Oregon Health Authority Managed Care

2015 External Quality Review Annual Report

February 2016

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Abbreviations and Acronyms Used in This Report

APD	Aging and People with Disabilities
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	clinical advisory panel
CCO	Coordinated Care Organization
CHW	community health worker
CLAS	culturally and linguistically appropriate services
CMS	Centers for Medicare & Medicaid Services
ED	emergency department
EDIE	Emergency Department Information Exchange
EHR	electronic health record
ISCA	Information Systems Capabilities Assessment
MMIS	Medicaid Management Information System
NEMT	non-emergent transportation
OHA	Oregon Health Authority
OHP	Oregon Health Plan
PCP	primary care provider
PCPCH	patient-centered primary care home
PIP	performance improvement project
PMV	performance measure validation
QA/PI	quality assessment and performance improvement
QHOC	Quality and Health Outcomes Committee
QI	quality improvement
SBIRT	Screening, Brief Intervention and Referral to Treatment
SHCN	special health care needs
SPMI	serious and persistent mental illness

Acronyms for individual CCOs are listed on page 9.

EXECUTIVE SUMMARY

In August 2012, following state legislation and the approval of Oregon's 1115 Medicaid Demonstration waiver by the Centers for Medicare & Medicaid Services (CMS), Oregon implemented Coordinated Care Organizations (CCOs) to deliver managed care for Medicaid recipients. The current 16 CCOs manage physical, behavioral, and dental health services for Oregon Health Plan (OHP) members across the state.

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 2015 were:

- *Compliance* with federal and state regulations and contract provisions related to Quality Assessment and Performance Improvement (QA/PI)
- *Validation of statewide performance measures*, including a follow-up 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 all 16 CCOs in 2015. 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 a review of Greater Oregon Behavioral Health, Inc. (GOBHI), a managed mental health organization. Results of that review appear in a separate section of the report narrative.

CCO Compliance Review

In 2015, Acumentra Health reviewed each CCO's compliance with QA/PI 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 in mind the goals of long-term improvement and the state's Triple Aim—better care for patients, better population health, and reduced costs.

The CCOs have matured as organizations since their inception in 2012. Most have hired CCO-level administrative staff and brought functions in-house that were performed by delegates during 2012–2014. Mental health services are now routinely integrated into the CCOs' care management services.

The CCOs have increased the number of patient-centered primary care homes (PCPCHs) and the number of enrollees served by them. According to OHA, all CCOs met the challenge benchmark of at least 60% enrollment in PCPCHs.[1] In general, the large medical clinics have become PCPCHs. Most CCOs are still working with smaller practices to help them meet PCPCH criteria.

CCOs have used transformation funds to initiate innovative projects to transform care, many of which are cited in this report.

Overall strengths

- Many CCOs have been able to expand their delivery networks in response to Medicaid expansion by increasing practitioner caseloads and/or adding new clinics and providers.
- The CCOs have established robust care management processes.
- All CCOs have made progress in integrating physical and behavioral health care, particularly through co-location strategies.
- Most CCOs have implemented alternative payment methodologies to provide incentives for providers to change practice patterns, and all are using such methodologies as incentives to meet quality performance metrics.

Major areas for improvement and recommendations

Acumentra Health developed recommendations for the individual CCOs (see Appendix A) and for OHA to assist the CCOs in addressing those issues. Some overarching recommendations for OHA and the CCOs appear below.

Service integration. Overall, the CCOs have made progress in transitioning to fully integrated care delivery systems. The CCOs have added dental care and non-emergent transportation (NEMT) services to their benefit plans during 2014–2015. However, integration and standardization across physical, dental, and behavioral health services remain limited. Lack of integrated data systems is a barrier to care management, especially for enrollees with special health care needs (SHCN).

[1] Oregon Health Authority. Oregon's Health System Transformation, 2014 Final Report. June 24, 2015. Available online: http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf.

In most cases, integration is occurring mainly at the practice level in the PCPCHs. Behavioral health staff are embedded in PCPCHs, but the care delivered at mental health and substance use disorder treatment agencies is not integrated into the CCOs' electronic data systems. CCOs continue to identify the need to improve communication between primary care and mental health. In many cases, dental care remains a separate service delivery system.

- ***OHA needs to provide guidance to the CCOs regarding its expectations for service integration at the CCO level.***

Quality management. Most CCOs have retooled their quality management programs to align with OHA's quality incentive measures. However, some aspects of quality management are not receiving the same levels of attention as in years past. For example, the CCOs' annual quality strategy evaluations typically no longer address access to routine, urgent, and emergent care.

Most CCOs have centralized their quality management functions. In general, however, CCO boards are rarely involved in reviewing the annual quality strategy evaluation or in approving the annual quality management plan.

- ***OHA needs to clarify its expectations regarding CCO-level oversight of quality management.***

Oversight of delegated functions. Since the delegation readiness review in 2013, the CCOs have begun clarifying the roles and responsibilities of their partners and delegates. Some CCOs have developed delegation oversight mechanisms. Most CCOs, however, have not formally evaluated their delegates' performance.

More work is needed to ensure that delegated functions are performed as required by the CCO contract. The CCOs need to revise their delegation agreements to clearly specify delegate performance expectations. CCOs also need to establish mechanisms to conduct oversight activities, and take action when delegates' and partners' performance is lacking.

- ***OHA needs to clarify expectations for oversight of delegated activities***

Culturally and linguistically appropriate services (CLAS). The CCOs' transformation plans address health care disparities, and CCOs have employed various CLAS strategies across the state. Some recognize health literacy and poverty as primary issues that affect how care needs to be adapted. Most of the community needs assessments have included Spanish-speaking focus groups. However, few CCOs have implemented interventions to address issues identified in the assessments.

Although the OHA contract requires CCOs to assess the cultural and linguistic needs of enrollees with SHCN, few CCOs have incorporated the CLAS assessment when screening those enrollees.

- ***OHA needs to continue to provide technical assistance and guidance for the CCOs regarding CLAS expectations, especially for enrollees with SHCN.***

For more details, see the compliance review section beginning on page 22.

Performance Measure Validation (PMV)

Per OHA's instruction, Acumentra Health validated 6 of the state's 17 incentive performance measures for CCOs. Those 6 measures were calculated using *only* encounter data that OHA collects and maintains The PMV sought to determine whether the data used to calculate the measures were complete and accurate and whether the calculation adhered to CMS specifications.

The associated ISCA activities 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

For the 6 measures reviewed, the code review and measure calculation process was adequate and represented an improvement over previous years. However, Acumentra Health assigned a "Partially met" compliance rating to all 6 measures because of concerns about the validity of the underlying data.

Acumentra Health recommends that OHA document the 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, and the data flow with external partners, is documented and understood
- OHA communication with CCOs and providers is documented and consistent
- current relationships with external partners are documented, as are any future changes in associations, roles, or responsibilities

Also, OHA should encourage CCOs to implement an encounter data validation process to ensure that data are complete and valid before submission to OHA.

For additional details, see pages 47–50.

ISCA follow-up results

In 2014, Acumentra Health conducted a full ISCA review of both OHA's data management and reporting systems and those of the individual CCOs. In 2015, Acumentra Health followed up with OHA and the CCOs regarding the status of the 2014 ISCA recommendations through interviews with key staff and review of additional documentation.

The state ISCA follow-up review found that OHA continues to strengthen its data warehouse management processes, including performing daily backups of Medicaid data and replicating 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 a decrease in data integrity issues relating to member eligibility files received from the state. OHA continues to work on addressing deficiencies related to:

- lack of clarity regarding IT staff roles and responsibilities
- inconsistencies in data submission by the CCOs
- maintenance and ongoing support for Medicaid Management Information System (MMIS) hardware and software
- data security issues (data encryption and media destruction/disposal practices)
- regular review and updating of policies, procedures, and business continuity/disaster recovery plans

Appendix C presents detailed results of the state ISCA follow-up review.

Acumentra Health followed up with the individual CCOs to review their progress in addressing the 2014 findings and recommendations. The CCO profiles in Appendix A summarize the status of each CCO's response.

Overall, the CCOs had begun to address most issues identified in the 2014 review but were still in planning and implementation stages. Many CCOs stated that some of the issues will take more time to implement, though some CCOs expected to have completed some items in time for the next full ISCA in 2016.

Acumentra Health developed specific recommendations for OHA to work with the CCOs on issues related to IT systems integration, encounter data certification, delegated IT activities and responsibilities, security policies/procedures and disaster recovery plans, and provider directories. See the ISCA section beginning on page 51.

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 nonclinical 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

Beginning in 2013, all CCOs took part in a statewide collaborative PIP, focused on monitoring the delivery of diabetes tests (HbA1c and LDL-C) for OHP members diagnosed with diabetes and co-occurring schizophrenia or bipolar disorder. Acumentra Health facilitated and documented the overall PIP; CCOs developed their own interventions and documented their progress in quarterly reports to OHA. In turn, OHA collected, calculated, and reported the aggregated statewide study indicator data for the study measurement periods.

This PIP was completed at the end of the second remeasurement period, June 30, 2015. Acumentra Health's analysis of the aggregated statewide study indicator calculated by OHA showed no statistically significant differences in diabetes testing rates for the study population across the baseline, first remeasurement, and second remeasurement periods. However, changes in the indicator calculated by OHA were not consistent with results reported by the CCOs individually.

Acumentra Health also evaluated the individual CCOs' fulfillment of the criteria for PIP Standard 8 (Improvement Strategies).

High-level details appear in the PIP section beginning on page 61. The full final report of the first Statewide PIP appears in Appendix B.

In June 2015, the OHA Quality Council approved the topic of a second Statewide PIP, to be conducted from July 1, 2015, through June 30, 2017. The topic is "Improving the Safety of Opioid Management."

The CCO profiles in Appendix A report the topics of each CCO's additional PIPs conducted in 2015.

INTRODUCTION

The Balanced Budget Act of 1997 (BBA) requires an annual EQR in states that use a managed care approach to provide Medicaid services. OHA contracts with 16 CCOs, and with GOBHI and CareOregon, to deliver services to OHP members through managed care. In turn, the CCOs contract with physical and mental health, addiction treatment, and dental service providers, and with pharmacy management companies and hospitals, to deliver care. Each 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' quality improvement (QI) programs
- annual validation of performance measures reported by plans or calculated by the state, including an ISCA

In 2013, the first full year of operation for the CCOs, OHA directed Acumentra Health to conduct "readiness reviews" of the CCOs to evaluate their capacity to meet federal requirements.

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 a full ISCA for OHA and for each CCO; and reviewed and scored work that the CCOs had completed for the first 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 conducted a compliance review of all CCOs and GOBHI, covering QA/PI standards; reviewed PIPs; and conducted PMV-related activities, including following up on the 2014 CCO ISCA reviews. Acumentra Health also conducted a full ISCA of GOBHI.

These review activities addressed 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
- *EQR Protocol 3: Validating Performance Improvement Projects (PIPs),* Version 2.0, September 2012
- *Appendix V: Information Systems Capabilities Assessment,* 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 November 2015.

Table 1. CCOs' OHP Enrollment, November 2015.

CCO	Total enrollees
AllCare Health Plan, Inc.	48,497
Cascade Health Alliance (CHA)	17,228
Columbia Pacific Coordinated Care Organization (CPCCO)	26,033
Eastern Oregon Coordinated Care Organization (EOCCO)	45,646
FamilyCare CCO	122,994
Health Share of Oregon (HSO)	228,405
Intercommunity Health Network (IHN)	55,215
Jackson Care Connect (JCC)	30,038
PacificSource Community Solutions–Central Oregon (PCS-CO)	49,983
PacificSource Community Solutions–Columbia Gorge (PCS-CG)	12,328
Primary Health of Josephine County (PHJC)	11,477
Trillium Community Health Plan (TCHP)	92,485
Umpqua Health Alliance (UHA)	25,246
Western Oregon Advanced Health, LLC (WOAH)	20,362
Willamette Valley Community Health, LLC (WVCH)	97,846
Yamhill County Care Organization (YCCO)	23,473
Total	**907,256**

Source: Oregon Health Authority. Oregon Health Plan: Coordinated Care, Managed Care and Fee for Service Enrollment for November 15, 2015.

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 QI staff from each CCO attend the meetings.

OHA's Transformation Center offers Transformation Fund Grant Awards to CCOs to support innovative efforts to transform health care delivery in Oregon. All 16 CCOs have received such grants to support a wide range of projects, which are summarized on the OHA website.[2]

The Transformation Center coordinates statewide learning collaboratives, the progress of which is discussed at the monthly QHOC meetings. Since July 2013, monthly sessions have covered topics such as Screening, Brief Intervention and Referral to Treatment (SBIRT), prenatal care, pain management, depression screening, and colorectal cancer screening.

