegated) are sufficient to enable a skilled IT person to recover or assist with resuming operations in a timely manner.

Finding #5 – Provider directory: The CCO's provider directory should include member-level information for all types of providers, including physical health, mental health, and dental services.

YCCO should work toward implementing a single data repository that contains all CCO encounters to enable reporting on integrated care. YCCO needs to implement a process to monitor its data warehouse on a regular basis to ensure that all CCO services are captured.

YCCO needs to address security issues related to updating policies and procedures; updating and testing the BC/DR plan; encryption of patient health information; and monitoring of provider agencies.

Compliance with Regulatory and Contractual Standards	
Section scores (out of 4.0)	***Section scores (out of 4.0)***
Enrollee Rights – Partially Met (2.5)	**Grievance Systems – Partially met (2.6)**
Enrollee rights: General –2.0	Grievance system: General – 2.0
Information requirements – 3.0	General requirements and filing requirements – 3.0
Notification timing – 3.5	Language and format of notice of action – 3.0
Notification content – 3.0	Content of notice of action – 4.0
Information on grievance process and time frames – 4.0	Timing of notice of action – 2.0
Respect and dignity – 3.0	Handling of grievances and appeals – 3.0
Treatment options – 3.0	Expedited resolution of appeals – 2.0
Advance directives – 2.0	Format and content of notice of appeal resolution – 3.0
Seclusion and restraint – 0.5	Action after denial of request for expedited resolution – 2.0
Compliance with other state/federal laws – 2.0	Information to providers and subcontractors – 2.0
	Record keeping and reporting requirements – 2.0
Certifications/Program Integrity – Partially Met (2.0)	Continuation of benefits during appeal – 3.0
Certifications – 2.0	Effectuation of reversed appeal resolutions – 3.0
Provider selection, excluded providers – 2.0	
General program integrity requirements – 2.0	
Specific program integrity requirements – 2.0	
Strengths	**Key Findings**
Enrollee Rights	
• YCCO has a visually attractive, integrated member handbook. • A front page of the YCCO member handbook informs the enrollee that information can be provided in alternative languages and formats.	• The CCO did not demonstrate monitoring of enrollee rights across all service areas, such as advance directives and seclusion and restraint. • The CCO did not demonstrate integration of its policies and procedures for all service lines. • The CCO lacked a non-discrimination policy and procedure addressing the enrollee's right to complain about discrimination.
Grievance Systems	
• CareOregon's QI committee and YCCO's board of directors review grievance results quarterly.	• The CCO did not demonstrate that its grievance system was consistently implemented across all service areas. • The CCO did not demonstrate that all service areas have policies and procedures in place to effectively manage the grievance process. • The CCO lacks a process to perform adjudication of final appeals.
Certification and Program Integrity	
• The CCO and its delegates have variety of processes in place to report compliance violations or fraud and abuse.	• The CCO's policies and procedures did not require all providers and subcontractors to comply with disclosure requirements. • The CCO lacks management practices designed to guard against fraud and abuse. • The CCO lacks internal arrangements that demonstrate the organization's commitment to detect and prevent fraud and abuse.

APPENDIX B. STATEWIDE PIP REPORT

Oregon Statewide PIP: Diabetes Monitoring for People with Diabetes and Schizophrenia or Bipolar Disorder

Prepared by Acumentra Health

Standard 1: Study Topic

Establish the importance of the study topic in general; present local data to demonstrate that the topic applies to a large or high-risk portion of the Medicaid population and will have a significant impact on enrollee health, functional status, or satisfaction; and demonstrate that a systematic selection and prioritization process, that includes opportunities for input by enrollees and providers, was used in choosing the topic.

This statewide performance improvement project (PIP) addresses one of the seven quality improvement focus areas in the state Accountability Plan and is focused on "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] This PIP addresses monitoring of annual diabetes care for individuals diagnosed with diabetes and schizophrenia or bipolar disorder. This topic is intended to 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.

[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: 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.

Increased prevalence of diabetes and cardiovascular disease has been documented among individuals diagnosed with severe mental illness, primarily for individuals with diagnoses of schizophrenia or bipolar disorder, due to the development of metabolic syndrome conditions associated with the use of antipsychotic medications.[3] In 2012, the National Committee on Quality Assurance (NCQA) developed several behavioral health measures for the 2013 Healthcare Effectiveness Data and Information Set (HEDIS®).[4] The "Diabetes monitoring for people with diabetes and schizophrenia" measure focuses on testing rates for both HbA1c and LDL-C during the measurement year. The National Quality Forum (NQF), a not-for-profit organization, dedicated to improving health care by establishing standards for performance measurement, evaluated and endorsed this measure (NQF #1934)[5] in 2012.

In its rationale for adopting the HEDIS measure, the NQF presented the following analysis from 2007 Medicaid fee-for-service (FFS) data collected in 22 states. The percentage of individuals in the plans, with both diabetes and schizophrenia, who received both tests (HbA1c and LDL-C) ranged from a minimum of 9% to a maximum of 82% (median=62%; 75th percentile=68%). The NQF also cited research that demonstrated a non-treatment rate of approximately 32% among people with co-occurring schizophrenia and diabetes.

In Oregon, 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 represents CCOs and members at large, and uses a public process to identify objective outcome and quality measures and to set benchmarks. In addition to the Statewide PIP, the Metrics and Scoring Committee has established a statewide incentive measure for CCOs to assess the percentage of individuals diagnosed with diabetes who have HbA1c values greater than 9.0%.

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

[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.

[4] National Committee on Quality Assurance, HEDIS 2013 measures. Available online (December 2014): www.ncqa.org/Portals/0/HEDISQM/HEDIS2013/List_of_HEDIS_2013_Measures_7.2.12.pdf.

[5] 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.

potential topics from the CCO incentive measures associated with integration. In addition, a topic that combined a core measure for chronic illness (diabetes control) with a focus on individuals with serious and persistent mental illness (SPMI) was presented:

- 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

Acumentra Health presented the options to CCO representatives 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 email 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 involving enrollees in the PIP topic selection and prioritization process, but did not require CCOs to document stakeholder input. It is not clear what, if any, influence enrollees had in the topic prioritization process.

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 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 which may ultimately reach larger patient populations.

CCOs were given the option of declining participation in the Statewide PIP and developing their own PIPs related to the integration of primary care and behavioral health. All CCOs elected to participate in the Statewide PIP.

CCOs are required by contract with OHA to improve coordination of care for enrollees with SPMI. The CCOs are also tasked with monitoring HbA1c values as part of their incentive measures. This Statewide PIP, focusing on enrollees with co-occurring diagnoses of diabetes and schizophrenia or bipolar disorder, thus aligns with one of the primary objectives of Oregon's health system redesign.

Statewide PIP responsibilities were designated as follows. Acumentra Health coordinates the project with participating CCOs and provides technical assistance. OHA provides data for the indicator. CCOs 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 the QHOC meeting on February 11, 2013. Discussion with representatives from the CCOs and OHA resulted in these definitions:

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

Standard 2: Study Question

Present a study question that provides a clear framework for data collection, analysis, and interpretation. The study question should refer to the proposed intervention, a study population (denominator), what is being measured (a numerator), a metric (e.g., average, percentage), and a direction of desired change.

All participating CCOs 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?*

Standard 3: Study Population

Provide a brief description of the study population; list all inclusion and exclusion criteria for the study population, including enrollment criteria; and provide definitions and data sources, including codes and calculations. If a sample is selected, describe the sampling methods.

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

- Oregon Health Plan (OHP) enrollment (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 or 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 FFS clients based on residential ZIP Code. OHA calculated the number of duplicates in the baseline list in order to provide an aggregate baseline for the state.

- *Continuous enrollment* – The 2013 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 FFS or plan enrollment. It is planned that when calculating the remeasurement, 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 whom continuous enrollment is not required, to maximize the number of members in the intervention.
- *Adults* – The 2013 HEDIS measure of 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."[6] The 2013 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 to define "adult" as enrollees ages 18–75 years as of December 31 of the measurement year.
- *Diagnosis of diabetes* – Diabetes is defined using 2013 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.*

[6] Center for Medicaid and CHIP Services. CHIP Eligibility Standards. Available online: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Eligibility-Standards-.html.

"Pharmacy data: Members who were dispensed insulin or oral hypoglycemics/ anti-hyperglycemics 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 for diabetes, including prescription, diagnosis, and visit type codes, appear in Attachment A.

- *Diagnosis of schizophrenia or bipolar disease*: Schizophrenia and bipolar disorder are defined according to 2013 HEDIS code specifications. The 2013 HEDIS measure of 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 in 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.[7] The complete HEDIS specifications for schizophrenia and bipolar disorder, including definitions, visit codes and diagnoses codes appear in Attachment B.

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, this PIP adheres to the majority of the 2013 HEDIS specifications. Including individuals with bipolar disorder in the study population will increase the study populations for CCOs.

[7] 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.

Denominator Exclusion Criteria

- Exclusion criteria follow the 2013 HEDIS exclusions specifications (see Attachment C).

This PIP will target the entire study population.

Standard 4: Study Indicator

To meet Standard 4, the CCO needs to define the numerator (what is being measured) and the denominator; define key terms; describe the target goal; discuss the basis for adopting the indicator as a valid proxy for enrollee outcomes, satisfaction, or quality of care; list all inclusion and exclusion criteria for the numerator (what is being measured), including enrollment criteria; and provide definitions and data sources, including codes and calculations.

In order to be consistent with OHA's goal for standardization and comparability for all performance measures, the indicator and indicator definitions from the 2013 HEDIS measure, "Diabetes monitoring for people with diabetes and schizophrenia," were adopted for this PIP. The indicator definitions have been modified to better reflect conditions in the local environment. These modifications were discussed under Standard 3.

In fall 2014, NCQA revised the 2015 HEDIS Comprehensive Diabetes measure by removing three indicators of quality from this measure: LDL-C Screening, LDL-C Control, and Blood Pressure Control.[8] However, both the American Diabetes Association[9] and the 2014 HEDIS measure of diabetes monitoring for people with diabetes and schizophrenia [10] support yearly monitoring of LDL-C for people with diabetes. After reviewing the literature, Acumentra Health and OHA agreed to leave the Statewide PIP study indicator unchanged.

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

[8] National Committee on Quality Assurance," NCQA Updates HEDIS Quality Measures," Available online (January 16, 2015): www.ncqa.org/Newsroom/NewsArchive/2014NewsArchive/NewsReleaseJuly12014.aspx.

