

Oregon Health Authority Managed Care: 2016 External Quality Review Annual Report

April 2017

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2016 External Quality Review Annual Report**

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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
CCO	coordinated care organization
CHW	community health worker
CMS	Centers for Medicare & Medicaid Services
DPN	dental provider network
ED	emergency department
EDIE	Emergency Department Information Exchange
EDV	encounter data validation
EHR	electronic health record
ISCA	Information Systems Capabilities Assessment
MAT	medication-assisted treatment
MMIS	Medicaid Management Information System
NEMT	non-emergent medical 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

Acronyms for individual CCOs are listed on page 9.

EXECUTIVE SUMMARY

Oregon implemented coordinated care organizations (CCOs) in 2012 to deliver managed care for Medicaid recipients, following approval of the state's 1115 Medicaid Demonstration waiver by the Centers for Medicare & Medicaid Services (CMS). 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 HealthInsight Oregon to perform the annual EQR in Oregon. HealthInsight Oregon (formerly known as Acumentra Health) has conducted the EQR for Oregon since 2005.

The major review areas for 2016 were:

- *Compliance* with federal and state regulations and contract provisions governing managed care delivery
- *Validation of statewide performance measures*, including a full 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

HealthInsight Oregon reviewed the activities of all 16 CCOs and reported the results for each CCO, identifying specific strengths and areas for improvement. This annual report summarizes the CCO reviews, focusing on common strengths and improvement needs. Detailed profiles of the individual CCO reviews appear in Appendix A.

HealthInsight Oregon 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.

Compliance Follow-up Review

In 2014, HealthInsight Oregon (then Acumentra Health) evaluated the CCOs' compliance with regulations and contract provisions related to enrollee rights, grievance systems and program integrity. In 2015, the compliance review

addressed quality assessment and performance improvement (QA/PI) standards. In 2016, HealthInsight Oregon followed up with CCOs regarding steps they had taken to address deficiencies identified in 2014 and 2015.

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 in previous years. 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 have met the challenge benchmark of at least 60% enrollment in PCPCHs.¹ In general, the large medical clinics have become PCPCHs. The CCOs have used transformation funds to initiate innovative projects to transform care.

Overall strengths

- All 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 working to increase coordination and integration of dental provider networks (DPNs) through workgroup meetings with the DPNs, other CCOs and OHA.
- Most CCOs have begun monitoring their delegates for compliance with managed care requirements. A few have issued corrective action plans for noncompliance.

Major areas for improvement and recommendations

HealthInsight Oregon developed recommendations for the individual CCOs and for OHA to help the CCOs address their improvement needs. Some general recommendations appear below.

¹ Oregon Health Authority. Oregon's Health System Transformation: CCO Metrics 2015 Final Report. June 2016. Available online: https://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf.

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

To date, integration has occurred mainly at the practice level in the PCPCHs where behavioral health staff are embedded. 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.

For the majority of CCOs, member grievances indicate significant concerns related to access to NEMT services. Members have not made it to their appointments or have arrived late, creating barriers to receiving care. Some CCOs are addressing these concerns through technical assistance and corrective action plans.

- *OHA needs to continue to support the CCOs in developing integrated policies and procedures, data systems, network and capacity planning and care coordination for all required services.*

Oversight of delegated functions. Since the delegation readiness review in 2013, the CCOs have been clarifying the roles and responsibilities of their partners and delegates. Continuing work is needed to ensure that delegated functions are performed as required by the managed care 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.

Certifications and program integrity. All CCOs are working toward effective compliance programs. Many CCOs monitor and audit internal and external risks. However, some CCOs incur significant risk by not screening key personnel monthly for exclusion from federal health care programs, not performing criminal background checks and not monitoring gifts, gratuities and vendor compensations and relationships.

- *OHA needs to clarify its expectations for CCOs to screen key personnel for exclusion from federal health care programs, conduct criminal background checks and monitor for conflicts of interest to reduce CCOs' overall risk.*

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

Performance Measure Validation (PMV)

Of the state's 17 incentive performance measures for CCOs, 7 measures were calculated using only encounter data that OHA collects and maintains. Per OHA's direction, HealthInsight Oregon validated those seven measures, seeking 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

HealthInsight Oregon assigned a "substantially met" score to all seven measures reviewed. In past years, performance measures have been scored as "partially met" because of concerns about data integrity and completeness and about a limited and undocumented validation process. The 2016 PMV found that OHA has made substantial improvements in both areas. The state's code review and measure calculation process was adequate, but HealthInsight Oregon remains concerned about the validity of the data used to calculate the measures.

Among other recommendations, HealthInsight Oregon recommends that OHA either conduct an encounter data validation (EDV) or require the CCOs or a third party to conduct an EDV, to ensure that complete and valid encounter data are submitted to OHA.

For additional details, see pages 38–42.

ISCA results

HealthInsight Oregon conducted a full ISCA review of OHA's data management and reporting systems and those of the individual CCOs.

The state ISCA review found that OHA continues efforts to strengthen its infrastructure and IT processes and procedures by performing daily backups of Medicaid data and replicating the backups to an offsite location. OHA reported continuing efforts to expand server, database and storage capability to handle workload increases due to Medicaid expansion. CCOs reported that OHA continues to improve the integrity of member eligibility data sent to the CCOs. OHA continues working to address issues related to:

- maintenance and ongoing support for Medicaid Management Information System hardware and software
- expanding the teams responsible for processing, reviewing and auditing the CCOs' claims and encounter data
- inconsistencies in data submission by the CCOs
- regular review and updating of policies, procedures and business continuity/disaster recovery plans

Overall, the individual CCOs have made significant progress in integrating all required services and associated claims/encounter data into their IT systems. Most CCOs have successfully integrated mental health and dental data into their IT systems and reporting. Some CCOs have integrated data on NEMT services, while others are still working toward that goal. To perform appropriate monitoring and oversight of in-house and outsourced IT services, the CCOs need to improve their understanding of service authorization processes, eligibility data flow and data validation for all services.