The center also issues semiannual reports on the CCOs' performance on key quality and financial measures. The most recent report, covering July 2014–June 2015, continued to show improvements for OHP members in areas such as enrollment in PCPCHs, reduced emergency department visits, and reduced hospital admissions due to chronic diseases.[3]

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 requirements of the U.S. Department of Health and Human Services.

OHA's 1115 waiver approved by CMS includes a Quality Strategy that defines:

- how OHA and the CCOs will work to achieve the Triple Aim
- specific goals for cost, quality, access, and population health
- 6 key levers to generate savings and quality improvements and to accelerate spread across the delivery system
- 7 QI focus areas
- care coordination for members with serious and persistent mental illness
- resources and supports

[2] See www.oregon.gov/oha/Transformation-Center/Documents/Transformation-Fund-Summaries.pdf.

[3] Oregon Health Authority, Office of Health Analytics. Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update. Available online: www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf.

Quality and transformation activities include creation of the Transformation Center and Innovator Agents; learning collaboratives and technical assistance; health equity initiatives to reduce disparities; and use of PCPCHs, community advisory councils, community health workers, and alternate payment models.

OHA developed its 2015–2018 Behavioral Health Strategic Plan with input from state mental health advisory committees and stakeholders across Oregon. The plan identifies six strategic initiatives 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.[4]

Wraparound services for children

OHA and the Department of Human Services conduct 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. State lawmakers approved funding to expand the initiative in 2013.

Consumer surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

OHA uses CAHPS survey results to evaluate two CCO incentive measures—access to care and satisfaction with care—as well as for statewide measures of tobacco use and member health status.

Mental health services surveys

On behalf of OHA, Acumentra Health conducts the annual Mental Health Statistics Improvement Program (MHSIP) Consumer Survey for Adults, the Youth Services Survey for Families (YSS-F), and the Youth Services Survey (YSS).[5] OHA adds questions to each survey to collect additional data to help evaluate the progress of

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

5 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.

ongoing programs. Survey participants have the option to complete the survey online or on paper.

Adult survey results. In 2015, Acumentra Health distributed a survey to adults who had received outpatient mental health services through OHP, and to adults in residential treatment programs or foster care, during January–December 2014. The survey was mailed to 9,231 adults who had received outpatient services and 1,660 adults in either residential or foster care. In all, 2,039 adults returned surveys, for a response rate of 18.7%, down from 24.1% the previous year.[6]

The survey 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.

From 2014 to 2015, the percentages of satisfied respondents fell in most domains, but these changes were not statistically significant. Similar to previous years, outpatient respondents were less satisfied in all but one domain compared to residential respondents. Differences were most notable in treatment outcomes, daily functioning, and social connectedness. A greater percentage of outpatient respondents than of residential respondents were satisfied with participation.

Youth survey results. The 2015 YSS-F asked about caregivers' perception of services delivered in seven 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 18% (down from 24% in 2014), with 2,364 responses from caregivers of 13,039 children with valid addresses.[7]

The 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 818 responses from among 4,388 young people with valid addresses, for a response rate of 19%, down from 23% in 2014.

6 Acumentra Health. 2015 Oregon Mental Health Statistics Improvement Project Survey for Adults–Outpatient and Residential. February 2016.

7 Acumentra Health. 2015 Oregon Youth Services Survey for Families and Youth Services Survey Report. January 2016.

Overall, YSS-F satisfaction scores have remained relatively stable over the past five years. From 2014 to 2015, the proportion of satisfied caregivers decreased in most domains, though the changes were not statistically significant. The cultural sensitivity and social connectedness domains continued to show the highest positive response rates, as in previous years. Compared with caregivers responding to the YSS-F, young people responding to the YSS typically have reported lower satisfaction across domains of care.

Home and community-based services survey

During 2015, Acumentra Health conducted a statewide survey of Home and Community-Based Services (HCBS) consumers and providers on behalf of OHA and the Department of Human Services (DHS). The survey results will inform the state's implementation of new federal requirements for HCBS providers, aimed at ensuring that people receive Medicaid-funded HCBS in settings that are integrated in and support full access to the greater community.

The Individual Experience Survey was designed to gather information about HCBS recipients' experience receiving services in residential settings. A separate Provider Self-Assessment Survey asked HCBS providers to describe the services in residential settings they owned, controlled, or operated.

The surveys went out in waves beginning in September 2015. Service recipients had the option to complete the survey online or to have a representative complete the survey on paper. Acumentra Health assisted recipients and providers who needed help completing the survey. In addition, OHA and its partner organizations held regional forums during August–October 2015 to educate individuals, providers, case management staff, and other community members about the new HCBS regulations and the surveys.

In all, more than 10,500 HCBS consumers and providers responded to the survey. Response rates were high—nearly 40% for adult and youth consumers, over 50% for youth service providers, and over 70% for adult service providers. Acumentra Health provided OHA and DHS with comprehensive survey results via a Tableau workbook containing multiple analytical "dashboards," enabling users to filter and sort the survey responses by program type, provider, age, and race.

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 health care network, and availability of transportation and translation services. Access to care affects an enrollee's experience of care 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 health care 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. Since then, the CCOs have made progress in expanding primary care and dental care capacity.
- The CCOs began providing NEMT services for enrollees in 2014 and 2015. Several CCOs used innovative approaches to improve these services.
- All CCOs have made progress in integrating physical and behavioral health care. Strategies for improving access to include:
    - co-locating mental health and substance use disorder treatment practitioners in primary care clinics
    - co-locating physical health practitioners in mental health clinics
    - co-locating dental care at some clinics and school-based health centers

- All CCOs met the incentive measure for PCPCH enrollment. As of March 2015, there were 548 recognized PCPCHs in Oregon. Most CCOs are working with small practices to help them meet the demands of operating as a PCPCH.
- One CCO works with its dental care delegate to deliver dental services in a van that travels between local behavioral health clinics to provide basic dental health services.

Areas for improvement

- Almost all of the community needs assessments identified access to care as a local concern. Most community health assessments lacked analysis that compared CCO demographic and utilization data with the community-wide data used for the assessment. This analysis is essential to identify disparities.

  Some CCOs have implemented strategies such as increasing after-hours availability, using mobile units to serve rural communities, and recruiting and retaining additional providers. However, more work is needed to improve access to care in rural areas.

  In addition to ongoing difficulty with ensuring access to primary care, most CCOs are struggling to provide access to specialists, especially psychiatrists and mental health practitioners. CCOs also report inconsistent access to dental care, particularly in rural parts of the state.

  - ***CCOs need to continue to work toward ensuring access to services for all enrollees.***

- During 2015, most CCOs did not monitor contractual requirements for provider network access. Some CCOs lacked system-wide mechanisms to monitor capacity and access to ensure an appropriate distribution of services and to identify gaps or disparities across the CCO network.

  - ***CCOs need to monitor the capacity of their entire service delivery networks to ensure an appropriate distribution of services and to identify gaps or disparities.***

- Few CCOs' policies and procedures related to providing direct access to specialists address access to behavioral health and dental care specialists.

  - ***The CCOs need to develop overarching policies regarding direct access to specialists in all service sectors.***

Timeliness

Strengths

- Some CCOs monitor hospital admissions and deploy community health workers (CHWs) to facilitate after-care and provide case management.
- Several CCOs' care management staff members meet daily to triage enrollees with SHCN.
- One CCO connects care coordinators/case managers with the Emergency Department Information Exchange (EDIE) system, alerting CCO staff to enrollee visits to enable timely care coordination and discharge planning.
- Some CCOs distribute health risk assessment (HRA) forms to new enrollees, enabling the CCO to provide timely intervention upon enrollment.

Areas for improvement

- All CCOs track the timeliness of prenatal care and whether developmental screenings are conducted in the first 36 months of life. However, most CCOs do not closely monitor the timeliness of access to routine, urgent, and emergent mental health services, substance use disorder treatment, dental care, or NEMT services.
    - ***CCOs need to monitor the timeliness of access to routine, urgent, and emergent care across the entire service delivery network.***
- Most CCOs do not monitor their delegates regarding the timeliness of routine and expedited service authorization decisions.
    - ***CCOs need to monitor the timeliness of routine and expedited service authorization decisions made by delegates across the entire service delivery network.***
- Several CCOs lack mechanisms to ensure that providers and delegates are screening practitioners for exclusion from participation in federal health care programs on a monthly basis.
    - ***CCOs need to ensure that all partners, delegates, and downstream entities perform monthly screening for exclusion from participation in federal health care programs.***
- Several CCOs lack policies and procedures addressing the required time frames for informing enrollees of service authorization decisions.
    - ***CCOs need to ensure that their service authorization policies address the time frames for informing enrollees of authorization decisions.***

Quality

As part of their transformation plans, 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 QA/PI standards.

Strengths

- Most CCOs use **alternative payment methodologies** to provide incentives for providers to change practice patterns, and all use such methodologies as incentives to meet quality performance metrics. Strategies include:
  - hiring and placing personnel in PCPCHs; for example, one CCO placed a women's health nurse practitioner and a nutritionist within a women's health specialty group
  - funding health care interpretation and other training for CHWs
  - providing incentives for providers to locate in and remain in rural communities
- All CCOs made progress on **integrating physical, behavioral, and dental health care** during 2015.
  - Some CCOs added behavioral health and dental health representatives to form integrated operations teams. A few hired behavioral health and dental medical directors or management staff. Some CCOs hired dental and behavioral health administrative staff and charged them with facilitating integration.
  - Most CCOs' clinical advisory panels (CAPs) include representatives from primary care and behavioral health. Some CAPs include dental representatives.
  - Several CCOs meet monthly with mental health and substance use treatment providers and Aging and People with Disabilities (APD) staff. Some CCOs jointly develop care plans for enrollees engaged in care with multiple systems. All CCOs' care management staff follow up on enrollee referrals to specialists.
  - Several CCOs have made strides toward integrating dental care. A few CCOs hired a dental manager and a dental hygienist who consult with the CCOs' PCPCHs.
  - An integration project by two CCOs, in partnership with the University of Colorado at Denver, focuses on data sharing between hospitals and medical and behavioral health providers.
  - One CCO holds planning meetings with the local health and human services agency to identify gaps in care coordination. The CCO has

facilitated the integration of a community care manager 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.
  - Another CCO convened an Interagency Quality and Accountability Committee that is the CCO's primary vehicle for integrating care between delegates.

- **Population management:** Many CCOs have invested in predictive modeling programs. Some use this resource to guide care coordination activities, conduct utilization management, and address the needs of high-cost/high-utilizing enrollees. A few CCOs have developed fully integrated data warehouses that encompass medical, mental health, substance use disorder, pharmacy, and dental services. One CCO employs analysts with behavioral health backgrounds to prepare detailed reports on potential disparities between physical health and mental health enrollees.
- All CCOs provide robust **care management**.
  - All CCOs use interdisciplinary teams to guide care coordination efforts. These teams include representatives from primary care, mental health, dental care, law enforcement, APD, home health, substance use disorder treatment, and enrollees and their family members.
  - CCO staff members hold regularly scheduled meetings with community partners to better coordinate care for members with complex needs.
  - In CCOs that distribute HRA forms to new enrollees, care management staff members review the forms to determine whether to refer enrollees to behavioral health or dental care, or to initiate care coordination.
  - A few CCOs use an evidence-based Transitional Care Model and a regional care manager to provide face-to-face in-home meetings for enrollees with complex needs and/or SHCN.
- The CCOs have employed strategies to increase the delivery of **culturally and linguistically appropriate services (CLAS)**.
  - Most CCOs have offered cultural competency training for staff and providers.
  - Some rural CCOs have identified poverty as the primary cultural issue facing enrollees. Other CCOs have focused on health literacy.
  - One CCO worked with the local community college to offer training for CHWs to become certified health care interpreters.

  - Two CCOs convened a Health Equity Task Force to identify ways to improve communication and outreach to Hispanic/Latino and American Indian/Alaskan Native populations. This task force produced a cultural competency report that is shared with the CCO governing board and standing committees.
  - Two CCOs recruited bilingual, bicultural specialists to develop member engagement and communication strategies. Another CCO contracted with Nuestra Comunidada Sana to form a task force aimed at bringing about needed reforms to achieve health equity and inclusiveness. Leadership at another CCO is involved in the Regional Health Equity Coalition.
  - One CCO adopted the CLAS standards as a framework to guide formal assessment of the capacities and gaps in its service delivery system.