[9] American Diabetes Association (ADA) Position Statement, Diabetes Care, Volume 37, Supplement 1, January 2014, p. 538.

[10] National Committee on Quality Assurance, HEDIS 2013 measures. Available online (January 2015): www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014/HEDIS2014FinalNDCLists.aspx.

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: *Individuals in the denominator who have received (both): at least one or more HbA1c test and at least one or more LDL-C test during the measurement year.*

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.

In terms of a target goal, CCOs were encouraged to assess their own data and resources and to set their own appropriate target goals.

Standard 5: Data Collection and Data Analysis Plan

Describe data collection and data validation procedures, including a plan for addressing errors and missing data, and present a clear data analysis plan, including time frames for the measurement and intervention periods and an appropriate statistical test to measure differences between the baseline and remeasurement periods.

Data Collection

As noted in Standard 4, this PIP collects administrative data.

OHA uses an encrypted system of web-based electronic mailboxes to receive Medicaid claims and encounter data from CCOs. This system ensures that data transfers are consistent with HIPAA confidentiality provisions. The state then uses the Medicaid Management Information System (MMIS) claims adjudication engine to process the CCO encounter data.

OHA data analysts pulled data from the MMIS database in order to calculate the baseline measurement period study indicator and to provide quarterly reports to each CCO.

- Baseline measurement period (July 1, 2011–June 30, 2012): Since the baseline measurement period predates the creation of CCOs, baseline client lists were derived from the predecessor plans and certain (enrollable) FFS clients. The baseline client lists are not mutually exclusive between CCOs. The entire MMIS database was used to determine if the client met the HEDIS criteria for diabetes, schizophrenia or bipolar disorder, and performance of HbA1c and LDL-C tests.
- Quarterly reports: OHA reports PIP data to the CCOs quarterly, and has shared quarterly data with Acumentra Health during the first remeasurement year. Only the CCOs received the list of their members. In addition to study indicator data (the composite of both HbA1c and LDL-C tests), OHA also reports individual member HbA1c and LDL-C testing rates separately. The member lists include individual member ID, the date of the most current HbA1c and LDL-C tests and the performing provider name, and the billing provider name. OHA has encouraged CCOs to develop and maintain their own ongoing lists of enrollees eligible for inclusion in the study population.

  For the initial quarterly report (5/3/13), OHA pulled tests for a 21-month period (7/1/11–3/30/13). The most current "15th of month" database was used to determine CCO membership. This list was mutually exclusive between CCOs.

  For subsequent quarterly reports (beginning with the first remeasurement period), OHA pulled tests for one year preceding the last day of the quarter. In order to maximize the number of members included in the intervention, the members on the quarterly lists are not required to be continuously enrolled. Membership in a CCO is determined by using the most current MMIS enrollment report. The quarterly patient list is mutually exclusive between CCOs. OHA continues to follow HEDIS specifications in determining evidence of diabetes (by looking back two years from the last day of the quarter) and schizophrenia or bipolar disorder (by looking back one year from the last day of the quarter).
- First remeasurement period (July 1, 2013–June 30, 2014): OHA used the entire MMIS database to calculate the first remeasurement results. The first remeasurement patient list is mutually exclusive between CCOs. HEDIS specifications for determining evidence of diabetes (by looking back two years from the last day of the quarter) and of schizophrenia or bipolar disorder (by looking back one year from the last day of the quarter), and for determining continuous enrollment (by lookingback 12 months from the last

day of the quarter and allowing for one 45-day CCO enrollment gap), were applied to the data.

Data Verification and Validation

Quality management personnel at each CCO are responsible for reviewing and comparing OHA quarterly reports against their own data reports in order to reconcile any discrepancies. Before submitting data to the state, CCOs perform automated edits and validation checks to ensure completeness and correctness of submitted claims. OHA states that it has established formal processes to validate the completeness of encounter data. Currently, there is no contractual requirement for the CCOs to perform an encounter data validation process in accordance with the CMS standards for encounter data validation.

Following the end of the first remeasurement period (June 30, 2014), OHA allowed for a 90-day period to receive all CCO claims (a 90-day period to collect and process claims is routine practice). To help ensure the accuracy of the data, OHA then provided a 30-day period during which CCOs could submit corrections and additions to their first remeasurement data. Having received responses from only a few CCOs, OHA extended the correction period for an additional week and instructed CCOs to submit requests for data changes by December 12, 2014. At the time of this report, OHA was in the process of analyzing the CCO responses.

Study Time Periods

- **Baseline measurement:** July 1, 2011–June 30, 2012
- **Intervention:** Begin third quarter 2013
- **First remeasurement:** July 1, 2013–June 30, 2014
- **Second remeasurement:** July 1, 2014-June 30. 2015

CCOs, OHA, and Acumentra Health selected the date range for the first remeasurement period based on the expected start date for intervention implementation.

The study results will be tested for a statistically significant difference between baseline and remeasurement periods using a probability level of $p \leq .05$. A chi-square test is appropriate for the categorical data that will result from the indicators.

As noted in Standard 1, OHA decided to aggregate the individual CCO data for a statewide total to measure overall improvement in the study indicator.

Standard 6: Study Results

Present results according to the data analysis plan, including the study indicator, the original data used to compute the indicator and a statistical test to measure differences between the baseline and remeasurement periods; and discuss any other data analyses for factors that may affect the study results.

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

Study Indicator	**Baseline** July 1, 2011–June 30, 2012	**First remeasurement** July 1, 2013–June 30, 2014
Numerator	1,407	1,090
Denominator	2,137	1,637
Calculated indicator	65.8%	66.6%

A Fisher's Exact test (appropriate for categorical data) with a probability of $p \leq .05$ was conducted to determine if there was a statistically significant difference between the 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 at baseline and at first remeasurement. Although there was a slight increase in the study indicator, the statistical test yielded a result of $p=.6519$, indicating that there was not a statistically significant difference between baseline and first remeasurement.

Differences in the percentages of the individual tests, HbA1 and LDL-C, between baseline and remeasurement were also analyzed (see Attachment F). There was a 2.8% increase between baseline and remeasurement in the percentage of the study population that received HbA1c tests. A Fisher's Exact test at the $p \leq .05$ level yielded a result of $p=.0377$, indicating that the increase in the HbA1c percentage from baseline to remeasurement was statistically significant. A 0.8% increase in LDL-C tests between baseline and remeasurement was not found to be statistically significant ($p=.8724$).

The percentage of members included in the study population who received both tests during the remeasurement year for each of the CCOs ranged from 51.2% to

92.1% with a median value of 67.05%. At baseline, the study indicator ranged from 49.8% to 78.0% with a median value of 67.3%. Six CCOs showed improvement in the study indicator between baseline and first remeasurement, while seven showed decreases in their indicators. Two CCOs had less than 1% change between baseline and first remeasurement and were regarded as showing no appreciable change between the two measurement periods.

There was a substantial decrease in both the denominator and the numerator between baseline and first remeasurement. The denominator decreased by 23.4% and the numerator decreased proportionally by 22.5%. OHA noted several reasons why the study population may have decreased. First, baseline study population data and first remeasurement data were not collected in the same manner. Baseline data were collected before the existence of CCOs, and OHA estimated individual CCO study populations using residential ZIP Codes of members. OHA noted the possibility that some members were counted more than once for the baseline. Second, OHA reported that the baseline had approximately three more months for claims to enter the data warehouse than the remeasurement period. Finally, continuous enrollment criteria applied to the study population at the individual CCO level may have resulted in members being excluded at the time of first remeasurement.

Standard 7: Interpretation of Results

List any changes to the study design and discuss the effect of those changes on the comparability of data and interpretation of results; describe any factors that threaten the internal or external validity of the study; discuss whether the intervention was implemented as planned; describe any improvement in enrollee health, functional status, or satisfaction and accomplishment of target goals, discuss how the intervention influenced the results; discuss lessons learned during the PIP process; draw a conclusion about the study results based on the above factors; and describe next steps for the study.

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

Results of the statistical analysis for the study indicator showed no statistically significant difference between baseline and first remeasurement. There was a statistically significant increase in the percentage of members in the study population who received HbA1c tests, but not for LDL-C tests. However, the interpretation of these results is not straightforward. The marked decrease in the study population (denominator) at first remeasurement is of particular concern and calls into question the comparability of the results from the two measurement periods.

A number of additional factors must be considered in considering the level of success of this PIP. In conjunction with OHA and the CCOs, Acumentra Health has identified a number of factors that affect the interpretation of the results. These include:

- Data issues:
  - In their quarterly reports, many CCOs cited discrepancies between internal data and OHA data. The inconsistencies can be attributed to a variety of factors, such as data entry errors, miscoding by providers, difficulty accessing data on dual-eligible and FFS members at the CCO level, and "member churn" (rapid turnover of enrollees).
  - As noted above, the baseline and first remeasurement data collection methodologies were not consistent, thereby calling into question the comparability of study results.
- Differences between CCOs: The study data are aggregated across 16 CCOs, but the CCOs are not standardized as to study population, level of physical and behavioral health system integration, or study interventions. In order to gain a better understanding of the actual progress on this measure, it will be necessary to analyze the individual CCO study results alongside the aggregated study indicator.
- Validity of the study indicator: As discussed in Standard 1, CCOs reviewed several options before selecting diabetic monitoring of individuals with schizophrenia and/or bipolar disorder as indicator for a Statewide PIP on the integration of physical and mental health. The validity of this indicator is supported by the integration research literature. However, at least one CCO observed that despite improvement in the CCO study indicator, discussions with physical health and mental health staff demonstrated that there was a "lack of active care coordination." The improvement in the study indicator could reflect more efficient data collection processes and more effective case management (from a single mental or physical health agency) rather than increased integration of the two systems.
- External factors: In January 2014, the Affordable Care Act Medicaid expansion took effect, providing more low-income Oregonians with health care coverage. OHA estimated that more than 340,000 people obtained health insurance since the first of the year.[11] According to their quarterly reports, CCOs were overwhelmed by the response, and processes that had

[11] Oregon Health Authority. http://www.oregon.gov/oha/pages/ohp2014.aspx. Accessed November 10, 2014.

functioned well prior to the expansion often suffered as a result of inadequate resources and staffing. Another factor affecting the validity of the study results is the inclusion of study enrollees in other ongoing CCO interventions, such as those targeting super-utilizers, establishing Patient Centered Primary Care Homes, or implementing tobacco cessation programs. It is possible that diabetes-related testing occurred as a result of these other interventions.