HealthInsight Oregon developed recommendations for OHA to work with the CCOs on specific issues related to IT systems integration, encounter data certification, delegated IT activities and responsibilities, disaster recovery plans, provider directories and zero- and low-dollar claims. See the ISCA section beginning on page 43.

Appendix C presents detailed results of the state ISCA review. The CCO profiles in Appendix A summarize the results of each CCO's ISCA review.

CCO Performance Improvement Projects (PIPs)

The managed care 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 study targeting improvements in care in designated quality improvement (QI) focus areas. One of the required PIPs is being conducted as a statewide collaborative and addresses the integration of primary care and behavioral health.

Statewide PIP

The first Statewide PIP (2013–2015) addressed monitoring for diabetes in people with schizophrenia or bipolar disorder. The second Statewide PIP focuses on improving the safety of prescription opioids, using a dosing threshold as the study indicator. The CCOs are measuring the percentage of their members age 12 years and older with opioid prescriptions for ≥ 120 mg and for ≥ 90 mg morphine equivalent dosage per day. Individual CCOs have the option of measuring one or both of the dosage thresholds.

HealthInsight Oregon is responsible for facilitating and documenting the overall PIP in accordance with CMS guidelines. CCOs are responsible for developing their own interventions and for documenting their progress in quarterly reports submitted to OHA. At the end of the first remeasurement period (January 1–December 31, 2016), HealthInsight Oregon evaluated each CCO’s fulfillment of the criteria for PIP Standard 8 (Improvement Strategies).

The CCO profiles in Appendix A report each CCO’s interventions, barriers and next steps for the Statewide PIP, as well as the topics of additional PIPs and focus projects the CCO conducted in 2016. Appendix B reports the interim results of the Statewide PIP.

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

HealthInsight Oregon and the CCOs completed the first three-year cycle of EQR reviews in 2016. The reviews have covered each CCO's compliance with standards for Enrollee Rights, Grievance Systems, Certifications and Program Integrity and QA/PI. HealthInsight Oregon has conducted two full ISCA reviews of OHA and CCO information systems, and has reviewed and scored the CCOs' work on two Statewide PIPs.

In 2016, HealthInsight Oregon followed up with CCOs on the results of the 2014 and 2015 compliance reviews; conducted PMV-related activities, including full ISCA reviews; facilitated and documented the Statewide PIP, and began evaluating CCO-specific PIPs and providing feedback to OHA. 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 HealthInsight Oregon for review.
3. HealthInsight Oregon staff visited the CCO to conduct onsite interviews and provided each CCO with an exit interview summarizing the results of the review, or conducted telephone interviews for follow-up reviews.
4. HealthInsight Oregon weighted the oral and written responses to each question and compiled results.

The scoring plan for each activity was adapted from CMS guidelines. 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 HealthInsight Oregon and approved by OHA.

Oregon’s Coordinated Care Organizations

Nearly 9 out of 10 OHP members receive managed care through a CCO. After extending Medicaid coverage to additional Oregonians as authorized by the federal Affordable Care Act, OHP now covers more adults (60%) than children (40%). Table 1 displays the current CCOs and their enrollment totals as of December 2016.

Table 1. CCOs’ OHP Enrollment, December 2016.	
CCO	Total Enrollees
AllCare Health Plan	48,005
Cascade Health Alliance (CHA)	16,787
Columbia Pacific CCO (CPCCO)	24,605
Eastern Oregon CCO (EOCCO)	45,097
FamilyCare CCO	114,314
Health Share of Oregon (HSO)	210,001
Intercommunity Health Network (IHN)	52,862
Jackson Care Connect (JCC)	28,970
PacificSource Community Solutions–Central Oregon (PSCS-CO)	46,956
PacificSource Community Solutions–Columbia Gorge (PSCS-CG)	11,899
PrimaryHealth of Josephine County (PHJC)	10,383
Trillium Community Health Plan (TCHP)	88,347
Umpqua Health Alliance (UHA)	25,000
Western Oregon Advanced Health (WOAH)	19,739
Willamette Valley Community Health (WVCH)	94,915
Yamhill Community Care Organization (YCCO)	24,160
Total	862,040

Source: Oregon Health Authority. Oregon Health Plan: Coordinated Care, Managed Care and Fee for Service Enrollment for December 15, 2016.

OHA's Quality Improvement Activities

OHA's Quality and Health Outcomes Committee (QHOC) convenes monthly meetings of CCOs' clinical leadership to coordinate QI efforts that support the implementation of innovative health care practices. Learning collaboratives for CCO leaders and community partners provide peer-to-peer learning experiences, education by subject matter experts and QI strategies.

OHA's Transformation Center is the innovation and QI hub for Oregon's health system transformation efforts. The center offers Transformation Fund Grant Awards to CCOs to support innovations in health care delivery. 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 administers the [Patient-Centered Primary Care Home program](#), which provides technical assistance to help primary care clinics transform to PCPCHs, and works with stakeholders across Oregon to support adoption of the PCPCH model. OHA requires the CCOs to include PCPCHs in their care delivery networks to the extent possible.

The center issues semiannual reports on the CCOs' performance on key quality and financial measures. The mid-2016 update reported ongoing improvements in areas such as developmental screening for young children, PCPCH enrollment and reduced hospital admissions for asthma and chronic obstructive pulmonary disease, while other measures show room for improvement.³ The center provides targeted technical assistance to CCOs on specific incentive measures.

OHA reports to the legislature regularly on the progress of Oregon's health care transformation. OHA's quarterly legislative report presents data related to OHP demographics, CCO performance on quality metrics, member satisfaction, health disparities, finance, PCPCHs, eligibility and enrollment and other topics.⁴

² See <http://www.oregon.gov/oha/Transformation-Center/Documents/Transformation-Fund-Final-Report.pdf>.