- CCOs are **employing CHWs as practice extenders**. Some CCOs assign these workers to enrollees with high utilization to reduce inappropriate use of the emergency room.
- Several CCOs have implemented strategies to reduce **inappropriate prescribing of opiates**. A few have developed practice guidelines related to opioid prescribing. These CCOs collaborate with private medical groups, public health, hospitals, emergency centers, pharmacies, and federally qualified health centers to reduce inappropriate use of opioids. One CCO opened a chronic pain clinic for enrollees with trauma histories and co-morbid mental health conditions, with staff including psychiatrists and qualified mental health professionals.

Areas for improvement

- **Care integration:** The CCOs have made progress toward care integration, but more work is needed.
  - Policies/procedures and provider manuals: Most CCOs' policies and provider manuals do not address integrated care. For example, policies and procedures related to second opinions address only second opinions in primary care. The policies and procedures also need to address second opinions in mental health, substance use disorder treatment, and dental care. Many CCOs lack overarching policies covering all contractual and regulatory requirements. Policies need to be approved by a CCO-level authority, and all providers need to be guided on how the CCO expects compliance issues to be handled.

- ***CCOs need to ensure that all partners and delegates are aware of the CCOs' expectations for care integration, and to ensure that services delivered across the entire network are aligned with the CCOs' policies and processes.***

  - Dental care: Some CCOs have not yet integrated dental care into their service delivery networks. In some instances, the dental care plans are fully autonomous with little CCO oversight.

    - ***CCOs need to continue to work on integrating dental care at the CCO administrative level and service delivery level.***

  - Mental health care: In most cases, mental health provider agencies are not integrated into the CCOs' delivery systems. In many CCOs, mental health agencies amount to a separate specialty care delivery system. A few CCOs allow limited access to their electronic health records to a few designated mental health practitioners who are charged with coordinating care. A few CCOs have identified the need to improve communication between primary care and mental health providers.

    - ***CCOs need to continue to work on integrating mental health care at the CCO administrative level and to integrate the mental health delivery system into the CCO's electronic clinical data system.***

  - Practice guidelines: Most CCOs' practice guidelines address physical health exclusively. Practice guidelines in place for dental care or behavioral health are not integrated into the CCOs' infrastructure for development, review, approval, and dissemination of guidelines.

    - ***CCOs need to integrate mental health, substance use disorder treatment, and dental health practice guidelines into their clinical infrastructure.***

- **Delegation oversight:** Most CCOs lack mechanisms to monitor activities delegated to partners and providers. The CCOs exercise limited oversight of functions delegated to the dental care plans. Few CCOs have conducted annual oversight of their delegates.

  - Utilization management: Most CCOs lack mechanisms to ensure that review criteria are applied consistently when authorization decisions are made by delegates.
  - Care coordination: Most CCOs do not oversee care delivered to enrollees with SHCN who are seen in mental health, substance use disorder treatment, and dental care.

  - Credentialing: The CCOs conduct little oversight of credentialing activities conducted by the mental health agencies or dental care plans. Most CCOs rely on the state's certification of licensed mental health practitioners to ensure that those providers are qualified to deliver care for CCO enrollees. In general, the CCOs do not conduct oversight of the credentials of non-licensed mental health staff or substance use disorder treatment staff. Most CCOs have delegated dental credentialing to the dental care plans and have not developed mechanisms to monitor the credentialing conducted by the dental plans.
    - ***CCOs need to work with partners and delegates to clarify expectations and increase oversight of activities delegated to the partners and other entities.***

- Data integration: The CCOs have made progress in integrating data from physical, behavioral, and dental health services. However, more work is needed to ensure that CCOs can use the data to manage the care delivered to enrollees, including those with SHCN.
  - ***Each CCO needs to continue to work toward developing a single data source to support integrated care across the entire service delivery network.***

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' performance of delegated activities to ensure regulatory and contractual compliance?

Review Sections

In 2015, Acumentra Health reviewed the CCOs' compliance with federal and state standards related to QA/PI.

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's review tool and scoring plan were adapted from CMS guidelines and approved by OHA. Acumentra Health used each CCO's written documentation, documents submitted to OHA or the Legislature, 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 and other areas in which the CCO did not clearly or comprehensively meet the requirements.

OHA took several steps to prepare the CCOs for the 2015 EQR.

- OHA hosted compliance training for CCOs in June 2015.
- In October 2015, many CCOs attended an OHA-hosted meeting that addressed the intent of each standard in the QA/PI section of the compliance protocol. OHA solicited input from CCOs before revising the protocol.

Acumentra Health's 2015 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 the CCOs that were reviewed earlier in the year.

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
Delivery Network	3.3	Substantially met
Primary Care and Coordination of Services	3.5	Fully met
Coverage and Authorization of Services	3.3	Substantially met
Provider Selection	3.3	Substantially met
Subcontractual Relationships and Delegation	2.8	Substantially met
Practice Guidelines	3.1	Substantially met
QA/PI General Rules and Basic Elements	3.5	Fully met

2014 compliance review follow-up

In addition to reviewing the compliance areas listed above, Acumentra Health followed up with each CCO on findings from the 2014 compliance review, which addressed Enrollee Rights, Grievances, and Certification and Program Integrity.

The follow-up review found that the CCOs had made progress on some of the 2014 findings. As a group, the CCOs had resolved 44 of the individual issues identified in 2014. The CCOs were in the process of resolving 69 findings, but had made no progress on 10 findings.

Details on the status of all findings appeared in the individual CCO reports that Acumentra Health delivered to OHA during 2015.

Section 1: Delivery Network

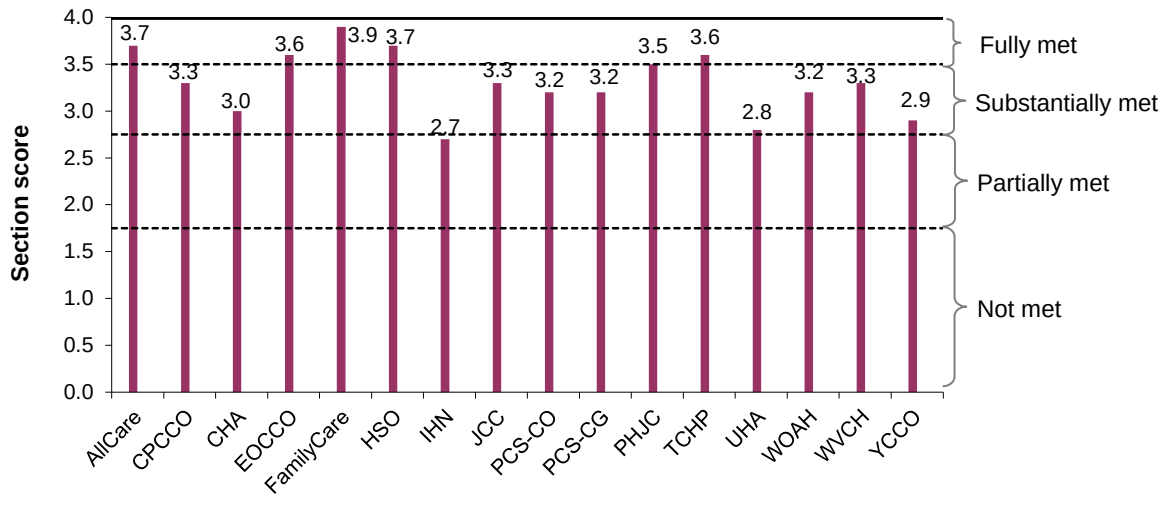
This section of the compliance protocol assesses the degree to which the CCO establishes, maintains, and monitors a network of providers, ensures adequate and timely access to all services covered under contract, and provides for second opinions. In network planning, CCOs need to consider and monitor:

- anticipated enrollment of Medicaid and fully dual-eligible (Medicaid and Medicare) individuals
- an appropriate range of preventive and specialty services for the population enrolled or expected to be enrolled
- expected utilization of services based on the characteristics and health care needs of enrollees
- numbers and types (training, experience, specialization) of providers required to furnish the contracted Medicaid services
- number of network providers who are accepting new Medicaid enrollees
- geographic location of participating providers and enrollees, considering distance, travel time, transportation, and physical access issues

If adequate and timely services are not available within the network, the CCO must obtain services outside the network for as long as the CCO cannot provide them.

As shown in Figure 1, most CCOs fully or substantially met the Delivery Network standards in 2015.

Figure 1. CCO Compliance Scores: Delivery Network.



Major strengths

All CCOs expanded their network capacity when Medicaid enrollment expanded. The CCOs opened new clinics, extended providers' office hours, formed mobile teams, contracted with additional dental and behavioral health providers, used transformation funds to establish detoxification capacity, and provided incentives for primary care providers (PCPs) to locate and stay in rural areas.

CCOs have implemented alternative payment models as incentives for PCP offices to become PCPCHs. All CCOs met the benchmark of 60% of their members being enrolled in PCPCHs.

Some CCOs assess care patterns of providers in out-of-area locations. CCO staff know which specialty services are not available in the network.

The CCOs' care management teams are experienced in arranging medically necessary care from out-of-network providers, if that care is not available within the network. Some CCOs have established long-term relationships with out-of-area specialists who provide medically necessary care to enrollees.

CCOs have implemented a variety of strategies to improve the cultural competency of services for enrollees. All CCOs have provided training for staff and providers to improve member interactions. CCOs have implemented several programs designed to increase enrollee engagement and activation. Some CCOs placed trained bilingual and bicultural CHWs in primary care homes and schools to reduce access barriers for enrollees.

Major areas for improvement

In general, the inadequate number of providers across the state creates access problems for enrollees. Most CCOs struggle to provide timely access to services covered under the contract (including access to specialists, dental care, and out-of-network services). Challenges include recruiting PCPs and specialists to rural areas, as well as monitoring capacity and access to ensure appropriate distribution of services in metropolitan areas.

Provider network issues. Some CCOs are challenged to monitor capacity closely and ensure that an appropriate range and distribution of practitioners is available for their population. Many CCOs lack documentation clearly defining expectations for all delegated activities. A few lack mechanisms to monitor providers' compliance with regulatory and contractual standards.

A few CCOs do not incorporate access to behavioral health and dental care into network planning to determine and maintain adequacy.

Second opinions. Many CCOs lack policies and procedures to ensure that members receiving mental health or dental services have access to second opinions. Many CCOs have not communicated clearly to staff, providers, and enrollees how to facilitate access to second opinions for all services. CCOs often do not know how many in-network second opinions are requested or provided.

Out-of-network services. A few CCOs lack an integrated policy addressing out-of-network services. Some CCOs' enrollee handbooks lack information about how to obtain physical health, mental health, and dental care services out-of-network.

Some CCOs' policies do not specify that out-of-network providers must coordinate with the CCO with respect to payment. CCOs generally do not monitor to ensure that the cost to the enrollee for out-of-network services is no greater than it would be if services were furnished within the network. Among the most frequent enrollee complaints and grievances are those related to billing, as borne out by OHA's Section 1115 Quarterly Report.[8] It is unclear how many billing issues are connected with out-of-network providers' billing practices.

Provision of and timely access to all contracted services. Many CCOs have inadequate processes related to ensuring timely access to routine, urgent, and emergent services and access to specialists. Some CCOs lack methods to ensure that members have access to mental health and dental care in a timely manner.

CCOs reported challenges with respect to access to services for new members in the Medicaid expansion population. A few CCOs lack the ability to assign new members to PCPs, or lack an adequate number of mental health providers.

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. Some CCOs need to develop an integrated policy that is detailed enough to guide staff performing utilization management functions in downstream settings (physical, behavioral, and oral health).

Table 4 lists findings and associated recommendations related to Delivery Network issues.

[8] Oregon Health Authority. Oregon Health Plan Section 1115 Quarterly Report, 1/1/2015–3/31/2015, page 6.