- Effective implementation of the interventions:
  - In order to evaluate the link between study results and intervention(s), it is necessary to ascertain whether or not the interventions were implemented effectively. Each CCO was tasked with tracking and monitoring its own interventions and reporting those results quarterly. Most CCOs relied on the quarterly study indicator from OHA to assess improvement instead of separately tracking and monitoring the successful implementation of their intervention efforts. This lack of clear and thorough documentation is reflected in the first remeasurement scoring of Standard 8 (see Attachment H), and complicated Acumentra Health's ability to draw inferences about the relationship between the study indicator and study interventions.
  - Many CCOs identified discrepancies between internal and OHA data as a barrier to the effective implementation of their interventions.

In terms of clinical outcomes, Acumentra Health solicited feedback from CCOs during the December 2014 QHOC meeting. Several CCOs reported that implementation of the Statewide PIP interventions promoted improved communication between physical and mental health providers. One CCO noted that increased discussion between physical and mental health providers resulted in better outcomes for patients. Another CCO observed that primary care providers (PCPs) in their area began offering more options to the SPMI population to address their care needs.

Given the number of factors that may have affected the results of this PIP, it is not possible to draw a conclusion about the success of the project at this time. The statistically significant improvement in the percentage of members who received HbA1c tests despite a substantial decrease in the study population, as well as anecdotal accounts from the CCOs about clinical process improvements, are encouraging. Data discrepancies and competing priorities for the CCOs continue to be concerns. Comparisons between first remeasurement and second remeasurement data are likely to be more illuminating as the data collection methodology will be

identical and significant external factors (e.g., Medicaid expansion) are less likely to occur and/or will be better controlled.

With regard to next steps, Acumentra Health will continue to provide technical assistance to CCOs as they progress through the second remeasurement period for this PIP. Technical assistance will include both phone conferences regarding the quarterly report and a PIP training to educate new QI staff about key QI concepts. In addition, Acumentra Health will conduct a workshop in the second quarter of 2015 to discuss the selection of a new PIP, scheduled to begin in July 2015.

Standard 8: Improvement Strategies

Describe and document the implementation of the intervention(s) and discuss the basis for adopting the intervention; how the intervention can be reasonably expected to result in measurable improvement; the cultural and linguistic appropriateness of the intervention; a tracking and monitoring plan (providing evidence of how the intervention was or will be implemented as planned); barriers encountered during implementation of the intervention and how they were addressed; and how the intervention will be adapted, adopted, or abandoned.

Each CCO was tasked with developing, implementing, and documenting an improvement strategy that addresses the overarching, statewide study topic of integrating physical and mental health through diabetic monitoring of individuals diagnosed with schizophrenia or bipolar disorder and diabetes. Because they differ significantly in terms of geography, provider networks, patient mix, level of integration, and population size, the CCOs were advised to develop strategies for this PIP in a manner that meet the needs of their local communities. Acumentra Health provided the CCOs with the criteria and scoring matrix for this standard, as well as ongoing technical assistance throughout much of the first remeasurement year (September 2013–July 2014).

OHA required that CCOs submit quarterly reports documenting their progress on the Statewide PIP beginning in September 2013. The CCOs have submitted five quarterly reports to date. Attachment I presents information on the current status of each CCO's progress. The CCOs have achieved varying degrees of progress in implementing interventions for this project due to variations in size, CCO structure, and presence or absence of existing integrated programs.

Following completion of the first remeasurement period (June 30, 2014) and based on their July 2014 quarterly report submission, each of the CCOs received a score (on a 100-point scale) for the degree of completeness on each of the Standard 8 criteria, as well as an overall score for documenting their work. See Attachment G for standard criteria and corresponding point values. Scoring reports were

developed and sent to the CCOs for review. All of the CCOs had the option of either accepting their initial score or resubmitting their Standard 8 documentation for re-scoring. Fourteen of the 16 CCOs resubmitted their Standard 8 documentation. The CCOs that elected to resubmit their Standard 8 documentation were generally responsive to feedback and recommendations made by Acumentra Health following their initial PIP submissions.

See Attachment H for final overall Standard 8 scores for each CCO.

The following is a discussion of high-level themes and average scores for the 16 CCOs' documentation of each of the Standard 8 criteria.

a. Root cause analysis or quality improvement (QI) process used to select the intervention

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, but lower rates for LDL-C. However, all CCOs demonstrated room for improvement with regard to the study indicator.

After receiving the baseline study indicator data, most CCOs analyzed the data in more depth in order to better understand the study population and current gaps in service. Additional data analyses included race/ethnicity, establishment with PCP, main source of care (physical versus mental health), dates of last tests, and the provider who ordered the tests.

In terms of root cause of the gap/problem, the following three high-level themes were common to all CCOs.

1. Mental health and physical health systems have historically been separated and there is limited communication across the systems. The lack of a shared data system between the mental and physical health systems greatly exacerbates communication barriers.
2. There are characteristics and needs specific to the SPMI population, such as fear of blood draws or interacting with unfamiliar medical staff, and cognitive limitations, which may interfere with consistent management of their chronic physical health issues.
3. Mental health and physical health providers may feel uncomfortable, have limited resources, or have limited knowledge related to working with members diagnosed with SPMI and chronic physical health conditions.

Many of the CCOs continued to "drill down" these themes in order to elicit the real barriers and contributing factors for their study population and situation, and some presented the fishbone or driver diagrams used in their analyses.

Scoring: The average score for the first remeasurement period for this element of Standard 8 was 18.1 points, out of a possible 20 points. Eleven CCOs completely met this criterion and received a score of 20 points. The higher-scoring CCOs were successful in identifying factors within their local systems and Medicaid population that contributed to members of the study population not receiving their tests within the required timeframe. A few CCOs cited general facts and statistics relevant to individuals diagnosed with SPMI, but did not document information that was specific to their local study population.

b. How the intervention could be expected to improve the study indicator

Overall, CCOs responded to this question by directly relating the interventions to the factors identified in their root cause analyses.

- Co-located care addresses characteristics and needs specific to the SPMI population by allowing members to receive services in a setting where they feel more comfortable. Also, co-location addresses communication barriers by facilitating improved collaboration. As a result, co-located care could be expected to improve outcomes and engagement in care.
- Health provider training and education target provider barriers and improve awareness of the characteristics and needs of the study population; whereas mental health provider training will increase provider confidence around addressing, documenting, and billing for services related to physical health promotion.
- Conducting interdisciplinary team meetings, providing education to medical residents about the SPMI population, and assigning staff to coordinate care for study population members help narrow the gap between mental and physical health providers.
- Providing an incentive that may appeal to members included in the study population, because many of these members lack financial resources, and employing community health workers and case workers to assist with transportation, remind members about appointment times, and provide support at the medical office also address some of the special needs of and barriers to treatment for the study population.

In addition, some CCOs observed that their interventions could be expected to improve the study indicator because the intervention methodologies (PDSA,

pilot projects) allowed for close monitoring and rapid modifications, leading to improvement on a small scale and a higher likelihood of improvement on a larger scale once the interventions were expanded; the interventions were evidence-based; and the interventions built on existing successful processes.

Scoring: The average score for the first remeasurement period for this element of Standard 8 was 13.9 points out of 15 points. Twelve CCOs fully met this criterion and received a score of 15 points by thoroughly explaining why each of their interventions could be expected to improve the study indicator. CCOs that had not yet fully met this criterion listed interventions but did not explicitly link those interventions to barriers identified in the root cause analyses or to any other explanations (such as evidence-based, previous knowledge, etc.).

c. Brief description of the intervention(s)

Six high-level themes were identified from the CCOs' documentation that described the interventions selected for this PIP. Detailed descriptions of the interventions selected by each of the CCOs appear in Attachment I. The six intervention themes include:

1. Facilitate communication with mental and physical health providers to increase awareness of members in the study population and encourage outreach, especially to those members who have not received HbA1c and/or LDL-C labs.
2. Use existing or create new interdisciplinary teams to facilitate care coordination for members included in the study population.
3. Use existing or develop co-located clinical settings (mental health staff in primary care clinics and PCPs in mental health clinics) for members included in the study population.
4. Engage and communicate with members included in the study population about the importance of chronic disease management.
5. Use traditional health workers and peer wellness specialists to assist with the coordination of care for members included in the study population.
6. Educate mental and physical health providers about characteristics and treatment approaches specific to members of the study population.

Two other intervention strategies were mentioned, but to a lesser extent: developing plans to implement integrated data systems for mental and physical health providers, and plans for incorporating this PIP into a larger improvement strategy.

Scoring: The average score for the first remeasurement period for this element of Standard 8 was 9.6 points out of 10 points. Twelve CCOs received a fully met score of 10 points for this criterion. Overall, CCOs selected interventions that involved both mental health and physical health providers and were generally thorough in outlining their improvement strategies.

d. Cultural and linguistic appropriateness of the intervention

In discussions with CCOs about the Standard 8 criteria, Acumentra Health reviewed the recently updated national standards for culturally and linguistically appropriate services (CLAS). Of particular relevance to the Statewide PIP was a broader definition of culture that incorporated customs and beliefs associated not only with race and ethnicity, but also with religious, spiritual, biological, geographical, and sociological factors.

Since data analyses revealed that the study populations for all CCOs were overwhelmingly Caucasian and English-speaking, CCOs focused on the more broadly defined cultural appropriateness of their interventions. Even so, many CCOs pledged to continue to track study enrollees' race and ethnicity in order to determine if a relationship exists between minority status and testing rates.

CCOs described how interventions addressed the cultural characteristics and needs specific to the SPMI population, most of which were identified in the root cause analysis.

- The interventions were developed taking into account enrollees' potential fears, cognitive limitations, and low socioeconomic status, and were intended to ease the burden of navigating two different health systems.
- The interventions increased awareness (through training and education) on the part of PCPs about the characteristics of the SPMI population, so providers can effectively address the unique needs of the study population.
- The interventions used staff such as peer wellness specialists, community health workers, and other patient advocates, who are sometimes better able to engage the study population than traditional medical and mental health staff.

Scoring: The average score for the first remeasurement period for this element of Standard 8 was 9.1 points out of 10 possible points. Eleven CCOs received 10 points and fully met this criterion. CCOs that scored highly on this criterion thoroughly described how their interventions addressed factors that were specific to the SPMI population such as cognitive limitations, low

socioeconomic status, or fears related to physical health interventions (e.g., blood draws). Two CCOs received lower scores (4 and 6 points) as they had presented only minimal documentation of the cultural appropriateness of their interventions.

e. Tracking and monitoring plans and results

By the end of the first remeasurement period, CCOs were expected to have not only developed tracking and monitoring plans, but also to have produced and presented the results of those plans, including how many members or the percentage of members who were reached by the selected interventions.