³ Oregon Health Authority, Office of Health Analytics. Oregon's Health System Transformation: CCO Metrics 2016 Mid-Year Report. Available online: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf.

⁴ Oregon Health Authority. Oregon's Health System Transformation Quarterly Legislative Report, Q2 and Q3 2016. Available online: https://www.oregon.gov/oha/analytics/Documents/LegislativeReport_Q2-Q3_2016.pdf.

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.

CMS renewed Oregon's [1115 Medicaid Demonstration waiver](#) in January 2017. The state has committed to continuing and expanding all elements of the 2012 waiver related to integration of behavioral, physical and oral health, with a new focus on social determinants of health, population health and quality of care.

OHA's Quality Strategy describes how CCOs will be held accountable for a model of care that relies on increased transparency, clear expectations and incentives for improvement. Key elements have included 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 (CHWs) and alternative payment models.

Behavioral health initiatives

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.⁵

In late 2016, OHA received a two-year demonstration grant award to establish Certified Community Behavioral Health Clinics (CCBHCs), as part of an eight-state demonstration program representing the single largest federal investment in community behavioral health in more than 50 years. The CCBCHs will serve adults with serious mental illness, children with serious emotional disturbance and those with long-term and serious substance use disorders, as well as others with mental illness and substance use disorders.

⁵ Oregon Health Authority. 2015–2018 Behavioral Health Strategic Plan. November 2014. Available online: <http://www.oregon.gov/oha/amh/Pages/strategic.aspx>.

OHA and its state agency partners have implemented the System of Care Wraparound Initiative in all regions of the state, providing services and supports for youth with complex behavioral health needs. Wraparound is an intensive care coordination process for young people involved in multiple child-serving systems, e.g., mental health, addictions, child welfare, developmental disabilities, juvenile justice and special education. The wraparound approach builds on each youth's and family's strengths and needs to develop an individualized plan for services and care coordination.

According to OHA, the wraparound initiative has delivered better outcomes at lower cost by supporting the integration and reorganization of state-funded services. CCOs coordinate local activities and are reimbursed for wraparound services under capitation.

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, HealthInsight Oregon 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).⁶ OHA adds questions to each survey to collect additional data to help evaluate the progress of ongoing programs. Survey participants have the option to complete the survey online or on paper.

Adult survey results. In 2016, 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 July–December 2015. The survey was mailed to 9,280 adults who had received outpatient services and

⁶ 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.

1,507 adults in either residential or foster care. In all, 1,046 adults returned surveys, for a response rate of 18%, down from 19% the previous year.⁷

The survey probed issues related to services in seven domains defined by MHSIP: general satisfaction, access to services, service quality, daily functioning, social connectedness, treatment participation and treatment outcomes.

Percentages of respondent satisfaction in most domains have been relatively consistent since 2012, though the percentage of those satisfied in the daily functioning domain has trended significantly upward. In 2016 as in previous years, outpatient respondents were less satisfied in most domains than were respondents in foster care and residential care; the differences were significant in treatment outcomes, daily functioning and social connectedness. In certain domains, the survey also revealed significantly different long-term trends in satisfaction depending on respondents' age and gender.

Youth survey results. The YSS-F asked about caregivers' perception of services delivered for their children during May–December 2015 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 23%, higher than in 2015 but similar to previous years, with 3,212 responses from caregivers of 13,794 children.⁸

The YSS asked young people age 14 to 18 years about their perceptions of services they received. The YSS, like the YSS-F, included a cluster of questions designed to assess the youths' 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 1,025 responses from 5,714 adolescents who received a survey, for an overall response rate of 22%, higher than the 2015 response but similar to other recent years.

Reported satisfaction in all YSS-F domains increased slightly in 2016. Satisfaction in the cultural sensitivity, outcomes and social connectedness domains has

⁷ HealthInsight Oregon. 2016 Oregon Mental Health Statistics Improvement Project Survey for Adults–Outpatient and Residential. March 2017.

⁸ HealthInsight Oregon. 2016 Oregon Youth Services Survey for Families and Youth Services Survey Report. January 2017.

trended significantly upward since 2012. Satisfaction with access to residential and day treatment services was significantly lower in 2016 than satisfaction with outpatient access, although satisfaction with treatment outcomes and daily functioning has trended significantly higher in the past five years.

Looking at the YSS, the percentage of young respondents who were satisfied with their treatment outcomes has shown a significant downward trend over the past five years. While satisfaction in other domains has fluctuated from year to year, none has showed a significant upward or downward trend.

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. HealthInsight Oregon used contract language, definitions of reliable and valid quality measures and research literature to guide the analytical approach.

Access 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 translation and transportation services.

Timeliness 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 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. The CCOs continue to make progress in expanding access to primary care, behavioral health care and dental care, and in providing specialists to meet members' needs. Strategies for improving access include:
 - co-locating mental health and substance use disorder treatment practitioners in primary care clinics
 - co-locating physical health practitioners in mental health clinics (behavioral health home/CCBCH model)

- co-locating dental care at some clinics and school-based health centers
- authorizing timely out-of-network services when needed
- using geo-access software to identify participating and non-participating providers in relation to members' addresses
- All CCOs have met the incentive measure for PCPCH enrollment. As of December 2016, there were more than 630 recognized PCPCHs in Oregon. In 2016, the program began transitioning from a three-tier to a five-tier designation to encourage clinics to continue to transform care.

Areas for improvement

- CCOs continue to struggle with integrating dental care into their delivery systems. Many CCOs and DPNs have taken formal steps to work together to integrate care and meet managed care requirements.
- Member grievances have identified access issues related to NEMT services—providers not providing rides, late pickups leading to missed appointments, lack of communication—as a significant concern. Some CCOs have implemented training, technical support and corrective action plans to address these issues.
- More work is needed to improve access to care in rural areas, and to improve processes for identifying and coordinating care for members with SHCN. Some CCOs have employed strategies such as increasing after-hours availability, using mobile units to serve rural communities and recruiting and retaining additional providers. A few CCOs have enhanced their networks by contracting with nonparticipating providers willing to serve members with SHCN.