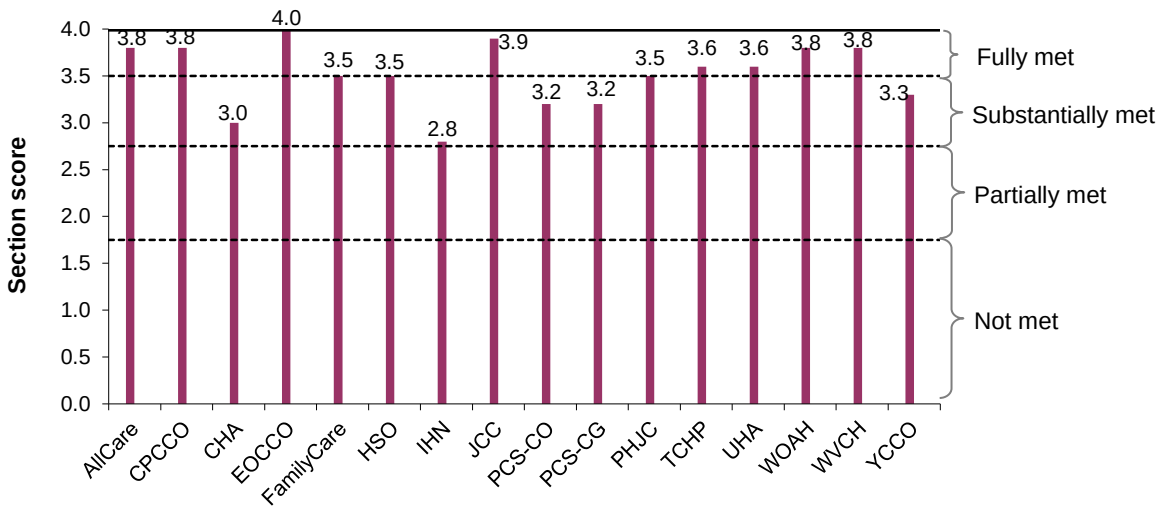
Table 4. Delivery Network: Summary of Findings and Recommendations.	
Findings	**Recommendations**
CCOs lacked a fully integrated policy defining expectations for all delegated activities, including physical, behavioral, and dental health care services.	CCOs need to develop and communicate policies and procedures related to expectations for all delegated activities and specify how the CCO will monitor the process.
CCOs lacked information about whether network capacity for mental health and dental care was adequate, and whether providers are accepting new Medicaid enrollees.	CCOs need to continue efforts to recruit providers to meet the needs of enrollees. CCOs need to incorporate dental capacity into overall network capacity assessment and ensure an appropriate number of practitioners are available to serve OHP enrollees. CCOs need to identify deficits and follow up on corrective action plans to ensure timely access to all contracted care.
The CCOs lacked methods or integrated policies/procedures to ensure that enrollees, staff, and providers understand how to facilitate and obtain second opinions for all contracted services.	CCOs need to ensure that policies and procedures describe to staff and providers how to facilitate and obtain a second opinion (including when warranted for mental health, substance use disorder treatment, and dental care) and ensure communication to enrollees. CCOs need to train their delegates regarding second opinions.
CCOs lacked an integrated policy addressing out-of-network services to guide all providers and delegates. CCOs did not demonstrate analysis of out-of-network encounters to maintain adequate and timely access to all contracted services.	The CCOs need to demonstrate analysis of out-of-network encounters to maintain adequate and timely access to services. CCOs need to monitor the use of all out-of-network providers. CCOs need to monitor all services closely to ensure availability of an appropriate range of practitioners for their population.
CCOs lacked follow-up/monitoring of timely access to all contracted services, including primary care, mental health, substance abuse disorder treatment, dental care, and non-emergent transportation.	CCOs need to closely monitor enrollees' access to all services to ensure that needed appointments are timely and appropriate. CCOs need to ensure routine analysis of CCO-wide access data to identify gaps and barriers to care. At a minimum, data analysis should be included in the delegation evaluation and the annual quality program evaluation.

Section 2: Primary Care and Coordination of Services

This review section evaluates the CCO's policies and procedures regarding delivery of primary care and coordination of health care services for all enrollees, operationalizing the state's definition of "special health care needs," and enabling direct access to specialists for those identified with such needs.

Figure 2 shows that all CCOs fully or substantially met the criteria for this section.

Figure 2. CCO Compliance Scores: Primary Care and Coordination of Services.



Major strengths

All CCOs achieved the benchmark of 60% of enrollees assigned to a PCPCH. Several CCOs established PCPCHs in behavioral health clinics. One CCO developed a maternal medical home at a women's health center.

Some CCOs have invested in population health management programs to identify enrollees with SHCN. CCOs' care management staffs conduct outreach to the identified enrollees.

All CCOs have expanded care management programs to include nurse case managers, behavioral health providers, and CHWs. A few CCOs have adopted an evidence-based Transitional Care Model to better support members and their caregivers in transition from a hospital or facility stay. Other CCOs have mobilized CHWs to conduct outreach to enrollees with complex needs.

The CCOs have negotiated memoranda of understanding with APD and the Area Agencies on Aging to improve coordination of care for enrollees served by the CCO and the agencies. All CCOs participate in multidisciplinary teams with APD, behavioral health providers, and other agencies working with enrollees. Some CCOs include substance use treatment providers in care management meetings. In some cases, these teams establish unified care plans for enrollees with exceptional needs.

A few CCOs are monitoring their delegates to ensure access to specialists for enrollees with SHCN.

Major areas for improvement

Care coordination. Many CCOs lack policies and procedures integrating dental, behavioral health, and physical health. A few CCOs demonstrated poor communication between providers of dental, behavioral, and physical health services (including screening and referral for alcohol, substance misuse, and mental health problems).

Special health care needs. OHA has expanded its definition of enrollees with SHCN beyond the rate categories (aged/blind/disabled, children in foster care, dual-eligibles) for which the former fully capitated health plans received funds to provide case management. The definition now includes people with high health care needs, multiple chronic conditions, substance use disorder, or mental illness who have functional disabilities or who live with a health or social condition that puts them at risk for developing functional disabilities. Some CCOs have not updated their policies and practices to address this broader population.

Many CCOs lack a process to periodically update needs assessments and monitor treatment/care plans for enrollees with SHCN.

Many CCOs lack mechanisms to ensure that mental health and dental providers are complying with care standards. A few CCOs lack policies addressing how they provide direct access to specialists for enrollees with SHCN.

Culturally competent services. Many CCOs do not address cultural/linguistic factors in assessments and care plans of enrollees with SHCN, or do not address cultural issues identified in community health assessments.

Table 5 shows common findings and corresponding recommendations from the 2015 review of compliance with these standards.

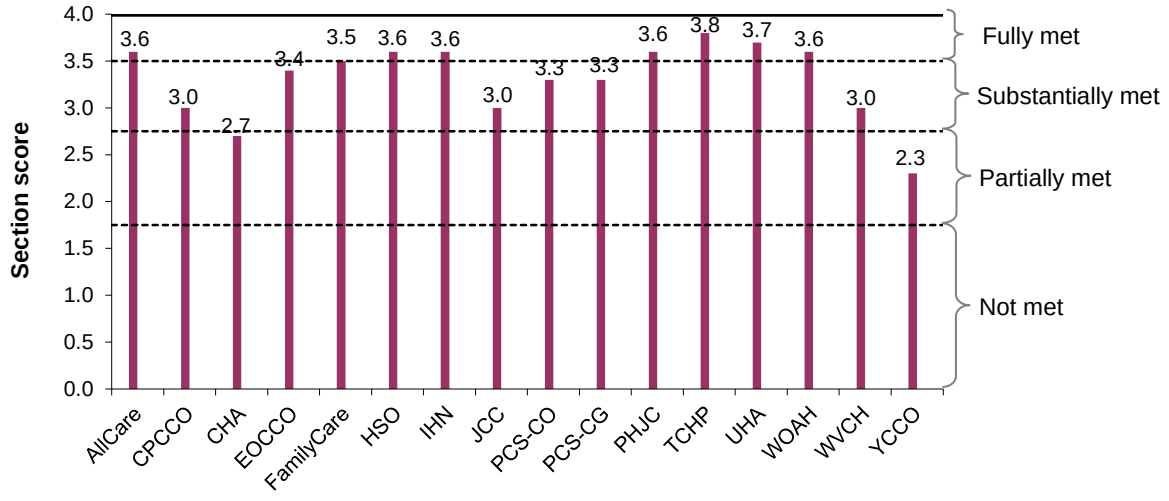
Table 5. Primary Care and Coordination of Services: Summary of Findings and Recommendations.	
Findings	**Recommendations**
CCOs lacked policies and procedures detailing expectations for integrating care coordination among dental care, behavioral health, and physical health providers.	CCOs need to develop integrated policies to inform all providers (including out-of-network providers) about the expectation that care will be coordinated across all services. CCOs need to continue to work to improve communication between physical and mental health practitioners. CCOS need to work with delegates to ensure that care coordination occurs when indicated.
CCOs lacked policies and procedures demonstrating how they provide direct access to specialists for enrollees with SHCN.	CCOs need to develop integrated policies and procedures demonstrating how they provide direct access to specialists for enrollees with SHCN.
CCOs lacked mechanisms to monitor services provided to enrollees with SHCN.	CCOs need to ensure that their definition of SHCN aligns with the state's definition. CCOs need to have formal processes for identifying and assessing enrollees with SHCN. CCOs need to address integration and oversight of services that delegates provide for enrollees with SHCN.
Many CCOs lacked mechanisms to coordinate services/treatment identified in assessments for enrollees with SHCN.	CCOs need to establish mechanisms to ensure that enrollees with SHCN are receiving appropriate coordinated care. CCOs need to establish mechanisms to monitor care plans of enrollees with SHCN, ensure periodic updates of needs assessments, and monitor all agencies involved in care. CCOs need to incorporate cultural and linguistic needs into assessments of enrollees with SHCN. CCOs need to expand cultural/linguistic policies and procedures to specify expectations of staff and delegates. CCOs need to ensure that PCPs develop care plans with enrollee and family involvement.

Section 3: Coverage and Authorization of Services

This section of the review protocol assesses whether the CCO has systems in place to ensure consistent application of review criteria for authorization decisions; ensure that denials or reductions of authorization requests are made by a health care professional with appropriate experience in treating the enrollee's condition; send appropriate notice for adverse actions; comply with required time frames for standard and expedited decisions; ensure that no incentives are in place to deny, limit, or discontinue medically necessary services; and ensure that the CCO covers and pays for emergency and post-stabilization services.

Figure 3 shows that most CCOs fully or substantially met the criteria for these standards.

Figure 3. CCO Compliance Scores: Coverage and Authorization of Services.



Major strengths

Many CCOs perform routine inter-rater reviews of internal authorization processes to ensure consistent application of review criteria. All physical health service denials are reviewed by medical staff.

The CCOs' utilization management committees actively review use of emergency services. Most CCOs have been able to reduce avoidable emergency department (ED) utilization.

Most CCOs have implemented incentive payments for physical health providers to improve the quality measures for reducing all-cause readmissions and avoidable ED utilization, and increasing outpatient utilization. A few CCO have established ED diversion projects, including assigning CHWs to help enrollees who are considered high utilizers of emergency services to find a PCP and obtain specialty or behavioral health care.

Major areas for improvement

Many CCOs demonstrate little oversight of delegates with respect to service authorization. Many lack integrated policies and procedures to monitor dental care plans with respect to coverage and authorizations.

Authorization process. Many CCOs lack a mechanism to ensure consistent application of review criteria when making authorization decisions and to ensure that providers are notified of adverse actions. Many CCOs lack an effective mechanism to ensure that all delegates have processes in place to perform service authorizations.

Some CCOs lack documentation demonstrating that service authorization denial decisions were made by a health care professional with appropriate clinical expertise in treating the enrollee's condition or disease.

Time frames for decisions. Many CCOs lack a process to monitor the timeliness of routine and expedited authorization decisions. Some CCOs send notices of expedited decisions to members via surface mail, which may be received outside of the required time frame.

Compensation for utilization management activities. A few CCOs lack policies and procedures to ensure that those performing utilization management activities do not receive incentives to deny, limit, or discontinue medically necessary services to enrollees.

Emergency and post-stabilization services. Some CCOs lack policies and procedures in this area. Some CCOs demonstrate a high number of crisis events involving a few individuals or inappropriate or avoidable ED use, possibly related to inadequate availability of outpatient or routine care.

In general, CCOs need to closely monitor the delegation of service authorizations, including the notice of action process. Initially, some delegated processes may require closer monitoring to ensure that delegates are comfortable with the complexities of performing service authorization activities.

Table 6 shows the most common findings and associated recommendations for this compliance section.

Table 6. Coverage and Authorization of Services: Summary of Findings and Recommendations.