Most CCOs tracked the study indicator data from OHA over time and documented the results in the quarterly report. Some CCOs presented their own revised quarterly study indicator data after having examined the state data for accuracy. The issue regarding receipt of accurate and timely study data was raised at several QHOC meetings, and OHA encouraged CCOs to develop their own internal databases to collect data and track outcomes. CCOs discussed the challenge of integrating multiple physical and mental health data systems in order to collect CCO-level data under this criterion as well as under the Standard 8 barriers section. At the time of this report, CCOs had achieved varying levels of success in developing and implementing integrated databases or analytic programs.

In terms of tracking the effective implementation of interventions, the following high-level themes were identified.

- Master lists, spreadsheets, and tables were developed to track data, such as each study population member's PCP, dates of testing, results of testing, mental health provider, dates of outreach efforts, and outcomes of outreach efforts.
- Surveys, pre-post tests, and attendance sheets were used to track training attendance and efficacy and provider satisfaction with educational activities.
- Ongoing team meetings were used to review the PIP interventions, barriers, and successes.

Scoring: The average score for the first remeasurement period was 11.5 points out of 15 possible points. CCOs had the most difficulty with this element of Standard 8, as only three CCOs fully met this criterion and received a score of 15 points. Following implementation of their interventions, most CCOs presented at least partial tracking and monitoring plans for determining the effectiveness of their interventions, but provided few if any results of those

plans. Many of these CCOs attributed the lack of results to loss of QI and IT staff, competing organizational priorities, difficulty accessing data from multiple sources, and dependence on data from OHA (which was not timely or accurate enough for their purposes). The majority of the CCOs also noted that the Medicaid expansion and competing priorities made it difficult to fully attend to and follow up on this project.

f. Barriers encountered during the implementation of the interventions and how they were addressed

Overall, the CCOs did a good job of documenting the barriers they encountered during implementation of their interventions. Detailed descriptions of barriers for individual CCOs appear in Attachment I. The high-level barrier themes include:

- data issues, including CCOs' reliance on data from OHA, delays in dissemination of PIP data, discrepancies between internal CCO data and OHA data, lack of integration of physical health and mental health information systems, and inconsistent or incomplete provider data collection
- organizational factors, such as competing priorities, heavy workloads, staff turnover, delayed establishment as a CCO, and absence of prior processes and procedures addressing integration
- size of the study population was either too small or too large
- difficulty tracking or contacting members of the study population due to factors such as "member churn" or homelessness
- difficulty communicating with providers, especially via email
- workflow issues, such as slower than expected enrollment in co-located or integrated clinics, glitches in the day-to-day operations of co-located clinics
- CCO was newly established and/or integrated care was new to the CCO and providers

Scoring: The average score for the first remeasurement period for this element of Standard 8 was 13.7 points out of 15 possible points. Ten CCOs fully met this criterion with a score of 15 points. Higher-scoring CCOs thoroughly identified barriers encountered during implementation and described how those barriers were addressed. CCOs that had not yet fully met this criterion did not indicate how the barriers were addressed or how they intended to address them.

g. Next steps: how the intervention(s) will be adapted, adopted or abandoned

Most CCOs had a well-established vision of the next steps for their intervention strategies. All CCOs were continuing with the interventions as described in section (c) or with minor modifications. A few CCOs were planning additional interventions based on identified barriers. The high-level themes for next steps for this project include:

- reconciling data discrepancies between internal CCO and/or provider data with OHA data by purchasing new software, creating real-time registries, and devoting staff time to conducting analyses
- continuing to improve communication between mental and physical health providers through ongoing training, shared reports about study enrollees, and follow up email and telephone calls
- using the original intervention to address issues associated with the study population (e.g., smoking cessation, dietitian groups, diabetes prevention groups)
- recruiting additional or replacement staff members to assist with the Statewide PIP

Scoring: The average score for the first remeasurement period for this element of Standard 8 was 14.8 points out of 15 possible points. The CCOs were generally clear and quite thorough in documenting the next steps for their Statewide PIP interventions, as 15 CCOs fully met this criterion and received a score of 15 points. In one instance, it was not clear if all aspects of an intervention strategy were still ongoing and should be included in the next steps of the project.

Strengths and Opportunities for Improvement

The overall average score on Standard 8 was 90.7 points out of 100 possible points, with scores ranging from 70 to 100. The majority of CCO scores fell in the 85 to 95 point range.

Three CCOs (EOCCO, HealthShare, and PHJC) fully met all of the Standard 8 criteria and received an overall score of 100 points. These high-scoring CCOs did an excellent job of conducting data and barrier analyses and then clearly linked the analyses to expected improvement in the study indicator, the development of interventions, and the cultural and linguistic appropriateness of the interventions. In addition, the CCOs thoroughly described barriers encountered and how they were addressed, and provided detailed data on the study indicator and intervention

implementation results during the entire measurement period and the next steps for this PIP.

In terms of the individual Standard 8 criteria, the tracking and monitoring criterion was by far the most challenging for CCOs. Most CCOs did not fully describe their tracking and monitoring plans and/or presented only partial results for their study indicator and effective implementation of their interventions.

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

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

Table CDC-A: Prescriptions to Identify Members With Diabetes (updated Nov. 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	• Pramlinitide
Antidiabetic combinations	• Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine • Insulin inhalation • Insulin isophane beef-pork • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin zinc human
Meglitinides	• Nateglinide • Repaglinide
Miscellaneous antidiabetic agents	• Exenatide • Linagliptin • Liraglutide • Saxagliptin • Sitagliptin
Sulfonylureas	• Acetohexamide • Chlorpropamide • Glimepiride • Glipizide • Glyburide • Tolazamide • Tolbutamide
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.

Statewide PIP, Attachment A (continued)

Table CDC-B: Codes to Identify Diabetes

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

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

Statewide PIP, Attachment B: Schizophrenia and Bipolar Disorder Codes

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

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				
Acute inpatient	UB Revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987			
	CPT: 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	POS: 21, 51
	CPT	HCPCS		UB Revenue
Outpatient, intensive outpatient and partial hospitalization	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: 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	POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
	CPT			UB Revenue
ED	99281-99285			045x, 0981
	CPT: 90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291		WITH	POS: 23
	CPT	HCPCS		UB Revenue
Nonacute inpatient	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: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291		WITH	POS: 31, 32, 56

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

Statewide PIP, Attachment C: Denominator Exclusion Criteria

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

- 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

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

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

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
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	**18,478**	**3.6%**	**3,280**	**17.8%**

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

Statewide PIP Attachment F: Baseline and First Remeasurement Results

(Percentage of CCO members with diabetes and schizophrenia/bipolar disorder who had at least one or more HbA1c test and at least one or more LDL-C test during the measurement year)

CCO Name	Base Deno	Remeas Deno	Base Num HbA1c	Remeas Num HbA1c	Base Rate HbA1c	Remeas Rate HbA1c	Base Num LDL-C	Remeas Num LDL-C	Base Rate LDL-C	Remeas Rate LDL-C	Base Num Compo-site	Remeas Num Compo-site	Base Rate Compo-site	Remeas Rate Compo-site	Trend
AllCare	82	62	67	47	81.7%	75.8%	60	45	73.2%	72.6%	56	39	68.3%	62.9%	↓
Cascade Health	66	41	48	33	72.7%	80.5%	48	25	72.7%	61.0%	41	21	62.1%	51.2%	↓
Columbia Pacific	46	22	36	21	78.3%	95.5%	37	18	80.4%	81.8%	32	18	69.6%	81.8%	↑
Eastern Oregon	46	71	42	54	91.3%	76.1%	34	38	73.9%	53.5%	33	38	71.7%	53.5%	↓
Family Care	136	47	99	41	72.8%	87.2%	94	34	69.1%	72.3%	87	31	64.0%	66.0%	↑
Health Share	841	681	662	527	78.7%	77.4%	586	456	69.7%	67.0%	550	429	65.4%	63.0%	↓
IHN	151	102	127	89	84.1%	87.3%	119	83	78.8%	81.4%	112	75	74.2%	73.5%	↓
Jackson Care Connect	49	38	43	38	87.8%	100.0%	32	35	65.3%	92.1%	32	35	65.3%	92.1%	↑
Pacific Source – Columbia Gorge	n/a	12	n/a	11	n/a	91.7%	n/a	8	n/a	66.7%	n/a	8	n/a	66.7%	n/a
Pacific Source – Central Oregon	n/a	53	n/a	46	n/a	86.8%	n/a	35	n/a	66.0%	n/a	34	n/a	64.2%	n/a
Pacific Source Community Solutions	77	65	64	n/a	83.1%	n/a	54	n/a	70.1%	n/a	50	42	64.9%	64.6%	↓
Primary Health Josephine	30	16	23	12	76.7%	75.0%	18	13	60.0%	81.3%	17	12	56.7%	75.0%	↑

CCO Name	Base Deno	Remeas Deno	Base Num HbA1c	Remeas Num HbA1c	Base Rate HbA1c	Remeas Rate HbA1c	Base Num LDL-C	Remeas Num LDL-C	Base Rate LDL-C	Remeas Rate LDL-C	Base Num Compo-site	Remeas Num Compo-site	Base Rate Compo-site	Remeas Rate Compo-site	Trend
Trillium	219	192	136	168	62.1%	87.5%	116	150	53.0%	78.1%	109	144	49.8%	75.0%	↑
Umpqua	67	46	57	34	85.1%	73.9%	52	33	77.6%	71.7%	47	31	70.1%	67.4%	↓
WOAH	41	31	37	26	90.2%	83.9%	34	22	82.9%	71.0%	32	19	78.0%	61.3%	↓
Willamette Valley	237	206	195	166	82.3%	80.6%	201	164	84.8%	79.6%	176	143	74.3%	69.4%	↓
Yamhill	49	17	40	16	81.6%	94.1%	37	13	75.5%	76.5%	33	13	67.3%	76.5%	↑
State Total	**2,137**	**1,637**	**1,676**	**1,329**	**78.4%**	**81.2%**	**1,522**	**1,172**	**71.2%**	**71.6%**	**1,407**	**1,090**	**65.8%**	**66.6%**	↑

Compiled by Susan Arbor, OHA, Medical Assistance Programs, Quality & Medical Services Section, 2/3/15.