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

- During 2016, most CCOs did not monitor contractual requirements for provider network access. Some CCOs lacked system-wide mechanisms to monitor network capacity to ensure access to all required services.

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

- Few CCOs' policies and procedures for 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 categories.*
- As of mid-2016, the majority of CCOs reported a decrease in childhood and adolescent access to primary care providers. No CCOs met the benchmark for this performance measure.
- Although health assessments for children in DHS custody generally increased, no CCOs met the benchmark for this incentive measure.

Timeliness

Strengths

- Most CCOs have reduced avoidable emergency department (ED) utilization. With OHA support, all CCOs are working to adopt the use of PreManage (real-time notifications to CCOs when their members have ED or inpatient hospital events) and the Emergency Department Information Exchange (EDIE). Alerting care coordinators/case managers to members' hospital visits enables timely care coordination and discharge planning.
- As of mid-2016, most CCOs exceeded the incentive measure benchmark for developmental screening in the first 36 months of life.
- Most CCOs have developed policies and procedures addressing the required time frames for informing members of service authorization decisions, and have begun monitoring their delegates to ensure the timeliness of routine and expedited authorization decisions.

Areas for improvement

- 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.
- Although avoidable ED utilization has declined, most CCOs reported an increase in overall ED utilization from 2015 to mid-2016.

CCOs need to monitor the timeliness of access to routine, urgent and emergent care across the entire service delivery network.

- Some CCOs still lack mechanisms to ensure that their delegates are screening practitioners on a monthly basis for exclusion from participation in federal health care programs.

CCOs need to ensure that all partners, delegates and downstream entities perform monthly screening for exclusion from participation in federal health care programs.

Quality

Strengths

- All CCOs made progress on **integrating physical, behavioral and dental health care** during 2016.
 - Some CCOs have hired behavioral health managers, dental managers and administrative staff to help facilitate service integration. Many CCOs are participating in workgroups with the DPNs to coordinate expectations, regulations and requirements.
 - 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.
- All CCOs provide robust **care management**.
 - All CCOs use interdisciplinary teams to guide care coordination efforts. These teams represent primary care, mental health, dental care, law enforcement, APD, home health, substance use disorder treatment and enrollees and their family members.
 - CCO staff members regularly meet with community partners to better coordinate care for members with complex needs.
- Many CCOs have invested in predictive modeling programs for **population management**. Some use this resource to guide care coordination and utilization management and to 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.

- Many CCOs have made strides in the areas of **health equity and cultural considerations**.
 - Some CCOs have recruited culturally specific providers to fill identified gaps in their service array.
 - Many CCOs have recognized the importance of using qualified and certified health care interpreters. Training has been provided statewide. Many CCOs use CHWs as certified health care interpreters.
 - One CCO, in partnership with a local health care coalition, trains providers on health equity and diversity. This CCO has created a Health Equity and Inclusion action team to focus on related initiatives across the provider network.
 - One CCO meets monthly with mental health directors and the Alliance of Culturally Specific Behavioral Health Providers and Programs to promote routine communication of unmet needs, outreach and engagement strategies, emerging best practices and new program development for specific populations.
- 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.
- All CCOs take part in the Statewide PIP to **improve the safety of opioid management**. This PIP has assisted the CCOs in implementing strategies to reduce inappropriate prescribing of opioids, developing practice guidelines related to opioid prescribing and collaborating within their communities to reduce inappropriate use of opioids and offer alternative treatment options for members with chronic pain.

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 manuals do not address integrated care. For example, policies and procedures need to address second opinions not only in primary care but 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 expectations for care integration, and that services delivered across the entire network are aligned with the CCOs' policies and procedures.

- *Mental health and dental care.* Policies and practices for integrating these services into the CCOs' delivery networks have lagged. In many CCOs, mental health provider agencies amount to a separate specialty care delivery system. In some cases, the DPNs are fully autonomous with little CCO oversight.

CCOs need to continue to work on integrating mental health and dental care at the administrative and service delivery levels, and on integrating these services into the CCOs' electronic clinical data systems.

- *Practice guidelines.* Most CCOs' practice guidelines address only physical health. Practice guidelines for behavioral health or dental care are not integrated into the CCOs' processes 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:** Many CCOs lack mechanisms to monitor certain functions that are delegated to partners and providers. The CCOs exercise limited oversight of functions delegated to the DPNs.
 - *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 the delivery of mental health, substance use disorder treatment and dental care for members with SHCN.
 - *Credentialing.* The CCOs conduct little oversight of the credentialing activities delegated to mental health agencies or DPNs. 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. Most CCOs have delegated dental credentialing to the DPNs and have not developed mechanisms to monitor this function.

CCOs need to work with their 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 on 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 repository to support integrated care across the delivery network.

COMPLIANCE FOLLOW-UP REVIEW

In 2014, HealthInsight Oregon (then Acumentra Health) reviewed the CCOs' compliance with federal and state regulations and contract provisions related to enrollee rights, grievance systems and program integrity. In 2015, the review covered compliance with QA/PI standards.

In 2016, HealthInsight Oregon followed up with each CCO regarding steps it had taken to address its 2014 and 2015 compliance findings and recommendations. In the past, HealthInsight Oregon followed up only on findings, but this year followed up on recommendations and findings at OHA's request.

The following results reflect the status of CCOs' compliance with specific standards as of 2016.

Enrollee Rights

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

Major strengths

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

The CCOs informed enrollees of their rights through "welcome" calls to new members and by employing health navigators to help members with complex needs obtain care. The CCOs provided member information in appropriate formats and languages to meet members' needs.

Provider communication. All CCOs worked with providers to ensure that they knew about and honored enrollee rights. Many CCOs held provider orientations and trainings related to enrollee rights. Some CCOs met often with providers, hospital discharge planners and provider office staff to review enrollee rights.