Findings	Recommendations
CCOs need to monitor delegates with respect to fully integrated policies for service authorization.	CCOs need to have a fully integrated authorization process encompassing physical, behavioral, and dental health.
Many CCOs lacked effective mechanisms to ensure that all delegates have processes in place to perform service authorizations.	CCOs need to have effective mechanisms to ensure that all delegates have processes in place to perform service authorizations.
Many CCOs lacked mechanisms to ensure consistent application of review criteria when making authorization decisions and to ensure that providers are notified of adverse actions.	CCOs need to follow through with delegation oversight and ensure that all delegates have policies/procedures and training for consistent application of review criteria. CCOs need to perform inter-rater reliability reviews or use other mechanisms to ensure consistent application of review criteria. CCOs need to ensure that authorization decisions are made by a health care professional with appropriate clinical expertise in treating the enrollee's condition. CCOs need to ensure that notices of action are sent on CCO letterhead in a format that meets OHA requirements, and instruct the recipient to appeal directly to the CCO. CCOs need to ensure that providers are notified of adverse actions, and that internal CCO processes verify that the provider has been notified. CCO notices of action need to use language that is understandable to enrollees.
Many CCOs lacked a process to monitor the timeliness of routine and expedited authorization decisions.	CCOs need to develop mechanisms to monitor timeliness of routine and expedited authorization decisions (both internally and with delegates). CCOs need to ensure that oral notice of expedited decisions is relayed to members.

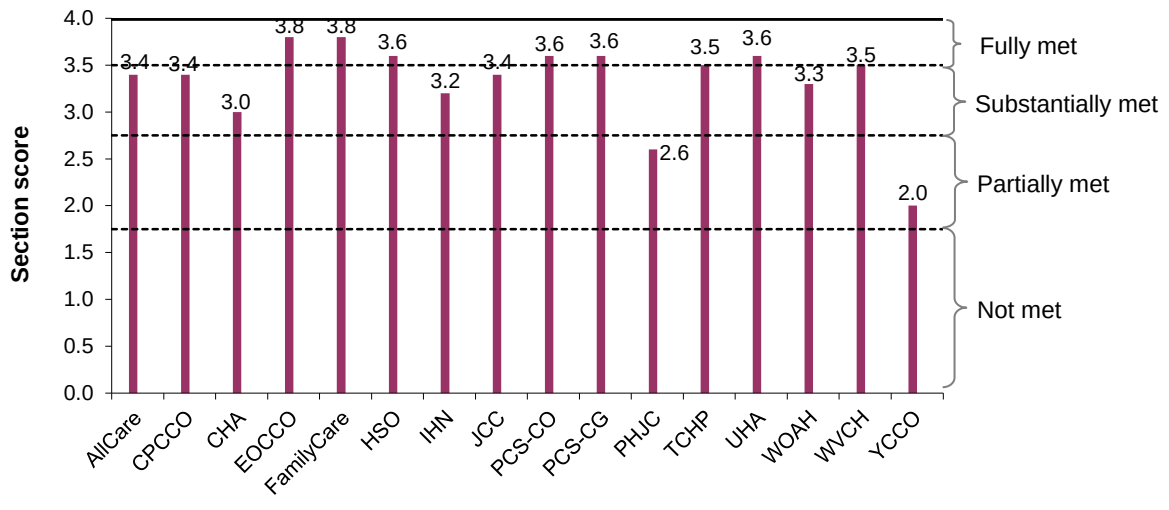
Table 6. Coverage and Authorization of Services: Summary of Findings and Recommendations (cont.).	
Findings	**Recommendations**
A few CCOs lacked policies and procedures to ensure that those performing utilization management activities do not receive incentives to deny, limit, or discontinue medically necessary services to enrollees.	CCOs need to develop policies and procedures to ensure that individuals or entities who conduct utilization management activities are not provided incentives to deny, limit, or discontinue medically necessary services to enrollees.
Some CCOs lacked policies and procedures pertaining to emergency and post-stabilization services.	CCOs need to develop an integrated policy on emergency and post-stabilization services that define physical health, behavioral health, and dental emergencies; specify that no preauthorization is required; describe how these services are monitored; and specify time frames for emergent and urgent response. CCOs need to establish mechanisms to monitor use of emergency and crisis services by enrollees in mental health and substance use disorder treatment.

Section 4: Provider Selection

This section of the compliance protocol assesses the degree to which the CCO implements policies and procedures for selection and retention of providers, and follows a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the CCO, including any delegated processes. Provider selection must not discriminate against particular practitioners who serve high-risk populations or who specialize in conditions that require costly treatment. CCOs must not employ or contract with providers excluded from participating in federal health care programs.

As shown in Figure 4, most CCOs fully or substantially met the Provider Selection standards.

Figure 4. CCO Compliance Scores: Provider Selection.



Major strengths

All CCOs have rigorous credentialing and recredentialing processes for physical health practitioners. Most CCOs assess the quality, safety, and accessibility of practitioner offices and facilities during initial credentialing through site visits.

The CCOs' credentialing committees review medical provider credentialing and recredentialing applications. Most CCOs monitor complaints and conduct site visits of medical offices when a threshold of complaints has been met. A few

CCOs participate in a consortium that uses a shared physical health credentialing audit process and common audit tool.

A few CCOs are performing credentialing and recredentialing of licensed mental health practitioners.

Major areas for improvement

Credentialing and recredentialing. Most CCOs lack integrated policies and procedures that adequately address credentialing and recredentialing expectations of delegates, including monitoring mechanisms and credentialing requirements for various health care professionals and allied health professionals, such as mental health professionals, dental hygienists, peer support specialists, traditional health care workers, CHWs, and NEMT providers. Issues range from needing to establish a credentialing committee to developing more comprehensive screening processes.

Many CCOs address credentialing of licensed or certified professionals but do not address other types of employees and/or paraprofessionals.

Nondiscrimination. A few CCOs lack policies to ensure a nondiscriminatory process when selecting provides, such as when the provider specializes in serving high-cost, high-risk populations.

Monitoring for excluded providers. A few CCOs do not monitor their staff and governing boards for exclusion from participation in federal health care programs. Many CCOs lack processes to monitor their delegates to ensure monthly screening of providers and downstream entities.

Table 7 reports common findings and corresponding recommendations from the 2015 review of compliance with Provider Selection.

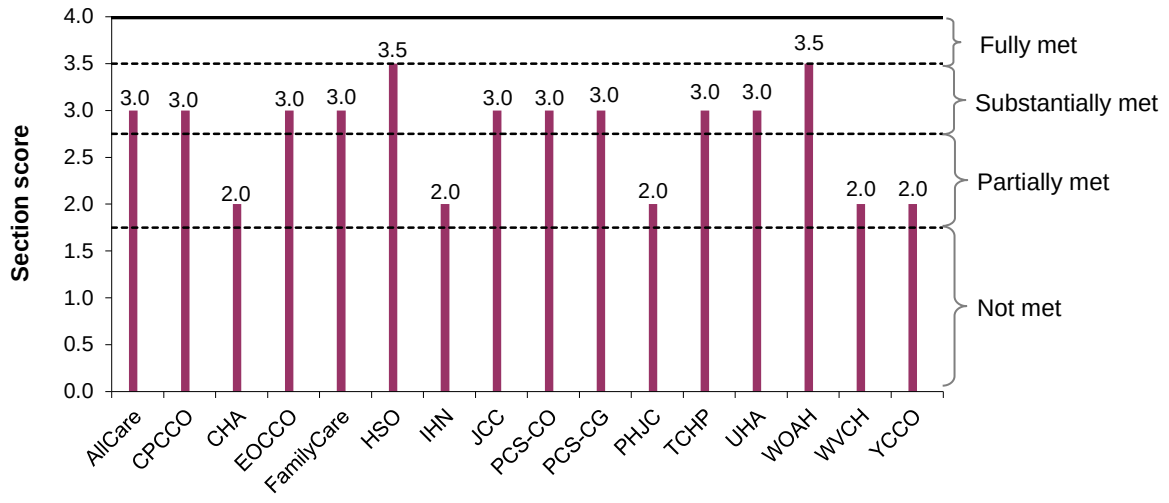
Table 7. Provider Selection: Summary of Findings and Recommendations.	
Findings	**Recommendations**
Most CCOs lacked integrated policies and procedures that adequately address the credentialing and recredentialing expectations of delegates.	CCOs need to develop integrated policies and procedures addressing credentialing and recredentialing. These policies need to address expectations to guide delegates, and include: • a mechanism to monitor the credentialing/ recredentialing process • credentialing requirements for various health care professionals and allied health professionals, including mental health professionals, dental hygienists. CHWs, and NEMT providers
A few CCOs lacked a policy to ensure a nondiscriminatory process when selecting providers, such as when the provider specializes in serving high-cost, high risk populations.	Policies and procedures need to cover all services, describe a nondiscriminatory process for selecting providers, and specify that providers are notified in writing when they are not chosen.
Many CCOs lacked processes to monitor delegates to ensure monthly screening of providers and downstream entities. Many CCOs did not monitor their staff and governing boards for exclusion from participation in federal health care programs.	CCOs need to ensure that contracted entities have processes in place to perform monthly screening for excluded providers within each office/clinic. CCOs need to conduct oversight monitoring at least on an annual basis.

Section 5: Subcontractual Relationships and Delegation

This review section evaluates the CCO's practices regarding formal monitoring of any functions and responsibilities that it delegates to any subcontractor. The CCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated, and must have a written agreement that specifies the activities and reporting responsibilities and outlines revocation or sanctions if performance is inadequate. If a CCO identifies deficiencies or areas for improvement, the CCO must work with the subcontractor on a corrective action plan.

Figure 5 shows that 11 of the 16 CCOs fully or substantially met the requirements for Subcontractual Relationships and Delegation.

Figure 5. CCO Compliance Scores: Subcontractual Relationships and Delegation.



Major strengths

Several CCOs conduct pre-delegation assessments of NEMT providers. These CCOs provide technical assistance to ensure that NEMT providers can meet contractual requirements. A few CCOs conduct pre-delegation assessments of their dental plans.

Several CCOs are working diligently to facilitate the transition of a mental health provider from a county-run facility to a private nonprofit agency.

Strategies for oversight of delegated functions and entities vary among the CCOs. A few CCOs track delegates' performance through oversight committees. Other

CCOs' compliance departments are responsible for delegation oversight. A few CCOs conduct annual evaluations of delegates and require corrective action as needed. One CCO has completed three annual evaluations of all delegates. A few CCOs are monitoring their delegates to track progress on the work plans.

Major areas for improvement

Some CCOs have draft policies and procedures pertaining to monitoring and oversight of delegates but have not yet implemented them.

In general, CCO delegates subdelegate some or all of the delegated activities to other downstream entities. In some situations, contracts between the CCO and delegates fail to specify performance and reporting expectations, revocation or sanctions for inadequate performance, CCO monitoring of the delegate's performance, and action the CCO would take when deficiencies are identified.

Many CCOs delegate functions without a mechanism to monitor the delegate's performance. In a few cases, the CCO has required corrective action but has not followed up to ensure that the issue has been addressed. Many CCOs have not performed annual evaluations of all delegates.

Table 8 on the following page reports common findings and corresponding recommendations from the 2015 review of Subcontractual Relationships and Delegation compliance.

Table 8. Subcontractual Relationships and Delegation: Summary of Findings and Recommendations.

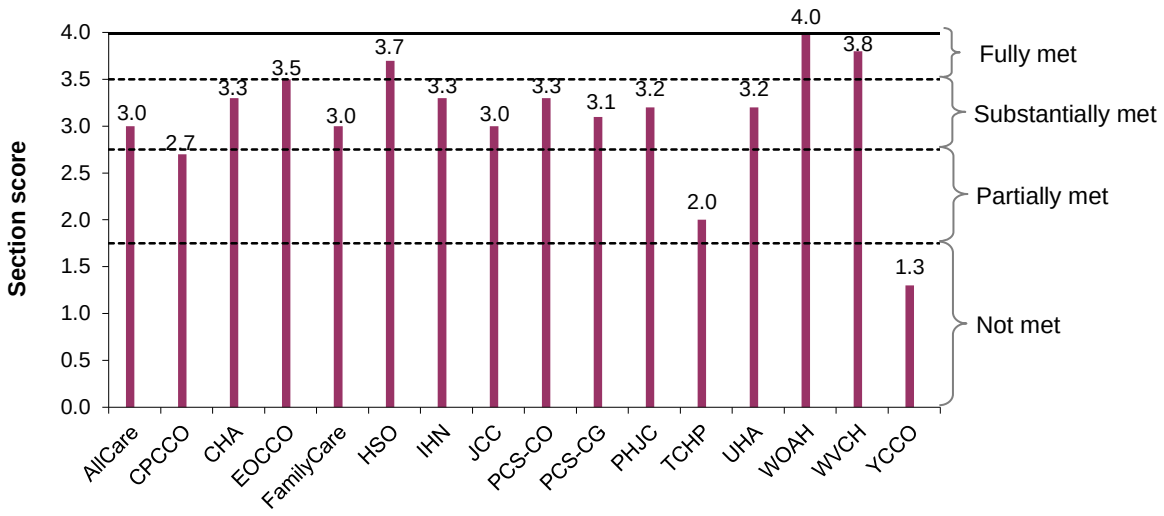
Findings	Recommendations
CCOs lacked policies and procedures pertaining to delegation monitoring and oversight.	CCOs need to finalize and implement their delegation policies and procedures. Policies need to fully describe: • specific activities delegated • reporting requirements and performance expectations • provisions governing nonperformance and corrective action • which body oversees the delegated activities and who has ultimate authority to sever a contractual relationship CCOs need to ensure that their delegates perform appropriate oversight/evaluation of subcontracted activities.
CCOs lacked a contract or delegation agreement containing required elements.	CCOs need to specify these aspects of delegated activities in writing: • reporting and performance requirements • revocation and sanctions for poor performance • performance monitoring at least annually • corrective action for poor performance
CCOs had inadequate processes for monitoring all delegates, including performing an annual evaluation of delegates' performance.	CCOs need to ensure that delegated activities are monitored and that the delegates monitor activities performed by downstream entities. CCOs need to perform an evaluation of each delegate at least annually. The evaluation should address the performance of each delegated activity, include a compilation of the year-long monitoring and a summary of audit results for each delegated activity.