Statewide PIP Attachment G: Standard 8 Scoring Criteria and Allotted Scores

8.1 Has the CCO described:

a. The root cause analysis or quality improvement process used to select the intervention? **(20)**
b. How the intervention could be expected to improve the study indicator (e.g., based on clinical knowledge, relevant research, local adoption, or previous experiences)? **(15)**
c. The intervention itself (dates, location, training, roles, tools/instruments, etc.) and how it addressed the goal of integration? **(10)**
d. Cultural and linguistic appropriateness of the intervention? **(10)**
e. A tracking and monitoring plan and results, including the # or % of study eligible enrollees reached by the intervention? **(15)**
f. Barriers encountered during implementation of the intervention(s) and how they were addressed? **(15)**
g. How the intervention was adapted, adopted, or abandoned? **(15)**

Statewide PIP Attachment H: Results of October 2014 Standard 8 Scoring by CCO

Name of CCO	Root cause	Improve indicator	Description	CLA**	Tracking	Barriers	Next steps	Total score
(Possible points)	**20**	**15**	**10**	**10**	**15**	**15**	**15**	**100**
AllCare Health Plan	20	15	10	10	10	12	15	**92**
Cascade Comprehensive Care	20	15	10	9	10	12	15	**91**
Columbia Pacific CCO	13	9	10	6	9	11	12	**70**
Eastern Oregon CCO	20	15	10	10	15	15	15	**100**
FamilyCare CCO	20	15	8	10	12	10	15	**90**
Health Share of Oregon	20	15	10	10	15	15	15	**100**
Intercommunity Health Network	20	15	10	4	7	15	15	**86**
Jackson Care Connect	18	11	10	8	12	15	15	**89**
PacificSource Community Solutions – Central Oregon	20	15	9	10	10	15	15	**94**
PacificSource Community Solutions – Columbia Gorge	20	15	9	10	13	15	15	**97**
PacificSource	20	15	10	10	15	15	15	**100**
PrimaryHealth of Josephine County	5	9	10	8	13	12	15	**72**
Trillium Community Health Plan	15	15	10	10	11	15	15	**91**
Umpqua Health Alliance	18	15	8	10	12	12	15	**90**
Western Oregon Advanced Health	20	14	10	10	10	15	15	**94**
Willamette Valley Community Health	20	15	10	10	10	15	15	**95**

* Did not resubmit Standard 8 criteria for rescoring.

** CLA – Cultural and linguistic appropriateness.

Statewide PIP Attachment I: Summary of Improvement Strategies by CCO

(Based on October 2014 Quarterly reports)

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
AllCare	• PCP co-located at Options outpatient mental health clinic in September 2013. • Started a mobile physical health clinic at Jackson County Mental Health outpatient clinic • Physical Health case managers determine if PH or MH has established relationship with enrollee. • Conducted monthly integration and care coordination meetings • AllCare and CMHP case managers provided transportation for and support at medical appointments. They also assist in addressing other barriers. • Developed an alternative payment method for preventative care • The Behavioral Health Medical Director and Behavioral Health Manager met with all three CMHPs (Jackson County Mental Health, Options of Southern Oregon, and Curry Community Mental Health) to standardize the definition of SPMI, the codes and	• Many PCPs misunderstood and thought that the health plan and Options would automatically enroll members. Also, PCPs were concerned that their established members would be "transferred"– *AllCare took this as an opportunity to educate clinicians*. • Questions about "taking call" – *these were issues that had to be worked out.* • SPMI symptomology presents different for each member – *care plans are individualized to address* • Staff turnover affect staff resources for PIP project work • There is a sizeable homeless population that is difficult to contact – *working with long-term care, foster home placement and finding suitable housing.*	• Work with the CMHP on building a sustainable data base. • Continue case management • Train new staff • Look at using Flex dollars to address non-medical issues • Address how PC providers and CMHP providers communicate is ongoing.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	processes needed to create a quarterly list of AllCare Members diagnosed with SPMI. • Peer wellness specialist hired to assist in Curry Community Health with drop-ins and peer-run support groups		
CHA	• Created patient lists and distributed them to PCP/PCPCH clinics in April and October 2013. • Conducted interdisciplinary team meetings (PCPCH/PCP case managers, DHS or APD case managers, MH, PH and SUD clinicians, CHA case managers, other stakeholders, such as DOJ) to discuss individuals and treatment planning. Enrollees have been selected because they are high utilizers, but now providers are also making recommendations. • Educated medical residents who rotate through clinic about the importance of conducting necessary testing for SPMI population. • Conducted monthly meetings with CHA case manager and MH providers, and now SUD providers to discuss outstanding issues, such as sharing information with PCPs,	• CHA did not become a CCO until 9/1/2013, resulting in limited access to data and staff feeling overwhelmed. • Claims data has been limited and tracking member PCP assignments has been difficult. *Resolved as of April 2014.* • County MH agency closed with limited notice and did not release records to CHA or new CMHP. • General misunderstanding and concern on the part of MH providers about HIPAA and sharing information with PH providers. *CHA is holding a meeting with MH providers to clarify HIPAA guidelines. CHA is trying to develop a MH summary sheet that could be made available to PH providers.* • Content of the PCP letters may be vague or there may be a dissemination problem. *Senior case manager will send a letter to individual clinicians about untested enrollees.*	• Continue to distribute patient lists to MH and PH providers. • Continue to conduct interdisciplinary team meetings. • Continue residency education. • Continue to address outstanding issues at MH monthly meetings. • Support the work of new case managers at provider agency as they work to ensure that eligible members receive testing. • Develop an integrated resource directory and make it available in providers' offices and online. • Review charts to ensure the MH summary sheet is being provided to PCP/PCPCHs.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	developing an integrated resource directory, how to make diabetes care a joint responsibility. • Case managers hired by one provider agency will help coordinate patient care with and educate PCPs. • Developed an incentive program to encourage enrollees to comply with the Standard of Care (7 exams recommended by the ADA) and offered enrollees $20 incentive for completing the tests.	• KODFM is using finger sticks to check HbA1c which is not captured through claims data (6/9/14). *Completed a chart audit and verified results*. • Dual eligible members are being tested, but claims are not captured by the state and the plan. • Dual diagnosis members seem less likely to be willing to complete lab draws, especially LDL which requires fasting. • Lack of community college program to train CHWs. *CHA will encourage PCPCH to hire workers and will investigate online training. Local community college is developing a training program.* • CHA is working toward developing a mobile lab, but the process is not complete. • Delays in implementing information system to access real time lab data.	• Send out another round of letters related to the incentive program and involve PCP/PCPCH and MH providers. • Continue to contact members and encourage testing. • Identify members eligible for NEMT and develop care plan to ensure testing is completed. • Continue contract negotiations to establish a mobile lab. • Survey PCPCH clinics to see if reports being sent from Sky Lake Medical Center are useful and how reports may be improved.
CPCCO	• <u>Targeting behavioral health providers</u>: After receipt of OHA data GOBHI will ask the local county MH offices to track the dates when testing was discussed with the member. Also, GOBHI will provide CareOregon with the names of the mental health providers of	• Data: – QI staff left CCO, leaving a significant gap in data analysis. *CPCCO expects to fill this position by December 2014.* - Validation of the initial report shows inconsistencies when compared against state data. *Barrier is being addressed by*	• Current interventions will be continued.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	members who had not received testing. • Targeting physical health providers: Send letters to PCPs about members needing tests; letters will also include the name of the mental health provider involved in the member's care. • Co-location: Behaviorists have been co-located at the following clinics: Tillamook Family Health, Dunes Family Medicine, Reedsport Medical, Scappoose, Legacy, Clatskanie Family Medicine and Reinhardt. • Health resilience workers are being deployed in the community and will focus on the SPMI population, and specifically the PIP study population. The workers provide individualized high-touch, trauma-informed care to high utilizers. • A PCP will be co-located at Columbia County Mental Health.	*having analysts review the report code and revalidating the data.* • Dual eligible members: CPCCO is not able to verify test results for dual eligible members not enrolled in CareOregon's Medicare Plan. • Competing CCO priorities: "Competing priorities at the CCO level remain a barrier to implementing interventions for this PIP." *Barrier addressed by ensuring that interventions align with larger organizational efforts around integration of BH and physical health.* • Poor response/lack of cooperation from county mental health departments regarding tracking of PIP study enrollees. *CPCCO continues to "struggle with report outs."* • Dramatic increase in CCO population, access (to primary care and behavioral health services) is an issue. "It is too early to tell how this influx of new members will impact this PIP."	
EOCCO	EOCCO's interventions target problem areas associated with PCPs, MH providers and enrollees: • PCP: Developed a process to mail customized letters to PCPs follow the release of quarterly data. The letters list the names of	• Data discrepancies: Investigation of enrollees with no tests revealed that some enrollees were dual eligibles or incorrectly diagnosed with diabetes. *EOCCO corrected its own data base and is still developing a process to deal with dual eligibles.*	• Continue PCP phone outreach following mailing of letters. • RN case manager will continue to coordinate outreach efforts with the