Some CCOs visited provider offices to assess access to appointments, access to medical records and privacy. One CCO distributed the results of member/patient satisfaction surveys to providers.

Customer service. Many CCOs provided training for customer service and other staff on enrollee rights. Most CCOs monitored customer service calls to evaluate whether the calls were handled in an appropriate and timely manner.

Member satisfaction. The CCOs used a variety of methods to gather input from members about their satisfaction with services and to identify service gaps. The CCOs closely monitored CAHPS survey scores on overall customer satisfaction with care quality and access.

Cultural diversity and competency. Many CCOs had initiated cultural diversity and competency strategies. One CCO convened a workgroup to explore health equity. Other CCOs established diversity and equity committees and learning sessions for providers, or conducted annual diversity training.

Seclusion and restraint. During credentialing and recredentialing, most CCOs asked to see providers' policies on the use of seclusion and restraint.

Major areas for improvement

Monitoring of enrollee rights. In general, the CCOs lacked mechanisms to monitor enrollee rights across all service categories. More work is needed in the following areas.

- *Respect, dignity and privacy.* Most CCOs lacked a process to monitor their delegates and providers to ensure that they are honoring members' rights to be treated with respect and consideration for dignity and privacy.
- *Advance directives and mental health treatment declarations.* Most CCOs lacked mechanisms to monitor for the presence of these directives for members and to ensure that providers knew about and observed these directives.
- *Seclusion and restraint.* Most CCOs did not monitor providers' and facilities' use of seclusion and restraint to ensure that members were free from the use of these high-risk activities as a means of coercion, discipline, convenience or retaliation.

Information about providers. Many CCOs' provider directories lacked required information for all services, particularly mental health, such as individual

practitioners' names, addresses, specialties, language capacities and whether practitioners were accepting new enrollees.

Many CCOs had posted provider directories on their websites. However, when tested, many websites proved incomplete. This was particularly true for mental health and dental services. Most CCOs listed mental health agencies without a mechanism to provide the required information for an individual practitioner. Very few CCOs listed individual dentists; often the enrollee was directed to call the dental organization or was routed to the dental organization's website. CCOs need to ensure that provider directories are available, easily searchable and contain the required elements.

Lack of integrated policies and procedures. Integration of CCO policies and procedures across all service areas remains incomplete. Many of the CCOs' physical health policies and processes addressed enrollee rights requirements, but those policies often did not refer to mental or dental health.

Grievance Systems

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

Major strengths

Most CCOs had robust grievance systems for physical health. Systems were in place to elevate grievances to the highest clinical or administrative level within the organization as necessary. Most CCOs investigated grievances thoroughly and conducted thorough analyses. Grievance reports were routinely reviewed in QI committee meetings. When a trend was identified, the CCO might modify an internal process or coach a provider or the provider's office staff. A few CCOs followed up with enrollees to ensure that they were satisfied with the handling of their grievances.

Working with providers. Most CCOs used a sequential process to address quality-of-care grievances. This process might begin with coaching the provider and lead to corrective action for noncompliance. Most CCOs incorporated quality-of-care concerns into provider recredentialing reviews. The CCOs were working with DPNs and NEMT vendors to ensure that grievance processes were in place that met state requirements and CCO expectations.

Delegation and monitoring of grievances. Most CCOs had established systems to monitor and oversee their delegates' grievance systems. A few CCOs handled all grievances rather than delegating grievances to mental health or dental care providers. Other CCOs met with delegates to review grievances and appeals.

The CCOs have made progress with monitoring grievances in all service areas. Most CCOs have developed processes to monitor the resolution and disposition of grievances and appeals, and to monitor the timeliness of member notices that are delegated to providers. Most CCOs reviewed all or a sample of notice-of-action (NOA) letters sent to members, and were working to ensure that NOA letters issued by delegates were written in easily understood language.

Integrated policies and procedures. Most CCOs had developed policies defining the timing of notices for termination, suspension or reduction of previously authorized Medicaid-covered services, as well as the exceptions for providing notice to members. Most had policies and procedures on the time frames for authorization decisions and for expedited authorization decisions.

Adjudication of final appeals. Most CCOs adjudicated final appeals as required by the OHA contract, though they often relied on their delegates' expertise.

Major areas for improvement

Lack of updated, integrated policies and procedures. Although improvements have been made, in many instances the CCO's physical health policies and procedures related to grievances had not been updated to incorporate mental health and dental services.

Discrepancies in handling grievances for physical and mental health. Many CCOs did not demonstrate that their grievances were handled consistently across all service categories. In particular, very few mental health grievances were reported. More work is needed to bring the two systems into alignment regarding how members' expressions of dissatisfaction are handled.

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

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

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

Monitoring. Some CCOs performed no monitoring to ensure that their delegates acknowledged grievances in writing. Although great strides have been made, the CCOs need to continue to work with their partners and delegates to ensure that the grievance system is implemented consistently across all service types.

Certifications and Program Integrity

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

Major strengths

Most CCOs had developed compliance programs that addressed the required elements. Most CCOs conducted external audits, and a few conducted internal audits of all departments, enabling those CCOs to conduct an annual evaluation of the effectiveness of their programs. All CCOs had a compliance officer with direct access to the governing board. A few compliance officers were certified in health care compliance or held other compliance-related certifications.

Compliance training. All CCOs conducted annual compliance training for employees. Many CCOs provided training for their boards of directors, and some also held training for providers. Many CCOs required board members to

complete conflict-of-interest attestations, and some extended that requirement to staff. A few CCOs included constraints against vendor gifts and gratuities in their codes of conduct.

Screening for exclusion. Most CCOs' credentialing and recredentialing of licensed providers included screening for exclusion from participation in federal health care programs. Most CCOs conducted screening monthly. A few screened non-contractor providers for exclusion before paying those providers' claims.

Major areas for improvement

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

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

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 medically necessary services outside the network.