Section 6: Practice Guidelines

This section of the review protocol assesses whether the CCO adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; reflect the needs of CCO enrollees; are adopted in consultation with the contracting health care professionals; and are updated periodically, as appropriate. CCOs must disseminate practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. CCOs need to demonstrate that decisions for utilization management, enrollee education, and coverage of services are consistent with the guidelines.

Figure 6 shows that most CCOs fully or substantially met these standards.

Figure 6. CCO Compliance Scores: Practice Guidelines.



Major strengths

All CCOs base physical health utilization management decisions on practice guidelines such as those of the Health Evidence Review Commission, American Diabetes Association, American Academy of Pediatrics, National Heart, Lung and Blood Institute, and Milliman Care Guidelines, to name a few. Some CCOs have developed practice guidelines for prescribing opiates and hepatitis C drugs.

The CCOs' Clinical Advisory Panels participate in identifying and adopting practice guidelines. One CCO has formed subcommittees to identify and adopt practice guidelines for behavioral health and dental care.

Major areas for improvement

Some CCOs lack documentation supporting how practice guidelines are adopted by delegates. Some CCOs lack a policy or consistent procedure for dissemination of clinical guidelines for all practice areas. Websites may provide access to one or two medical or mental health guidelines, but not dental practice guidelines.

A few CCOs lack monitoring mechanisms to ensure that internal decisions on utilization management are consistent with CCO guidelines. Most CCOs lack a mechanism to ensure consistency of authorization decisions made by delegates.

Two CCOs have detailed reports that identify disparities and disease burden for some subpopulations of enrollees. However, the CCOs do not use these reports to inform the selection or prioritization process for practice guidelines.

Table 9 shows the most common findings and recommendations related to Practice Guidelines.

Table 9. Practice Guidelines: Summary of Findings and Recommendations.

Findings	Recommendations
Some CCOs lacked documentation supporting the adoption and use of clinical practice guidelines.	CCOs need to ensure that delegates adopt and use practice guidelines in accordance with CCO policies. CCOs need to ensure that the guidelines used by delegates: • are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field • consider the needs of enrollees • are adopted in consultation with the contracting health care professionals • are reviewed and updated periodically, as appropriate
Some CCOs lacked a policy that addressed dissemination of practice guidelines for physical health, mental health, substance use disorder treatment, and dental care.	CCOs need to ensure that practice guidelines are disseminated to providers across the CCO for physical health, mental health, substance use disorder treatment, and dental care. CCOs need to ensure that practice guidelines are available to members.
A few CCOs lacked a process to ensure that utilization decisions are consistent with guidelines, including decisions made by delegates.	CCOs need to ensure that utilization decisions by CCO staff and delegates are consistent with adopted guidelines and aligned with community practice.

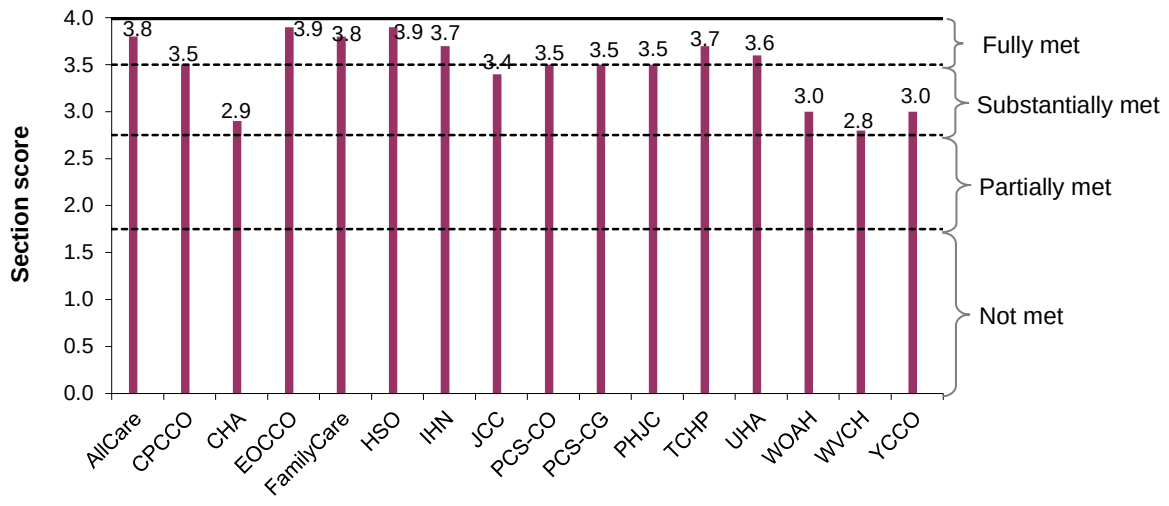
Section 7: QA/PI General Rules and Basic Elements

This section of the review protocol assesses whether the CCO has an ongoing QA/PI program that includes:

- conducting PIPs on clinical and nonclinical topics to achieve improvement in quality
- reporting specified performance measures to the state
- mechanisms to detect both under- and overutilization of services
- mechanisms to assess the quality and appropriateness of care furnished to enrollees with SHCN
- maintaining a health information system that can collect, analyze, integrate, and report data

Figure 7 shows that all CCOs fully or substantially met the criteria for this section.

Figure 7. CCO Compliance Scores: QA/PI General Rules and Basic Elements.



Major strengths

The CCOs have aligned their QA/PI plans with their transformation plans. The CCOs' annual evaluations address performance on quality metrics, progress on PIPs and focus areas, and grievances. A few CCOs' quality work plans include objectives to reduce health care disparities.

In most cases, the CCOs have expanded the membership of their quality improvement committees (QICs) to include behavioral health providers and specialists. A few CCOs' committees include pharmacy and dental care representatives. One CCO has an Interagency Quality and Accountability Committee that provides a platform for collaboration and coordination between the CCO and its delegates and community partners. One CCO's QIC includes analysts who produce comprehensive management reports.

All CCOs have mechanisms to identify and intervene with high service utilizers. Some CCOs use the EDIE system to track ED use and follow up with enrollees after ED visits. One CCO demonstrated a 27.5% decrease in health care expenditures for high utilizers assigned to a CHW.

Most CCOs have invested in risk and population care management programs. The CCOs use predictive risk management software to produce a probability rating for individual enrollees related to inpatient admissions, ED visits, and potential adverse incidents. In most cases, PCPs receive this information about the enrollees assigned to their practice.

A few CCOs have integrated physical and behavioral data into data warehouses from which reports can be generated. One CCO's data warehouse includes pharmacy data. One CCO provides risk model performance reports to hospitals considered essential to the CCO's ability to meet quality incentive goals.

Major areas for improvement

CCOs generally need to expand their QA/PI programs to cover mental health and dental services as well as physical health. The programs should guide downstream entities regarding the program's mission, objectives, and priorities; integrate all services; define the scope of QI activities; and specify the oversight body.

- Some QA/PI programs lack integration of all services and description of the results from monitoring activities, such as delegation, utilization, access, and care coordination/case management efforts, including for enrollees with SHCN.
- Some QA/PI plans are not reviewed or approved by CCO governance. CCOs submitted no documentation to demonstrate how their governing boards were involved with the overall quality work plan.
- A few CCOs did not make available documentation to fully describe how they monitor under- and overutilization of services.

In general, the CCOs have programs designed to assess the needs of enrollees with SHCN. However, the CCOs lack mechanisms to track the quality and

appropriateness of these programs. Little information is available regarding the quantity of services delivered and effectiveness of these programs. As these programs mature, the CCOs and their delegates need to evaluate the quality and appropriateness of care furnished to members with SHCN.

Many CCOs need to work toward development of a single, fully integrated source of data on physical and mental health, addictions, vision, pharmacy, and dental services to enable aggregated reporting. CCOs and their delegates need to ensure that processes are in place to ensure accuracy and timeliness of encounter data, including encounter data validation.

Table 10 shows the most common findings and recommendations related to this compliance section.

Table 10. Quality Assessment and Performance Improvement: Summary of Findings and Recommendations.

Findings	Recommendations
CCOs did not demonstrate oversight of their quality management programs (including delegated activities) by the CCO's governing structure.	CCOs need to ensure that their governing boards perform oversight of the quality management program. The CCO governing board needs to review and approve the annual QA/PI evaluation.
CCOs did not incorporate dental services into analysis of utilization.	CCOs need to incorporate all services into analysis of utilization.
CCOs' quality committees did not include dental care plan representatives.	CCOs' quality committees need to ensure input from all stakeholders.
CCOs lacked integrated policies and procedures specifying how the CCO monitors delegates in order to detect under- and overutilization.	CCOs need to develop policies and procedures that specify mechanisms to detect, track, and address under- and overutilization of all services.

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 from CMS, OHA's Metrics and Scoring Committee developed 17 CCO Incentive Measures effective in 2013 and 2014. OHA used those metrics to evaluate Oregon's performance on health care quality and access, and to hold CCOs accountable for improved outcomes. In 2015, OHA retired some measures and added others. This review covers only the measures in effect in 2014.

CCOs receive funds from a quality pool based on their annual performance on these 17 measures and whether they meet state or national benchmarks and 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.

- Adolescent well-care visits
- Alcohol or other substance misuse (SBIRT)
- Ambulatory care: Outpatient and emergency department utilization
- CAHPS composite: Access to care
- CAHPS composite: Satisfaction with care
- Colorectal cancer screening
- Controlling high blood pressure
- Depression screening and follow-up plan
- Developmental screening in the first 36 months of life
- Early elective delivery
- Diabetes: HbA1c poor control
- Electronic health record (EHR) adoption
- Follow-up after hospitalization for mental illness
- Follow-up for children prescribed ADHD medication
- Health assessments within 60 days for children in DHS custody
- PCPCH enrollment
- Timeliness of prenatal care

Validation Results

Six of the 17 measures are calculated using *only* encounter data that OHA collects and maintains. Per OHA's instruction, Acumentra Health validated only those 6 measures. The remaining 11 measures are calculated with clinical data collected through record review or EHR extraction, with non-encounter data from other systems, or with data from the CAHPS survey, administered by a contractor. Some measures combine encounter data with one or more of these alternate data sources.

Acumentra Health did not validate the 33 State Performance "Test" Measures, for which OHA is accountable to CMS. The Test Measures overlap with 14 of the 17 Incentive Measures, but include 19 additional measures.

OHA improved the validation process considerably in 2014 by engaging more partners in the validation process. First, OHA sends complete encounter data files to the Providence Center for Outcomes Research and Education (CORE). Refresh data are sent monthly. CORE writes its own metric code, calculates the metrics using the data from OHA, and sends the results back to OHA. OHA then validates the results by calculating the metrics using its own code and the same data as sent to CORE. CORE and OHA use frequent email communication and weekly meetings to discuss agreement and discrepancies between results, and to troubleshoot any variation. This process continues until OHA is satisfied that the results are comparable, and OHA approves the CORE code.

Once approved, CORE publishes CCO-specific results to a dashboard. CCOs then are invited to validate their results by downloading the member-level data from the dashboard, which includes flags for members in the numerator and denominator of each measure. Many CCOs run their own measure code in-house and compare results, identifying discrepancies and working with OHA to resolve them. While CCO validation is not required until the calendar year-end report, OHA encourages CCOs to perform interim data quality checks.