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	noncompliant enrollees and offers RN case management assistance. The RN case manager calls the PCP for follow and status check. • MH: Developed a process whereby the LPC contacted the CMHP clinician or ENCC of the enrollees in the study who received either diabetic test, but not both, and encouraged the clinician to contact the enrollee and encourage them to get the remaining test. EICC sent the MH provider the PCP letter if the enrollee was in active MH case management. • Enrollee: EOCCO members with diabetes (including the study population) are sent an invitation for diabetes health coaching (once a year) and/or diabetes gaps in care letter (as appropriate). If a member signs up for health coaching, the nurse sends a letter to the PCP with the information. EOCCO complements the gaps in care letter with one to the members' PCPs to ask their help to get the members in for testing. Also where available, peer support services are used to engage enrollees.	• There is a core group of enrollees who are non-compliant despite multiple outreach efforts. *EOCCO is using an intensive care management approach with these enrollees.* • PCPs are aware of MH component, but are still not communicating directly with the MH providers. • Possible barriers to active coordination include: PCP belief that medical needs are being met; continuing cultural estrangement between PH and MH; lack of PCP resources for outreach; lack of formal structure for coordination. *PCPCHs should provide structure and means for communication.*	MH nurse. • LPC team members to contact CMHPs to verify study data and investigate identity of ordering clinician, communication with PCP and availability of lab information. • Develop processes and procedures for data collection and entry on dual eligible. • Survey PCPs of compliant and non-compliant members to inform improvements to care coordination and provider interventions. • The EOCCO PIP team will continue work on the Access database.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
FamilyCare	• Identified PH clinic to pilot intervention - Care Coordinator shares list of SPMI/DM members with clinic. • Survey sent to MH providers about receiving lab tests.	• Less than half of MH clinics received lab results. • Lack of perceived benefit and lack of response related to receiving lab results were the primary barriers • Lack of adequate staffing to develop and implement this PIP • Rapid expansion of CCO membership after April 2014 • PH providers unwilling to take on any new tasks • MH providers not providing case management for integration • PH and MH providers expect the other to initiate record requests	• With help from MH providers, FamilyCare plans to identify PH providers of members and engage them in the intervention. • Develop process to track lab rates monthly. • Distribute lab data to PH and MH providers quarterly. • Standardize process for getting signed ROIs. • Survey MH providers quarterly about integration.
Health Share	• The CCO-sponsored intervention is coordinated through Oregon Partnership for Health Integration (OPHI)-Cascadia and implemented at two clinics. Following assessment, members are assigned a Peer Wellness Specialist who provides support and helps with compliance. • RAE-specific interventions: - Tuality: Implementing a pilot project with Washington County to facilitate communication between the PCP and MH provider - Kaiser Permanente: does outreach when receives list of eligible study members	• Member churn/enrollees coming on and off the list provided by the state – *Created a master list from two quarterly lists.* • Discrepancy with state data (duals) – *Met with PH provider (Providence) to discuss discrepancies. PH provider staff were not aware that HealthShare send MH claims data and 7/11 drug data to each RAE on a monthly basis. HealthShare provided contact information.* • Standardizing member assignment process among MH RAEs – *QAPI established a standardized process by which MH RAEs are able to consistently identify member.*	• Collect and review data on a quarterly basis to determine whether to adapt, adopt, or abandon the project. • If the OPHI intervention is successful (meets members where they are at, assesses their medical needs, engages them in managing their health needs, improves health outcomes, and reduces costs expand the model to other RAEs. • Develop improved study tracking system for Clackamas County.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	- Providence: Case and disease management contacts members who need labs - Washington County: NAMI chapter provides limited information and education to families and members - Multnomah County: addresses PIP in conjunction with regional partners in monthly Clinical Directors meetings. - Clackamas County: Developing a registry with the Clackamas FQHC.	*assignment.* • Size and complexity of the organization – *Reduced the focus group down to three MH RAEs to identify an intervention.* • Competing organizational priorities ("if a project is not integral to core business functions there are not the resources available to invest") - *Plan to tailor any initiatives that are undertaken to align with other priorities, particularly those priorities that relate to integration.* • Difficult to extrapolate Tuality pilot to rest of Washington County due to small study population numbers.	• RAEs will continue their interventions.
IHN	• Distribute lists of members in need of tests to PH providers. • IHN and PH providers collaborate with Linn County Mental Health to identify members with persistent mental illness and promote communication between PH and MH providers. • Pilot intervention at Geary Street Clinic with one provider. • Health Psychologist at Geary Street Clinic does initial MH assessment for Linn County MH and works with SPMI members at Geary Street Clinic.	• Data discrepancies – *established master list of members in the study population*. • Discrepancy between provider listed in Facets system and provider the member is actually seeing. • Loss of data analyst assigned to this PIP has resulted in delay in updating the master list. *Working to resolve this issue.* • Health psychologist found to have very limited time. - *a referral process was established so that the psychologist can focus on members with SPMI.*	• Continue project as planned with changes made to address barriers. • Develop a process in which Linn County Mental Health refers IHN members diagnosed with SPMI who are only being seen by a MH provider to the chosen PH provider. • Communicate with Linn County Mental Health and selected PH provider to determine how best to keep the project moving forward.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
JCC	• Each quarter, the JCC RN Case Manager gives list of established study members to JCMH Clinical Nurse Specialist; and those not established to the JCMH Utilization Team Coordinator (UC). • The JCC RN Case Manager, JCMH UC and JCMH RN specialist engage high utilizing members, identify and remove drivers for utilization. • JCC Nurse Case Manager to increase member engagement through face-to-face meetings with members; will use Peer Specialist from Compass House to do home visits when unable to reach by phone. • Implemented an integrated clinic - Birch Grove clinic – in JCMH that will accept members with SPMI diagnoses. • JCC will outreach to members who are not established with a PCP. • JCMH will offering Living Well classes for diabetics, and JCC will try to get study members enrolled in classes. • PCPs can consult with Psychiatric NP from JCMH to collaborate on	• Timely data – Need to generate internal report to identify members who meet inclusion criteria for the study population in order to provide timely lists to MH and PH providers. • Data inconsistencies – Validation of the initial report shows inconsistencies when compared against state data. *Barrier is being addressed by having analysts review the report code and revalidating the data.* • Demand for services at Birch Grove clinic exceeds capacity – *Priority is given to study members who have had difficulty establishing care in PCP offices or at JCMH.* • Lack of staff – *JCMH has increased number of staff and can devote more time to this PIP and other QI projects. Also, JCC is filling a data analyst position in December 2014.* • Busy providers ignore written outreach efforts. *Abandoned this intervention and exploring other strategies.*	• Continue implementing and monitoring all current interventions. • Action team consisting of JCMH and JCC leaders has begun meeting regularly since September 2014 to develop a charter and driver diagram to direct the PIP and other QI work.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	developing/implementing a care plan. • Provider education: - Conduct in-service on antipsychotic meds and metabolic syndrome for MH providers - Training for MH providers on including diabetic care management in treatment plan - Educate PCPs on including MH conditions in medical treatment plan • Develop workflow to send MH progress notes to members' PCP.		
PSCS - CO	• Educate PH providers about non-fasting LDL test - PSCS Medical Director will discuss and seek agreement from labs to do non-fasting LDL-C. - QUAMPT reps will "spread" non-fasting LDL to standard clinic practice. - QI staff will write an article on topic for August IPA newsletter. • BH training Plan for PSCS BH staff to facilitate training for Mosaic staff on incorporating physical health conditions and	• Loss QI staff has delayed reevaluation of the new CCO gaps and barriers – *position was filled July 28, 2014.* • Current lack of capacity at Mosaic – *additional staff hired.* • Competing priorities for BH providers prevented implementation of the BH training intervention. • Change in HEDIS measure created uncertainty in terms of provider education efforts – *will review when technical specifications are finalized.* • Encounters for dual-eligible members are not being submitted by Medicaid providers.	• Continue to work with Deschutes County MH and Mosaic on PIP • Still planning to write article for provider newsletter • Analyze how many clinics are ordering non-fasting LDLs. • Provide training to Mosaic and expand to other clinics.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	prevention into the mental health treatment plans and how to code or encounter that service. • Integrated co-location sites - Deschutes County Annex/Mosaic clinic does primary care one day/week and currently sees 125 members - 50% of physical health clinics have BH staff onsite - 20% of clinics have case managers to assist with coordinating care • PSCS BH staff will facilitate training for Mosaic staff on incorporating physical health conditions and prevention into the mental health treatment plans and how to code or encounter that service.		
PSCS - CG	• Educate PH providers about non-fasting LDL test - PSCS Medical Director will discuss and seek agreement from labs to do non-fasting LDL-C. - QUAMPT reps will "spread" non-fasting LDL to standard clinic practice. - QI staff will write an article on topic for August IPA	• Loss QI staff has delayed reevaluation of the new CCO gaps and barriers – *position has been filled.* • Lack of BH staff – *now have capacity to provide training if re-evaluation supports this intervention.* • Change in CCO infrastructure – there are now two distinct regions, and the Columbia Gorge study population is very small.	• Continue to work with Mid-Columbia Center on PIP • Still planning to write article for provider newsletter • Analyze how many clinics are ordering non-fasting LDLs • Determine if provider education is needed in this CCO and how to proceed

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	newsletter. • BH training - Planning to facilitate training for county MH providers on incorporation PH information into MH treatment plans and how to code/encounter that service. The training will include, but not be limited to, diabetes. • Integrated co-location sites • Four PH clinics have a BH component. • The largest PH provider has a chronic illness management program. • Mid-Columbia Centers for Living, an outpatient BH provider, has co-located a clinician in two locations.	• Change in HEDIS measure created uncertainty in terms of provider education efforts – *will review when technical specifications are finalized.* • CGCCO does not have an IPA newsletter – *consider writing article for PacificSource newsletter.*	(or not) with this intervention
PHJC	• <u>Fine tuning existing communications between MH and PH</u> - PHJC implemented the Inteligenz analytics program, which contains both physical and mental health data. All labs are scanned and all EZ Cap data along with PH Tech data from Options is collected in the new program. - Two of the PCP offices, which	• Difficulty reconciling inconsistencies between OHA data and Inteligenz (new data system) database. • The analytics vendor did not program the diabetes patient list to follow the PIP denominator rules (include ALL MH diagnoses). This makes identifying study members difficult. • Staffing: Newly hired staff is not freeing up other staff to work on the PIP.	• Evaluate MH 1st Aid Training feedback to determine next steps with this intervention. Will consider shortening training to 1-2 hours and adapt it specifically to the medical community. • Continue working on reconciling discrepancies in analytic program.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	see the largest number of members, started scanning in all paperwork received from outside sources, making it easier to locate labs and ordering provider. - The first reports, including diabetes reports, from the Inteligez analytic program have been run and are being distributed to clinics. - Medical assistants are flagging very specific medical information for PCPs. "This has led to several attempts and restarts to make sure the flagging was for very relevant information and testing." - PHJC, Options and clinics continue to have quarterly meets and chart review to assess data and making necessary modifications. • <u>Mental Health First Aid Training</u> - In May 2014, a MH 1st Aid Training was held at Options. "Several providers were in attendance." - Options have offered two Youth Mental Health trainings to the community. Post-training evaluation feedback has been very positive.	• Competing priorities: PHJC has prioritized other projects, some related to the incentive measures, leaving little time for this PIP. • PCP capacity – Although invited, medical staff did not participate in the MH 1st Aid training probably because could not take time out of direct patient care.	• Continue quarterly meetings and chart reviews and distribution of study member lists. • Create a real time registry of patients with schizophrenia/bipolar disorder and diabetes.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
TCHP	• Use community health workers to assist with transportation. • Each quarter, distribute lists of study members needing tests to MH providers. • MH personnel will assist members with getting labs.	• Members with no contact information and difficulty contacting members – *continues to be problematic.* • Member enrollment changes and new members add/drop from the study population. • PH providers unable to participate due to workload as access issues increase – *still a barrier.* • Temporary CCO closure to new members with estimated 2,500 members unassigned. • Data discrepancies, possibly due to member turnover	• Study population list will continue to be distributed to specific MH providers. • MH providers will continue to work with PCPs of the study population to follow up and/or schedule necessary tests. Expect the number to increase as enrollment re-opens. • Continue to use CHWs to assist with transporting high-risk members.
UHA	• Established extended care clinic where members can receive integrated PH and BH services in one location. - A Care Coordinator takes responsibility for case management (including communicating lab results, conducting patient education and developing a care plan). • Douglas County has received a grant to fund a mobile crisis team, which will respond to mental health crisis situations and appropriately manage the SPMI population.	• Very small population identified; should have more members in study population based on county-wide data. • Data challenges - UHA has not been able to isolate PIP study members from the general SPMI population. Also, not all of the enrollees eligible for the study are seen in the ECC – *ECC Team reviews some of the statistical reports.* - Data collection for LDL and other clinical outcomes is done by chart review, which is labor intensive and there is not enough staff - *QI staff has been hired to help with*	• Plan to purchase software that will be able to provide reports based on data pulled from the EHR. • ECC team and clinic COO will continue to meet on a weekly basis to discuss work flow issues, re-engaging patient, and focus on lab studies. • ECC team continues to meet on a daily basis to discuss and plan for patients scheduled for each day. The team will continue to meet and fine tune processes.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
		analyzing ECC data. • Unanticipated need for certain staff skill sets - *UHA reconfigured ECC team staff for a better fit.* • Organizational culture tended to be more traditional and hierarchical, which did not work well in new integrated team model. - *ECC has committed resources to improving team dynamics and relationships.* • Increased clinical time demands due to multiple and complex needs of patients - *Constant monitoring (in daily huddles) allows ECC to adjust schedule accordingly.* • Keeping providers excited about providing mental and physical health care - *Providers encourage each other and have ongoing conversations to lend support and set goals.* • Intent was to have 100 members assigned to ECC clinic; as of mid-June 2014, there were 84 members assigned. There have been fewer referrals, unwillingness of members to join ECC, and reduced capacity. • The team is continuing to assess challenges and barriers. Considering having the mental health provider become the lead of the team.	