OHA requires each CCO to submit an annual Delivery System Network (DSN) report demonstrating the CCO's capacity to serve the expected enrollment in its service area, in accordance with state standards for access to care. As a special EQR project in 2016, OHA asked HealthInsight Oregon to review the CCOs' DSN reports and provide feedback and recommendations. Results of that review appear in a separate report submitted to OHA in February 2017.

Major strengths

All CCOs had expanded their network capacity to accommodate Medicaid expansion. Strategies included opening new clinics, extending providers' office hours, forming mobile teams, contracting with additional dental and behavioral health providers and providing incentives for primary care providers (PCPs) to locate and stay in rural areas. Most CCOs had begun to incorporate access to behavioral health and dental care into their network planning to determine and maintain adequacy.

Out-of-area care. Most CCOs assessed care patterns of providers in out-of-area locations. The CCOs' care management teams knew which specialty services were not available within the network, and were experienced in arranging medically necessary care from out-of-network providers. Some CCOs had established long-term relationships with out-of-area specialists.

Cultural competency. CCOs had implemented strategies to improve members' access to culturally competent services. All CCOs had provided training for staff and providers to improve member interactions. CCOs had implemented several programs designed to increase enrollee engagement and activation.

Major areas for improvement

In general, the inadequate number of providers across the state creates ongoing access problems. Most CCOs struggled to provide timely access to services

covered under the contract (including access to specialists, dental care and out-of-network services). Challenges included recruiting PCPs and specialists to rural areas, as well as monitoring capacity and access to ensure an appropriate distribution of services in metropolitan areas.

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

Out-of-network services. A few CCOs lacked integrated policies on out-of-network services. Some CCOs' enrollee handbooks lacked information about how to obtain services outside the network.

Some CCOs' policies did not specify that out-of-network providers must coordinate with the CCO with respect to payment. CCOs generally did not monitor to ensure that the cost to the enrollee for out-of-network services was no greater than it would have been if services were furnished within the network. Many enrollee complaints and grievances have been related to billing, though such issues have decreased. It is unclear how many billing issues are connected with out-of-network providers' billing practices.

Timely access to all contracted services. Many CCOs had inadequate processes for ensuring timely access to routine, urgent and emergent services and access to specialists. Some CCOs lacked methods to ensure that members had timely access to mental health and dental care.

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.

Major strengths

All CCOs achieved the benchmark of 60% of enrollees assigned to a PCPCH. Some CCOs had embedded PCPs in behavioral health clinics. Many CCOs had behavioral health providers within their PCPCHs.

Care management. Some CCOs had invested in population health management programs to identify enrollees with SHCN. CCOs' care management staffs conducted outreach to the identified enrollees. All CCOs had expanded care management programs to include nurse case managers, behavioral health providers and CHWs. Many CCOs supported the use of traditional health workers and other non-billable providers to increase care coordination and to connect members to services.

The CCOs had negotiated memoranda of understanding with APD and the Area Agencies on Aging to improve coordination of care for CCO members. All CCOs took part in multidisciplinary teams with APD, behavioral health providers and other agencies serving enrollees. Some CCOs brought substance use treatment providers into their care management meetings. In some cases, these teams had established unified care plans for enrollees with exceptional needs.

Major areas for improvement

Care coordination. Many CCOs lacked policies and procedures integrating dental, behavioral and physical health. A few CCOs demonstrated poor communication between providers of dental, behavioral and physical health services (including screening and referral for alcohol and 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 lacked a process to periodically update needs assessments and to monitor treatment/care plans for enrollees with SHCN. Many CCOs lacked mechanisms to ensure that mental health and dental providers were complying with care standards. Many CCOs' assessments and care plans for enrollees with SHCN did not address cultural or linguistic factors.

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 service requests are made by a health care professional with appropriate experience in treating the enrollee's condition; send appropriate notice of 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.

Major strengths

Many CCOs performed routine inter-rater reviews of internal authorization processes to ensure consistent application of review criteria. All physical health service denials were reviewed by medical staff. The CCOs had improved their processes to monitor the timeliness of routine and expedited authorization decisions.

CCOs' utilization management committees reviewed the use of emergency services in an effort to reduce avoidable ED utilization. Most CCOs had adopted incentive payments for physical health providers to reduce readmissions and avoidable ED utilization, and to increase outpatient utilization.

Major areas for improvement

Authorization processes. Some CCOs lacked a mechanism to ensure consistent application of review criteria when making authorization decisions and to ensure that providers were notified of adverse actions. Some CCOs lacked policies and procedures to address post-stabilization service requirements.

Delegated authorizations. Many CCOs exhibited little oversight of delegates (particularly DPNs) with respect to service authorization. CCOs need to closely monitor the delegation of service authorization, including the NOA process, to ensure that delegates are comfortable with the complexities of performing those activities.

Provider Selection

This section of the compliance protocol assesses the degree to which the CCO implements policies and procedures for selecting and retaining 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 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.

Major strengths

All CCOs had rigorous credentialing and recredentialing processes for physical health practitioners. Most CCOs assessed the quality, safety and accessibility of provider offices during initial credentialing through site visits. Most CCOs monitored member complaints and visited medical offices when a threshold of complaints had been received. A few CCOs performed credentialing and recredentialing of licensed mental health practitioners.

Major areas for improvement

Credentialing and recredentialing. Most CCOs lacked policies and procedures that adequately addressed the credentialing and recredentialing expectations of delegates, including monitoring mechanisms and credentialing requirements for mental health professionals, dental hygienists, peer support specialists, CHWs and NEMT providers. Issues ranged from needing to establish a credentialing committee to developing more comprehensive screening processes.

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

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

Subcontractual Relationships and Delegation

This review section evaluates the CCO's practices for monitoring the 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.

Major strengths

Most CCOs conducted pre-delegation assessments and provided technical assistance to ensure that providers could meet contractual requirements.