Simultaneously, the Oregon Health Care Quality Corporation (Q Corp) validates the metric code and results as well. Q Corp reviews the OHA programming code and works with OHA to resolve errors. Then Q Corp, through its contractor Milliman, conducts a parallel calculation of the measures using the OHA code and a multi-payer claims dataset that includes Medicaid data. These results provide a point of comparison for the metrics produced by OHA and CORE.

For the 6 measures reviewed, the code review and measure calculation process was adequate and represented an improvement over previous years. However, Acumentra Health assigned a "Partially met" compliance rating to all 6 measures because of concerns about the validity of the underlying data.

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. OHA recognizes the importance of complete and valid data, and in December 2015 contracted with Acumentra Health to provide training for CCOs on how to conduct encounter data validation.

It is unclear how OHA ensures that it has received all encounters before calculating the measures. CCOs may be reluctant to submit late encounters due to concerns about financial withholds. However, OHA reports that there are many excusable reasons for submitting late encounters that would exempt the CCOs from financial penalty. OHA encourages CCOs to submit encounter data no matter how old the data may be. Regardless, OHA and the CCOs lack processes to account for missing encounters. This creates a risk of calculating performance measures on the basis of incomplete data (in addition to lower capitation payments to the CCO).

The new CCO validation process is commendable, and appears to be effective in increasing the validity of the metrics as new members are discovered and added to the numerators and denominators. However, the QI processes implemented to identify these members should encompass the entire system, ensuring that all data are complete and valid, not just those data that inform the incentive measures. An all-encompassing QI initiative would also decrease the burden on CCOs to validate member-level data for each performance measure.

Table 11 shows the validation ratings for each of the six performance measures reviewed in 2015.

Table 11. Performance Measure Validation Ratings, 2015.		
Measure	**Status**	**Compliance Rating**
Alcohol or other substance misuse (SBIRT)	Complete validation by OHA	Partially met
Follow-up after hospitalization for mental illness	Complete validation by OHA	Partially met
Follow-up care for children prescribed ADHD medications	Complete validation by OHA	Partially met
Ambulatory care: Outpatient and emergency department utilization	Complete validation by OHA of ED utilization, no validation of OP	Partially met
Developmental screening in the first 36 months of life	Complete validation by OHA	Partially met
Adolescent well-care visits	Complete validation by OHA	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, and the data flow with external partners, is documented and understood
- OHA communication with CCOs and provider agencies is documented and consistent
- current relationships with external partners are documented, as are any future changes in associations, roles, or responsibilities

OHA should encourage CCOs to implement an encounter data validation process to ensure that data are complete and valid before submission to OHA.

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."

Although CCOs may subcontract certain 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. CCOs may not delegate certification of claims and encounter data (see Exhibit B–Part 4, 11.d.; Exhibit B–Part 8, 7.c.,d.(1)(2); and Exhibit B–Part 8, 7.e.).

In 2014, Acumentra Health conducted a full ISCA review of both OHA's data management and reporting systems and those of the individual CCOs. In 2015, Acumentra Health followed up with OHA and the CCOs on the status of the 2014 recommendations through interviews with key staff and review of additional documentation Results of the follow-up reviews are summarized below.

State-level ISCA follow-up summary

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:

- 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 (data encryption and media destruction/disposal practices)
- regular review and updating of policies, procedures, and business continuity/disaster recovery plans

See Appendix C for additional details.

CCO-level ISCA follow-up summary

Following the full ISCA reviews in 2014, OHA began incorporating ISCA issues into the CCOs' individual work plans. Throughout 2015, Acumentra Health followed up with the CCOs to review their progress in addressing the 2014 issues and recommendations, which are reproduced in Table 12. The CCO profiles in Appendix A summarize the status of each CCO's response. High-level results are summarized below.

Overall, the CCOs had begun to address most issues identified in the 2014 review but were still in planning and implementation stages. Many CCOs stated that some of the issues will require more comprehensive changes that will take more time to implement, though some CCOs expected to have completed some items in time for the next full ISCA in 2016.

CCO training. Many CCOs are still struggling with certain issues for which they need additional guidance—most notably, encounter data validation and IT monitoring and oversight of risk-accepting entities, providers, and other partner organizations. In response, OHA directed Acumentra Health to conduct training on Strengthening CCO IT Practices in December 2015. Many CCOs reported that the training gave them a better idea of how to incorporate the recommended practices into their CCO activities. OHA and Acumentra Health are exploring options for

additional training in 2016, such as on developing Business Continuity/Disaster Recovery plans.

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 procedures. Most CCOs' physical, mental, and dental health services remain segregated. For example, encounter data for most dental services are processed by the dental plan or by a third-party administrator. As a result, reporting on integrated care is difficult.

OHA needs to:

- work with CCOs to expedite the integration of IT activities, communication, policies, and procedures across all CCO services
- encourage 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 certification processes 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 establish 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 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
- work with the CCOs to implement appropriate strategies for upgrading and replacing critical hardware, and for enforcing similar practices for partner organizations

Provider directories. Overall, the CCOs are struggling to develop integrated and accessible directories with 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 present 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 numbers are used for billing

Table 12. CCO-Level ISCA: Major Areas for Improvement Identified in 2014.

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, instead of at the individual provider level. In January 2016, OHA issued guidance on behavioral health NPIs, which will be incorporated into the 2016 ISCA reviews.

- 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 designed to improve care in at least four of the seven QI focus 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 conducted as a statewide collaborative project addressing the integration of primary care and behavioral health. The Statewide PIP is conducted in accordance with the 2012 CMS PIP protocol.

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.

In addition to the Statewide PIP, CCOs are required to select two additional PIPs and one focus project from the above list of seven focus areas.

Table 13 presents the federal standards for PIP validation.

Table 13. 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

Statewide PIP: Diabetes Monitoring and the SPMI Population

The first Statewide PIP monitored two elements of comprehensive diabetes care (HbA1c and LDL-C testing) for OHP members diagnosed with diabetes and with serious and persistent mental illness (SPMI), either schizophrenia or bipolar disorder. All CCOs participated in the Statewide PIP, which was initiated in 2013 and completed at the end of the second remeasurement on June 30, 2015.

OHA provided each CCO with quarterly reports that included 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 collected, calculated, and reported aggregated statewide study indicator data for the study measurement periods.

Appendix B presents the full report of the first Statewide PIP.

Technical assistance

From the inception of the Statewide PIP, Acumentra Health has provided support and technical assistance to the CCOs through presentations at monthly QHOC meetings and through individual technical assistance meetings and calls.

QHOC meeting topics have included rapid-cycle improvement using Plan-Do-Study-Act methodology, monitoring improvement by using run charts, building an effective project team, diabetes management of the SPMI population, how to address the Standard 8 criteria in quarterly report documentation, and understanding Standard 8 criteria scoring.

Since September 2013, Acumentra Health has held technical assistance meetings for individual CCOs quarterly or by request. Acumentra Health has met with representatives from all CCOs at least once, and most CCOs took part in several meetings. Feedback solicited at these meetings indicated that CCOs found the technical assistance very helpful.

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 validation criteria (see Appendix B, Attachment H). Acumentra Health offered ongoing assistance throughout the first remeasurement (July 1, 2013–June 30, 2014) and second remeasurement (July 1, 2014–June 30, 2015) periods.

Following each remeasurement period, Acumentra Health scored each CCO's quarterly report submissions. Each CCO received a score (on a 100-point scale) for the degree of completeness of each Standard 8 criterion, and an overall score for documenting their work. CCOs had the option of either accepting their initial scores or resubmitting their Standard 8 documentation for rescoring. Standard 8 scores for each CCO appear in the CCO profiles in Appendix A.

First remeasurement period. Fourteen of the 16 CCOs asked to be rescored on their July 2014 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. The CCOs' average total score on Standard 8 was 90.7 points out of 100 possible points, with scores ranging from 70 to 100. 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, HSO, and PHJC) fully met all of the Standard 8 criteria and received an overall score of 100.

Second remeasurement period. For their July 2015 reports, CCOs were asked to summarize the progress of their intervention strategies, report the results of tracking and monitoring, and describe how they would incorporate the PIP interventions into routine monitoring of the needs of people with diabetes and co-occurring schizophrenia or bipolar disorder. Only two of the CCOs resubmitted their Standard 8 documentation for rescoring. The CCOs' average total score on

Standard 8 was 94.6 out of 100, compared to an average of 90.7 for the first remeasurement period. Individual CCO scores generally improved as a result of better report documentation. As with first remeasurement reports, monitoring and tracking of the study indicator and of the effective implementation of interventions remained the area most in need of improvement.

Three CCOs (EOCCO, PCS-CO, and PHJC) fully met all of the Standard 8 criteria and received an overall score of 100.

Following is a brief review of high-level themes drawn from the July 2015 CCO quarterly reports. Details of individual CCO interventions, barriers, and next steps can be found in Appendix B, Attachment K.

Root cause analysis. The main barriers/factors identified in root cause analyses of the gaps in CCO 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 enrollees with SPMI who also have chronic illnesses

Interventions. Compared to the first remeasurement period, more CCOs in the second remeasurement period had implemented interventions focusing on integration or co-location of services. All CCOs reported implementing at least one (often several) interventions that used intermediaries (community health workers, peer support specialists, case managers, and care coordinators) to increase member engagement, facilitate communication between providers, and ensure proper chart documentation. Interventions that focused on providing transportation assistance to members were generally found to be very successful. Several CCOs reported that they did not develop interventions specifically to target members in the study, but instead focused their efforts on a broader organizational strategy for chronic disease management or metabolic syndrome. Individual CCO plans for the future involved a combination of adopting, adapting, and abandoning their existing PIP interventions.

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 integration processes and procedures also presented significant barriers to intervention implementation.

Statewide PIP results

Table 14 shows the aggregated Statewide PIP results.

Table 14. Aggregated Results of Statewide PIP.

Study indicator*	Baseline** July 1, 2011–June 30, 2012	First remeasurement July 1, 2013–June 30, 2014	Second remeasurement July 1, 2014–June 30, 2015
Numerator	1,407	1,090	1,330
Denominator	2,137	1,637	2,088
Calculated indicator	65.8%	66.6%	63.7%

*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.

**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 identify statistically significant differences 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 each remeasurement. The results showed no statistically significant differences between baseline and first remeasurement, first and second remeasurement, or baseline and second remeasurement.

The decrease in the OHA-calculated study indicator in the second remeasurement period is not consistent with results reported in the CCOs' July 2015 reports. More than half of the CCOs calculated the study indicator using internal data, and all of those CCOs reported study indicator results significantly higher than the results based on state data. Several factors may account for this discrepancy.

1. Most CCOs did not submit PIP data revisions to OHA at the end of the second remeasurement period, even though they may have included those revisions in their own calculations.
2. CCOs may have calculated their data in a manner not consistent with the PIP study metric criteria. For example, one CCO excluded a member from the denominator who was on metformin (a diabetes criterion), but chart review did not reveal an inclusion diagnosis of diabetes or an exclusion diagnosis (e.g., polycystic ovaries). While the CCO believed that exclusion of the

member was appropriate (no history of "real" diabetes), the member still met the PIP criteria and would have been included in the OHA calculations.

3. Many CCOs still lack a process to capture Medicaid claims for the dual-eligible population.

Several CCOs supported their assertion of an improvement in the study indicator by citing improvement in other performance measures that require coordination between physical health and mental health.

Generalizing of the aggregated statewide study indicator results to individual CCOs is confounded by differences among CCOs in terms of study population, level of physical and behavioral health system integration at baseline, and intervention effectiveness.

In terms of clinical improvements and lessons learned as a result of this PIP, CCOs made the following observations.

- Improving communication between physical and mental health providers is key to integration efforts.
- Diabetes testing in the SPMI population is too narrow a focus for a stand-alone project. Instead, it would be more valuable to incorporate this project into broader organizational strategies for chronic disease management or into a continuum of diabetes services (prevention, monitoring, and control) for the SPMI population.
- Intermediaries (care coordinators, RN case managers, medical assistants, care teams, CHWs, etc.) serve an important function by facilitating care coordination for members and helping to ensure accurate and consistent chart documentation.

Recommendations

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

- OHA needs to:
  1. encourage CCOs to participate in technical assistance meetings with Acumentra Health so that documentation issues, study modifications, and/or data problems can be addressed in a timely manner
  2. encourage CCOs to develop robust encounter data validation processes

- CCOs need to:
  1. develop their own systems and processes for tracking their internal 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. collect data and analyze several different study indicators in order to monitor performance and improvement

Second Statewide PIP: Improving the Safety of Opioid Management

At the April 2015 QHOC meeting, QI directors and managers met to discuss topics for the second Statewide PIP (July 1, 2015–June 30, 2017). Topics that received the most support were presented to the CCO medical directors for review. The overwhelming majority of CCO medical directors identified the topic of opioid management as their first preference. This topic received final approval from the OHA Quality Council in June 2015.