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
WOAH	• Create list that is continually updated to track members in the study population: current PCP, BH prescriber, and labs received. • Monthly meetings between PH case managers from WOAH and MH case managers from Coos County Mental Health to identify study members who need testing, verify data, engage in corrective action when intervention is needed, and undertake continuous process of member education and engagement. • MH case managers responsible for engaging members in scheduling medical exams and ensuring attendance at scheduled exams, tracking members for completion of tests, and ongoing continuous member education and engagement. • Use care management meetings to foster communication between MH and PH providers and teams. • Information given to PCPs about members' MH providers and to MH case managers about members' current PCP.	• Unplanned retirement of WOAH's QA Director. • New CCMH Case Management supervisor. • Addition of 8,103 new WOAH members between 1/1/2014 and 6/30/2014. • Inconsistency in testing practices among clinicians – *Can be addressed by individual clinician education and/or changes in LDL testing best practice guidelines.*	• No major changes planned for the interventions. • Future intervention efforts will be focused on newly enrolled WOAH members. • Will develop an intervention to address the factors contributing to inconsistent provider testing practices.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
WVCH	• ENCC sends letters to PCP offices about PIP and followed up about enrollees not receiving MH services. • PIP team contacted MH agencies about those enrollees receiving MH services to expand services, outreach strategies. Initiated November and December 2013. • MVBCN staff contacted FQHC, which provides mental and physical health and houses the local homeless outreach program, in October 2013 about the PIP and internal procedures for required testing. • Care manager and coordinator of peer services program met with county MH program to identify barriers to testing and problem solve solutions. • CCO and MVBCN staff were trained in the use of patient activation measure (PAM) to improve member engagement • MVBCN and WVP staff have developed an algorithm focused on reducing metabolic side effects of psychiatric medications. WVCH described the selection and prioritization process for this intervention. The algorithm and training/education	• Data: - Delays in receiving State data - Discrepancies between OHA and CCO data, especially around DM diagnoses and CCO enrollment. - Lab data was incomplete due to staff absences. - BH staff, who were funded through a grant process, did not encounter services, making it difficult to monitor intervention effectiveness • Slow response from MH agencies. • Difficulty getting MH providers to respond to MVBCN messages about the PIP. • Some e-mails ended up in spam folders. • At its inception, the Marion County peer wellness team was not familiar with MH or PH providers working on the PIP. • Use of peer wellness specialists for enrollees not currently enrolled in MH services delayed until received guidance from OHA about billing/reimbursement. • Some psychiatrists are resistant to receiving practice guidelines from non-medical staff and input from the MVBCN medical director and to the	• PIP team will call to “learn outcomes of outreach strategies” instead of using e-mail. • Continue all interventions except PAM, which has not proven helpful • Verify OHA data against WVCH internal data in order to identify members who have not been tested in order to intensify outreach. • Use peer wellness specialists as needed. • Meet with BH staff monthly to review study data and discuss any modifications. • Improve tracking system.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	has been presented to MH agencies in June 2014, to the Clinic Advisory Panel in July 2014, and will be presented to PCPs. Algorithm includes dietician consults, diabetes classes, living well classes. A variety of different wellness classes are offered to all CCO members (including the study population). • Peer support specialists are available to coach mental health staff on outreach efforts and to do in-home engagements and accompany members to appointments. • April 2014 – Behavioral health consultants were added to nine PCPCHs, who serve the bulk of the CCO members.	concept of shared decision-making. • Individuals with mental illness refuse or drop out of care or change PCPs with some frequency. • Staff are busy and having to squeeze this project into scarce time. • WVCH ENCC staff is not always available for meetings. • Diabetes control incentive measure not applicable at the clinic level until 2014, which delays prioritization of focus on this population within the PCPCH.	
YCCO	YCCO developed the initial interventions according to whether or not the members were receiving MH services. For those not receiving MH services, each quarter: • CareOregon QI staff initially sent letters to PCPs that discussed the PIP, described available services and asked PCPs to reach out to their patients.	• Crimson data tool has not yet been implemented, so MH and PH data remain separated. • Shifting study population • Delays in receiving data from OHA make it difficult to conduct rapid-cycle work. • MH staff do not have access to PCP lab results and must either call the PCP or re-order the labs.- Consider giving QI staff access to the MH claims data via PH Tech.	• Continue to reconcile state and CCO data. • Continue to use OHA lists for PCP outreach. • Identify new staff for this PIP (CareOregon coordinator, YCHHS staff). • Continue to work with Peer Wellness Specialists on outreach strategies and outcomes. • Explore whether it is more

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	• MH RN made follow phone calls to the PCPs. For those receiving MH services: • MH RN called each PCP office to ask about what services had been offered and challenges encountered. • MH RN met with supervisor of intensive MH services and peer staff in November and December 2013 to identify members who could benefit from peer services. • Behaviorists and PWS received training on using Patient Activation Measure (PAM) in order to engage members, assist with tailoring health education and measure changes in health activation over time. • Work with Yamhill County Yamhill County Health & Human Services, Mental Health • In February 2014, MVBCN required YCHHS to develop a corrective action plan for monitoring individuals receiving anti-psychotics. • "Data is reported monthly along with identified process improvements in a modified	• Multiple staff challenges – loss of staff without replacement; project leads located in different geographic areas, making meeting difficult; CareOregon project lead has been moved to a different role; shifting leadership and assignments for Peer Support Specialists has resulted in loss of PIP intervention data. • The primary MH provider has been slow to incorporate metabolic monitoring. • YCPH has not been able to readily access data from HER – *but ability is improving.* • Shared MH and PH data gaps • Low organization priority to focus on a small cohort of members.	effective to give QI staff access to the MH claims data via PH Tech. • Continue to monitor data from Yamhill County Public Health and report to MVBCN QMC until they are reliably screening at the 90% level. • Continue MH and PH clinic integration at McMinnville and Newberg sites.

CCO	Improvement strategies	Barriers and how they were addressed	Next steps
	PDSA process within the Quality Management Committee." Co-location • Plans to locate primary care services at McMinnville MH in August 2014 • Existing co-location services at Virginia Garcia Medical Clinic, Newburg		

Appendix C. State-Level ISCA Results

Oregon's Medicaid Management Information System (MMIS) receives encounter data from the CCOs and their third-party administrators (TPAs). MMIS houses data for all encounter types, including pharmacy and dental services. The Electronic Data Interchange (EDI) process runs a series of edits to accept, pend, or reject claims before importing the data into MMIS. Claims that are rejected are not imported into MMIS and are not tracked by OHA.

DSSURS is the data warehouse for the main reporting database for MMIS. Medicaid data are loaded into DSSURS by an Extract, Transform, Load (ETL) process weekly. Another reporting tool, COLD, uses data from the MMIS to run standard Hewlett Packard (HP)-created reports and stores them in PDF format.

HP manages several key systems but is not authorized to make financial decisions on behalf of OHA. Currently, HP manages the software and hardware for MMIS, DSSURS, and the provider portal. Servers for these systems reside in the Oregon state data center. HP has managed these systems since 2005. OHA and HP have begun a technology refresh project, scheduled for completion in early 2016. Some hardware has reached end of life and is near the end of support. Some hardware has been updated to handle the increased volume of MMIS activity due to Medicaid expansion.

OHA staff uses SQL or SAS software to calculate the incentive performance measures, based on data from DSSURS. OHA contracts with the Oregon Health Care Quality Corporation (Q Corp) to validate the code used to calculate the 10 performance measures that use encounter data. OHA's Health Analytics staff sends a subset of data to Q Corp and to the Providence Center for Outcome and Research (CORE), depending on the measure year. CORE manages performance data reporting on behalf of the Health Share of Oregon CCO.

In late 2014, OHA began working with CORE to create additional reporting for performance measure calculation and individual data detail for each CCO. The long-term goal is for CORE to create this reporting structure and move reporting back to OHA.

OHA has an informal system development practice (i.e., a process for planning, creating, testing, and deploying an information system, software, or reports) for the incentive performance measures. The main testing for data accuracy is delegated to individual CCOs. OHA uses an informal version control and peer review process for internally developed reports such as performance measures.