Strategies for oversight of delegated functions and entities varied among CCOs. CCOs' oversight committees or compliance departments were responsible for tracking delegates' performance. A few CCOs conducted annual evaluations of delegates and required corrective action as needed. Many CCOs monitored their delegates to track progress on the work plans.

Major areas for improvement

Many CCOs had draft policies and procedures pertaining to monitoring and oversight of delegates. CCOs need to follow through with monitoring of their delegates to ensure that they meet CCO expectations.

CCO delegates often subdelegated some or all of the delegated activities to other downstream entities. In some cases, contracts between the CCO and delegates failed 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 were identified.

In a few instances, the CCO had required corrective action but had not followed up to ensure that the issue was addressed. Many CCOs had not performed annual evaluations of all delegates.

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; 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 and coverage of services are consistent with the guidelines.

Major strengths

All CCOs based 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. Some CCOs had developed practice guidelines for prescribing opioids and hepatitis C drugs.

CCOs' Clinical Advisory Panels often participated in identifying and adopting practice guidelines.

Major areas for improvement

Some CCOs lacked documentation of how their delegates adopted practice guidelines. Some CCOs lacked a policy or consistent procedure for disseminating clinical guidelines for all practice areas. Websites might provide access to one or two medical or mental health guidelines, but not dental practice guidelines.

A few CCOs lacked monitoring mechanisms to ensure that internal decisions on utilization management were consistent with CCO guidelines. Most CCOs lacked mechanisms to ensure consistency of delegates' authorization decisions.

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 improve quality
- reporting specified performance measures to the state
- mechanisms to detect 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

Major strengths

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

QI committees. In most cases, the CCOs had added behavioral health providers and specialists to their QI committees; a few committees included pharmacy and dental care representatives. Many CCOs' QI committee processes included analysts who produced comprehensive management reports.

Risk management. Most CCOs had invested in risk and population care management programs. The CCOs used predictive risk management software to produce probability ratings for individual enrollees related to inpatient admissions, ED visits and potential adverse incidents. In most cases, PCPs received this information about CCO members assigned to their practice. One CCO provided risk model performance reports to hospitals considered essential for the CCO's ability to meet quality incentive goals.

Major areas for improvement

CCOs generally need to expand their QA/PI programs to apply to mental health and dental services as well as physical health. QA/PI programs need to define the scope of QI activities for all services; describe the results of CCO monitoring of utilization, care coordination/case management efforts and delegated activities; specify the CCO's quality oversight body; and include guidance for downstream entities on the program's mission, objectives and priorities.

Enrollees with SHCN. In general, the CCOs lacked mechanisms to track the quality and appropriateness of programs to assess the needs of enrollees with SHCN. Little information was available on the volume of services delivered and the effectiveness of those programs.

Health information systems. Many CCOs need to work toward establishing 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.

Recommendations for OHA

Enrollee Rights

- Continue to assist CCOs in ensuring that member materials and communications are available in easily understood language.
- Continue to work with CCOs to ensure members' free choice of providers, specifically mental health providers.
- Continue to assist CCOs in coordinating and honoring advance directives and mental health treatment declarations for the benefit of members.
- Clarify expectations with respect to monitoring providers and facilities for the use of high-risk activities of seclusion and restraint.

Grievance Systems

- Continue to work with the CCOs to ensure that grievances are gathered and reported consistently as expected. OHA may need to define what constitutes a grievance, which grievances need to be reported, etc.

Certifications and Program Integrity

- Clarify the CCOs' obligation to search the Office of Inspector General's exclusion database monthly for all employees, providers, provider entities, contractors and individuals with ownership or control interests.
- Clarify OHA's expectation of who should undergo criminal background checks upon hire or credentialing.
- Clarify expectations for disclosure of information related to vendor relations, gifts, gratuities and other compensations.

Quality Assessment and Performance Improvement

- Continue to work with CCOs to address how they maintain and monitor a DSN of appropriate providers (including specific subcontracted activities) to provide adequate access to all covered services, including for enrollees with SHCN.

- Direct the CCOs to use proactive means to monitor providers' compliance with standards of timely access to care and services, such as through regular reporting, access surveys, etc.
- Assist the CCOs in exploring additional means beyond review of grievances to monitor availability of services.
- Direct the CCOs to report how they monitor specific subcontracted activities related to ensuring provider capacity. OHA may need to clarify the intent of this requirement. Many CCOs reported what they were doing to monitor the delegates' provider capacity. The delegates also need to be monitored on their oversight of downstream providers.

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.

OHA's Metrics and Scoring Committee uses 17 CCO Incentive Measures to evaluate Oregon's performance on health care quality and access, and to hold CCOs accountable for improved outcomes. In the 2015 performance measure calculation period, OHA added two measures and dropped two measures. Additional changes were made in 2016 and planned for 2017, but this review covers the 2015 calculation period only.

The 17 incentive measures used in 2015 are listed below. CCOs receive funds from a quality pool based on their performance on these measures and whether the CCOs meet state benchmarks or demonstrate improvement from their own baselines.

- Adolescent well-care visits
- Alcohol or other substance misuse (SBIRT)⁹
- Ambulatory care: outpatient and emergency department utilization
- CAHPS composite: access to care
- CAHPS composite: satisfaction with care
- Colorectal cancer screening
- Controlling high blood pressure
- Dental sealants (*added in 2015*)
- Depression screening and follow up plan
- Developmental screening in the first 36 months of life
- Diabetes: HbA1c poor control
- Effective contraceptive use (*added in 2015*)
- Electronic health record (EHR) adoption
- Follow-up after hospitalization for mental illness¹⁰
- Health assessments within 60 days for children in DHS custody
- PCPCH enrollment
- Timeliness of prenatal care

⁹ Modified in 2015: age reduced from 18 to 12.

¹⁰ Modified in 2015: same-day follow-up services added to the numerator.

Scope of the Review

Seven of the 17 measures were calculated using *only* encounter data that OHA collects and maintains. Per OHA's instruction, HealthInsight validated only those seven measures. The remaining 10 measures are calculated with clinical data collected by 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 combined encounter data with one or more of these alternate data sources.