Following the topic confirmation, Acumentra Health conducted a literature review and identified a list of potential metrics. OHA's Office of Health Analytics, several members of Acumentra Health's Prescription Drug Monitoring Program research team, and the Healthy Columbia Willamette Collaborative opioid monitoring workgroup reviewed and commented on the list. At the July 2015 QHOC meeting, three metrics were chosen for further consideration:

1. Percentage of individuals on opioid doses ≥120 mg morphine equivalent dosage (MED) per day
2. Proportion of individuals with overlapping prescriptions for an outpatient opioid and a benzodiazepine
3. Percentage of adolescents and adults, previously naïve to use of opioid pain relievers, who became chronic users of opioid pain relievers

After reviewing the feedback from CCOs about the different metrics and dosage thresholds, as well as baseline data provided by the Office of Health Analytics, the QI directors selected the following PIP study metric:

> *Percentage of Medicaid enrollees who filled prescriptions totaling ≥120 mg and ≥90 mg morphine equivalent dose (MED) on at least one day within the measurement year*

All CCOs are participating in the second Statewide PIP.

Technical assistance

At the October 2015 QHOC meeting, Acumentra Health facilitated a four-hour learning forum session for CCOs on opioid management. The forum included two panel discussions, a presentation by the Oregon Public Health Division, and small-group discussions. Post-forum evaluations revealed that the large majority of QHOC attendees found the session very valuable.

Acumentra Health and OHA plan to present a series of one-and-a-half-hour learning collaborative sessions on topics pertinent to the Statewide PIP. The topics, selected on the basis of input from CCOs, subject experts, and others, will include non-opioid therapies, medication-assisted therapy, and cognitive behavioral therapy for opioid disorder.

As with the first Statewide PIP, Acumentra Health encourages CCOs to participate in technical assistance meetings and calls during the course of the project.

Standard 8 validation and scoring

Using CCO feedback collected at technical assistance meetings, Acumentra Health revised the Standard 8 scoring format to clarify criteria and improve usability. At the November 2015 QHOC meeting, QI directors and managers reviewed two draft versions of the Standard 8 format and selected the version to be used by all CCOs in their quarterly reports.

The first quarterly reports on the Statewide PIP on improving the safety of opioid management were due at the end of January 2016. After the first remeasurement period, Acumentra Health will score each CCO's quarterly report submissions for the degree of completeness of each of the 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.

GOBHI Review Results

GOBHI, a managed mental health organization (MHO), provides services through local community mental health programs (CMHPs) in Baker, Clatsop, Columbia, Douglas, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, and Wheeler counties.

GOBHI's governing board is comprised of elected officials or their designees from all counties that GOBHI serves. GOBHI's management philosophy of "local control" guides its policies and practices. Most MHO activities are delegated to the counties, which receive a capitation payment to deliver mental health care for GOBHI enrollees.

Four CCOs contract with GOBHI to provide behavioral health services. GOBHI manages alcohol and drug residential treatment for JCC and UHA. EOCCO serves enrollees in 13 of GOBHI's eastern Oregon counties, and GOBHI has worked closely with Moda, EOCCO's physical health partner. GOBHI is also a delegate of CareOregon for CPCCO in Tillamook, Columbia, and Clatsop counties.

Compliance review summary

Acumentra Health has conducted compliance reviews of GOBHI since 2005. GOBHI's previous review for compliance with QA/PI standards was in 2012. As shown in Table 15, the 2015 review found lower levels of compliance in most of the QA/PI review sections.

Table 15. GOBHI's Weighted Average Scores and Ratings on Compliance Review Sections.

Review section	2012	2015
Delivery Network	2.5 (Partially met)	1.9 (Partially met)
Primary Care and Coordination of Services	2.9 (Substantially met)	2.3 (Partially met)
Coverage and Authorization of Services	2.6 Partially met)	2.6 (Partially met)
Provider Selection	4.0 (Fully met)	3.6 (Fully met)
Subcontractual Relationships and Delegation	3.0 (Substantially met)	1.0 (Not met)
Practice Guidelines	1.3 (Not met)	1.0 (Not met)
QA/PI General Rules and Basic Elements	3.3 (Substantially met)	1.8 (Partially met)

In 2012, GOBHI had nearly 72,000 enrollees, and all of the MHO's policies and practices applied to its entire population. As CCOs were implemented, most of GOBHI's enrollees became members of a CCO. GOBHI has worked closely with CPCCO and EOCCO to align the MHO's practices with the CCOs' efforts in its service area.

GOBHI's current MHO population is 3,080, most of whom have opted out of managed physical health care. The 2015 review identified significant gaps in GOBHI's ability to identify and address the needs of this subpopulation, and to monitor the quality and appropriateness of care delivered to MHO enrollees.

GOBHI is in the process of developing the required infrastructure to apply to the National Committee on Quality Assurance (NCQA) for designation as a behavioral health organization. As GOBHI retools its administrative practices, more managed care functions will be performed by GOBHI's central office, rather than delegated to the CMHPs. This should improve GOBHI's ability to guide practices and hold the CMHPs accountable.

Overall strengths

- GOBHI has a thorough credentialing and recredentialing process for individual practitioners and facilities.
- GOBHI provides technical assistance to its network of providers through annual spring conferences. In 2014, GOBHI provided trainings on numerous relevant clinical and administrative topics.
- GOBHI successfully implemented Adult Mental Health Initiative programs in all contracted counties.
- The MHO is actively involved in developing and implementing care coordination efforts with the CCOs in its service area.

Major areas for improvement

- Lack of network planning: GOBHI did not demonstrate that it had identified the needs of MHO enrollees. All documentation submitted by the MHO addressed either EOCCO or CPCCO enrollees, and did not demonstrate that the MHO considers anticipated Medicaid enrollment, expected utilization, or the characteristics and health care needs of MHO enrollees.
- Coordination with primary care, allied social service agencies, and other managed care plans: The MHO lacked documentation to demonstrate that MHO enrollees had a source of primary medical care. GOBHI did not

demonstrate that the clinical chart audits routinely conducted by the CMHPs included MHO enrollees.

- Lack of policies: Many of the policies and procedures submitted by GOBHI were in draft form and had not been approved by the MHO board of directors. Many of these draft policies were aligned with NCQA's behavioral health organization requirements, but could not be used to demonstrate compliance for this review, since GOBHI had not yet implemented the procedures.
- Lack of documentation regarding oversight of delegated activities: GOBHI submitted no documentation to demonstrate oversight of the services for MHO enrollees that had been delegated to GOBHI's provider network. The documentation submitted was aggregated and primarily related to either mental health licensing or CCO transformation efforts.
- Lack of practice guidelines: GOBHI submitted no documentation related to practice guidelines, although GOBHI has implemented several evidence-based practices, in varying degrees, across its service area.
- Lack of utilization management: GOBHI submitted no documentation to demonstrate that it manages utilization of services for MHO enrollees. The UM reports submitted applied to EOCCO or CPCCO enrollees.

  GOBHI's draft utilization management program clearly outlines mechanisms to manage utilization. When the program is implemented, many activities now performed by GOBHI's providers will be performed centrally by GOBHI staff.

Follow-up on 2014 compliance results

GOBHI's 2014 compliance review addressed Enrollee Rights, Grievance Systems, and Certification and Program Integrity. In following up on the results, Acumentra Health found that GOBHI had addressed 6 of the 16 findings. GOBHI had partially addressed five issues and was working on another. GOBHI had not addressed four of the issues.

PIP validation summary

OHA requires GOBHI to conduct two PIPs each year, one clinical and one nonclinical. The MHO may select the topics for both PIPs. In 2015, Acumentra Health reviewed two PIPs conducted by GOBHI:

1. **Nonclinical PIP—Youth Mental Health First Aid**

   This PIP, started in 2013, aimed to increase the percentage of GOBHI children 6–18 years of age who use mental health services by conducting Mental Health First Aid trainings with school staff. In 2015, after encountering a series of barriers, GOBHI revised this PIP to focus solely on Grant County, which has an extremely small MHO study population. Acumentra Health reviewed the updated PIP and assigned a score of 57 on an 85-point scale, resulting in a rating of Substantially Met.

2. **Clinical PIP—Victory Over Child Abuse (VOCA) Camp**

   This PIP, new for 2015, received approval from OHA to include GOBHI CCO-enrolled children in the study population, as a preliminary review revealed that only one MHO-enrolled child met the study eligibility criteria. At the time of the PIP review, GOBHI could not determine if any of the 20 children in the study population met the GOBHI CCO-enrollment criteria. After discussion with OHA, Acumentra Health agreed to accept this PIP, but will not score individual standards or assign an overall PIP score.

Both of GOBHI's PIPs focus on study populations that are too small to support a PIP. Acumentra Health recommends that GOBHI select two new PIP topics for 2016 that target a significant number of MHO enrollees and have the potential to significantly affect enrollee health, functional status, or satisfaction.

ISCA summary

Acumentra Health has conducted a full ISCA review of GOBHI every two years since 2005. In alternating years, Acumentra Health has followed up with the MHO to determine how it addressed recommendations from the previous year's ISCA.

GOBHI outsources claims processing, encounter verification and data submission, enrollee eligibility verification, and fee-for-service payments to PH Tech, a third-party administrator. The 2015 ISCA evaluation reflects GOBHI's internal reporting and PH Tech's data processing and reporting procedures, as well as GOBHI's oversight and monitoring of PH Tech-contracted services.

The full ISCA in 2015 found that GOBHI fully met 3, partially met 5, and did not meet 2 of the 10 standards reviewed. See the MHO profile in Appendix A for more detailed results and findings.

DISCUSSION AND OVERALL RECOMMENDATIONS

The past year has been both transformative and challenging for the CCOs, whose enrollment stabilized after the Medicaid expansion in 2014.

By January 2015, all CCOs had incorporated dental care and NEMT services into their benefit package. The overarching need for ongoing improvement applies to full integration of services, particularly dental services.

From the 2015 EQR activities, Acumentra Health identified the following major areas for improvement in which the CCOs need OHA's guidance.

Ongoing integration efforts

Acumentra Health found a need for the CCOs to integrate dental services into their strategic planning and to continue their efforts to integrate mental health services.

- ***OHA should guide the CCOs in developing integrated policies and procedures, integration of data, network and capacity planning, and care coordination for all services provided.***

Provider directories

In 2015, OHA provided additional direction for the CCOs on the use of behavioral health National Provider Identification (NPI) numbers. The ability to track services by the rendering provider is essential to comply with requirements related to fraud, waste, and abuse, network planning, and enrollee choice.

- ***OHA should continue to work with the CCOs to ensure that all providers receive the appropriate NPI, so the rendering provider can be tracked and incorporated into each CCO's provider directory.***

Data integration

Most CCOs have made progress on developing integrated data reporting systems for physical and behavioral health. More progress is needed to integrate dental health services into CCO data systems.

- ***OHA needs to encourage the CCOs to continue integrating all service data into a single data repository for each CCO to enable better reporting on integrated care.***

Quality management

Most CCOs have centralized their quality management functions. In general, however, CCO boards are rarely involved in reviewing the annual quality strategy evaluation or in approving the annual quality management plan.

- ***OHA needs to clarify its expectations regarding CCO-level oversight of quality management.***

Care management

Although the OHA contract requires CCOs to assess the cultural and linguistic needs of enrollees with SHCN, few CCOs have incorporated the CLAS assessment when screening those enrollees.

- ***OHA needs to continue to provide technical assistance and guidance for the CCOs regarding CLAS expectations, especially for enrollees with SHCN.***

Monitoring of 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 have made progress on implementing mechanisms to monitor the compliance of their partner organizations and subcontractors with managed care requirements.

- ***OHA should provide guidance to the CCOs on the frequency and scope of monitoring necessary for delegates and partners, including authorization, care management, and services for enrollees with SHCN.***
- ***OHA should continue to guide the CCOs in developing processes for monitoring their providers to enforce contractual requirements for timely data submission, IT security, and business continuity planning.***

Certification of encounter data

Many CCOs are combining data from multiple sources but lack 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 have 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 needs to document the 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, and the data flow with external partners, is documented and understood
- OHA communication with CCOs and provider agencies is documented and consistent
- current relationships with external partners are documented, as are any future changes in associations, roles, or responsibilities

OHA should encourage CCOs to implement an encounter data validation process to ensure that data are complete and valid before submission to OHA.