Table C-1. State-Level ISCA Review: Strengths and Recommendations.
Information Systems (data flow) – Partially met (2.4)
Strengths
OHA's data warehouse is updated weekly.
Recommendations
OHA outsources MMIS support, maintenance, and design to HP, but state personnel appear to have little knowledge of the system. Experts able to answer questions about the MMIS seem difficult to locate. • The state should identify ways to increase internal knowledge of the MMIS and make existing expertise and documentation more accessible.
OHA's strategic plan appears to omit IT activities, which can require considerable resources, planning, and prioritization. The strategic plan should incorporate IT activities into operational strategic planning. • OHA should define roles and responsibilities for IT strategic planning. • OHA should align its IT development goals with CCO operational planning.
OHA lacks a formal system development practice (a process for planning, creating, testing, and deploying an information system, software, or reports) and a formal peer review process for computer programming of ad-hoc reports and performance measure reporting. • OHA needs to adopt and thoroughly document a system development life cycle. • OHA needs to formalize its process for peer review of computer programming. • OHA needs to ensure that delegated or contracted activities have similar formalized peer review processes and system development practices.
OHA submitted limited documentation explaining how different types of data are received from the CCOs, processed, integrated, and submitted to CMS. The current data flow diagram showed only how data was sent to MMIS, and did not explain what systems MMIS is feeding data. Such documentation could help OHA monitor various data sources. • OHA needs to develop an integrated data flow diagram that describes the data process for all CCO services. The diagram should include receipt of encounter data, MMIS and reporting solutions. This documentation should be stored and/or communicated in a manner that is easily accessible to staff members who need it.
OHA does not use version control management software or processes. Instead, staff renames previous versions of files or programs, and edits new copies as needed. OHA uses informal version control for DSSURS and Health Analytics group reports and output. Version control software can improve the ability to identify changes and return to previous versions of files if needed, and automates revision history. • OHA should develop and implement a formal version control process for Medicaid data reporting. • OHA should explore options and implement enterprise version-control management software for its Medicaid reporting.

Staffing (claims and encounter, authorization) – Partially met (2.5)

Recommendations

It was unclear whether OHA has a budget for training to keep programmers abreast of rapid changes in information technology. Roles and responsibilities were difficult to identify during the interviews with OHA staff and partner organizations (e.g., HP). Although OHA reported some ongoing HIPAA and security training, it was unclear whether staff responsible for programming of key reports or performance measure calculations were required to receive additional technical training to ensure that their skills remain current. It was difficult to identify backup personnel, and a cohesive organizational chart was not provided.

- OHA should formalize its training policy to ensure ongoing training for IT staff (internal and delegated) to support up-to-date skills and knowledge of current industry trends.
- OHA needs to document IT staff roles and responsibilities, as well as backup coverage.

OHA and the CCOs reported inconsistencies in data submission (rejected encounters, pends, gaps in dental and vision service data). It was unclear who, if anyone, was responsible for tracking, monitoring, and following up to correct these data issues.

- OHA should ensure that appropriate staff is assigned to monitor and enforce corrective action for CCOs who submit incomplete, inaccurate, or untimely encounter data.

Hardware Systems – Partially met (2.5)

Strengths

OHA performs daily backups of Medicaid data and replicates the backups to an offsite location.

OHA has added databases and production servers to accommodate the increased workload.

Recommendations

OHA has not upgraded or applied patches to its MMIS implementation, hardware or software, since 2005. Regular maintenance and upgrades were not included in the 2003 contract with HP, which is still in place. This software remains supported until summer 2015. OHA's servers have approached end of life. Some production hardware has not been upgraded since 2005.

- OHA should continue with its plans to upgrade IT systems to ensure that they remain current with supported hardware and software.
- OHA should implement a formal process to monitor the age of hardware for critical servers, and replace them before experiencing end-of-life issues.
- OHA should review and implement planned upgrade strategies for critical hardware.
- OHA should implement a process to monitor hardware replacement practices of its contracted and/or partner organizations (e.g., HP and Enterprise Technology Services).

Security (incident management, risk management) – Not met (1.8)

Recommendations

Finding #1 – Lack of policies and procedures

Exhibit B – Part 8, 1.d.1

OHA submitted limited security and IT policies and procedures for review. Most policies submitted had not been reviewed or updated recently (e.g., approved in 2002, 2008).

- OHA needs to develop and adopt formal policies and procedures, identify roles and responsibilities, and define functions for all Medicaid IT activities.

- OHA should ensure that policies and procedures are reviewed for accuracy at least every two years.

Finding #2 – Lack of business continuity/disaster recovery (BC/DR) plan

OHA has a draft BC/DR plan in process, and is working on an internal Continuity of Operations Plan and a stop-gap recovery plan with HP. The first testing of the current plan is scheduled for June 2015.

- OHA needs to implement a strategy to recover data in the event of a disaster.
- OHA needs to determine the level of detail necessary to include in the plan to enable a skilled IT person to recover or assist with resuming operations in a timely manner.
- OHA should monitor and verify that the plan is tested at least every other year, reviewed at least every two years, and updated when significant changes occur.

Finding #3 –Encryption/Media destruction and disposal

As part of MMIS activities, HP transports unencrypted backup media (tapes and hard drives) from the state data center to the HP office to await destruction by a vendor, for an unknown period of time. It was unclear why these media were not encrypted and whether they contain protected health information (PHI).

Limited information was available regarding media destruction and disposal practices. Policies were vague and lacked detail regarding appropriate drive wiping or removal standards and whether these standards would vary depending on the classification of data (i.e., assigning value to information to classify it according to its risk of loss or harm from disclosure).

- OHA needs to develop, implement and distribute policies regarding:
  - data classification, transportation, and storage
  - data encryption: user-focused and IT staff policies addressing stationary media (PCs and servers) and portable media (thumb drives, backup tapes, and hard drives)
  - destruction and/or disposal of all applicable types of media
  - oversight of adherence to security policies and procedures to safeguard IT assets

Administrative Data (claims and encounter data) – Partially met (2.2)

Recommendations

Finding #4 – Encounter data validation (EDV)

OHA does not require CCOs to maintain an EDV process to validate their encounter data against clinical records, nor does OHA validate the submitted data. OHA is in the process of determining who should perform this activity.

- OHA needs to develop a process to validate the completeness, accuracy, and truthfulness of all data submitted to OHA.
- OHA should develop and implement a process to regularly compare a sample of the state's encounter data with the clinical records in order to validate the completeness, accuracy, and truthfulness of the data. This process could be conducted by OHA, by the CCOs, or by a third party.

OHA reports that CCOs may interpret "encounters" (e.g., bundled services, non-traditional services, and zero-dollar services) somewhat differently. This lack of consistency may cause confusion for provider agencies and OHA staff who use the encounter data. OHA may wish to provide additional guidance related to performance measure encounter data.

- OHA should develop, implement, and distribute a formal document for CCOs containing more specific reporting instructions on services identified as being inconsistently used. This document should be updated regularly.

OHA has an editing process to reject encounters that do not meet certain criteria. The volume of rejections indicates that some CCOs are not reviewing, correcting, and resubmitting claims that OHA has rejected. It is difficult to determine how many of the rejected encounters are valid, but need additional or corrected information for them to be accepted into MMIS, and therefore included in performance measure calculation and other strategic and required reporting.

- OHA should continue its plan to develop and implement a process to confirm that rejected encounters are tracked, reviewed, corrected, and/or appropriately rejected.

Enrollment Systems (Medicaid eligibility) – Fully met (2.8)

Strengths

CCOs reported that the accuracy of eligibility files from the state had significantly improved.

Recommendations

In the past, the state had difficulty supplying managed care plans with complete, accurate, and timely enrollment data. The process to compile and distribute enrollment data was unclear.

- OHA should formalize its process of compiling and distributing enrollment data to CCOs.
- OHA should continue to monitor its enrollment data to ensure completeness, accuracy, and timeliness of these files supplied to CCOs and their partner organizations.

Vendor Data Integration and Ancillary Systems – Fully met (2.6)

Recommendations

OHA reports that variations in CCOs' data submission practices make it difficult to compare pharmacy data. Many CCOs use vendors to manage pharmacy data, and those CCOs may lack expertise to monitor the accuracy of the pharmacy data format (National Council for Prescription Drug Programs). Formalizing the processes for submitting encounters could benefit both the CCOs and the data users at OHA.

- OHA should continue to work with CCOs that contract with pharmacy vendors to standardize the file structure of encounters.
- OHA should formalize and distribute the process for submitting pharmacy encounters.

Report Production and Integration and Control of Data for Performance Measure Reporting – Partially met (2.0)

Recommendations

OHA calculates the incentive measures based on data in DSSURS. OHA has an informal system development practice (i.e., a process for planning, creating, testing, and deploying an information system, software, or reports) for the incentive performance measures. The main testing for data accuracy is delegated to individual CCOs. OHA uses an informal version control and peer review process for internally developed reports such as performance measures.

OHA sent a subset of data to its vendor Q Corp to validate the performance measure code. Q Corp reviewed all performance measure code except for one measure that used encounter data. It was unclear why this performance measure code was not reviewed. OHA plans review all performance measures that include encounter data in the future.

OHA needs to implement a process to document processes, policies, and procedures for all performance measures. This documentation should specify the steps taken to ensure that:

- OHA receives complete encounter data from all CCOs in a timely manner
- the data flow between and within OHA systems is documented and understood
- OHA's communication with CCOs and provider agencies is documented and consistent
- performance measure calculation code review is conducted for all measures that use encounter data

Provider Data (Compensation and profiles) – Partially met (2.5)

Recommendations

OHA has difficulty tracking service provider activity due to inconsistent use of national provider identifier (NPI) numbers submitted on encounters. For example, many mental health agencies report encounters using the agency-level NPI numbers; in these cases, it is unclear how OHA could validate that the individual provider meets the required education, certification, or training for the services provided. It is also unclear whether the state is meeting its required documentation standards by having encounter data in aggregate, in lieu of encounter data activity at the individual provider level.

- OHA should clarify its expectations of who is required to report individual provider NPI numbers on encounters, and of the provider types or services for which agency-level NPI numbers are appropriate.
- OHA should ensure that all eligible providers report provider-level NPI numbers on encounters.
- OHA should develop and implement edits to identify inaccurate NPI reporting to ensure accurate reporting of individual rendering providers.
- OHA needs to formally communicate its expectations and requirements to CCOs and providers, in accordance with CMS regulations regarding the reporting of NPI numbers on encounters.

Meaningful Use of Electronic Health Records – Partially met (2.5)

Recommendations

Overall, CCOs had few or no policies and procedures regarding partners or delegates that implement, upgrade, or change their EHR implementation. Such changes may significantly affect a CCO's ability to submit complete, accurate, and timely encounter data to the state. OHA should provide guidance to CCOs and their partners and delegates regarding the state's expectations as to EHR system changes and potential outages.

- OHA should provide direction regarding EHR implementation, testing, and planning for transition periods when data may be unavailable, and the CCOs' role in EHR adoption by provider agencies.