Validation Results

Dental sealants and effective contraceptive use were new measures in 2015, and as such, they received full validation by OHA. All other existing measures received a full validation in 2014 and varying degrees of validation in 2015, depending on the scope of measure specification changes from previous years.

The full validation process is quite comprehensive. 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 sends the same data 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's results are within 3% of CORE's results, at which point OHA approves the CORE code.

Once approved, CORE publishes CCO-specific results to a CCO-specific dashboard housed in an online data repository called Business Objects. The CCOs are invited to validate their results by downloading member-level data from the dashboard, which includes flags for members in the numerator and denominator of each measure. Many CCOs ran their own measure code in-house and compared 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 Corp. (Q Corp), through its contractor Milliman, validated the metric code and results as well. Milliman

validated the measures using data sent by OHA, writing its own code in collaboration with Q Corp. This additional validation was performed only for the new incentive measures in the 2015 calculation period.

In October 2015, CMS issued the International Classification of Diseases, 10th Revision (ICD-10) for medical coding and reporting, replacing the ICD-9. This change affected the codes used to identify patients in the numerator and denominator of many measures. OHA created crosswalks to validate the new code sets used to identify patients in the numerator and denominator.

In past years, performance measures have been scored “partially met” because of concerns about data integrity and completeness and concerns about a limited and undocumented validation process. As OHA has made substantial improvements in both areas, all seven performance measures are scored as “substantially met” this year (see Table 2). The code review and measure calculation process for these measures was adequate, but the measures are not scored as “fully met” because HealthInsight Oregon still has concerns about the validity of the data used to calculate the measures.

Incentive measures are now reported according to member race and ethnicity as identified on the Medicaid enrollment forms. This is a positive step forward in addressing health equity. However, member race and ethnicity are not required fields on the enrollment forms, so information is missing for a large proportion of Medicaid enrollees, rendering these stratified results unreliable.

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. This is important because performance measure calculations based on incomplete or inaccurate data will not yield valid results. OHA recognizes these deficiencies and has plans to address them at the state level, as follows.

First, encounter data staff in the Service Data Reporting Unit of OHA’s Health Systems Division will be reorganized into entry-level and senior-level positions, performing data mining and providing better monitoring of incoming encounter data. This is commendable, but the CCOs are also responsible and should be held accountable. Conducting an encounter data validation (EDV) would enable CCOs to identify and correct any anomalies before sending data to the state, and

to identify encounters that were rejected. OHA does not currently require CCOs to conduct EDV.

Second, OHA plans to rework the 1% withhold rule. Currently, CCOs are subject to financial withholds for late encounter submissions, and thus appear to be incentivized *not* to submit encounters if they are late. This creates a risk of calculating performance measures on the basis of incomplete data (in addition to lower capitation payments to the CCO). The planned rule revision would make adjudication part of the withholding rule. This change is intended to reduce the number of pended encounters, improving the completeness of OHA’s encounter data.

The CCO validation process is laudable and appears effective in increasing the validity of the metrics as new members are discovered to enter the numerator and denominator. However, the QI processes implemented to find these members should encompass the entire system, ensuring that all data are complete and valid, not only those data that inform the incentive measures. An all-encompassing QI initiative would also reduce the burden on CCOs to validate member-level data for each performance measure.

Table 2 shows the validation ratings for each of the seven performance measures reviewed from the 2015 measurement year.

Table 2. Performance Measure Validation Ratings, 2016.		
Measure	Status	Compliance Rating
Adolescent well-care visits	Complete validation by OHA	Substantially met
Alcohol or other substance misuse (SBIRT) ¹¹	Complete validation by OHA	Substantially met
Ambulatory care: emergency department utilization	Complete validation by OHA	Substantially met
Dental sealants	Complete validation by OHA	Substantially met
Developmental screening in the first 36 months of life	Complete validation by OHA	Substantially met
Effective contraceptive use	Complete validation by OHA	Substantially met
Follow-up after hospitalization for mental illness	Complete validation by OHA	Substantially met

¹¹ In advance of the 2017 incentive measure calculation year, the Metrics and Scoring Committee voted to remove the SBIRT measure due to data completeness shortcomings identified through OHA’s validation process.

Recommendations

- OHA should document processes, policies and procedures specific to each performance measure, specifying 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 is documented and consistent
 - current relationships with external partners are documented, as are any future changes in associations, roles or responsibilities
- OHA should either conduct an EDV or require the CCOs or a third party to conduct an EDV, to ensure submission of complete and valid encounter data to OHA
- OHA should follow through with its plans to reorganize staff in the Service Data Reporting Unit and to rework the withholding rule.
- OHA should require race and ethnicity fields to be completed on Medicaid enrollment forms.

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 organization “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, and Exhibit B–Part 8, 7.c–d).

In 2016, HealthInsight Oregon conducted a full ISCA review of both OHA’s data management and reporting systems and those of the individual CCOs. Results of those reviews are summarized below.

Review procedures

HealthInsight Oregon organized the ISCA in 10 sections, each of which contains review elements corresponding to relevant federal standards.

- Information Systems
- Staffing
- Configuration Management (hardware systems)
- Security
- Administrative Data (claims and encounter data)
- Enrollment Systems (Medicaid eligibility downloads)
- Vendor Data Integration and Ancillary Systems
- Report Production and Integration and Control of Data for Performance Measure Reporting
- Provider Data
- Meaningful Use of Electronic Health Records

HealthInsight Oregon’s review drew on information that OHA or the CCO provided in the ISCA questionnaire; interviews with the organization’s staff, partners and providers; and the results of a security walkthrough of data center facilities operated by the CCO. Within each review section, HealthInsight Oregon scored each element on a scale from 1 to 3 (see Table 3).

Table 3. Scoring Scheme for ISCA Elements.		
Score	Rating	Definition
2.6–3.0	Fully met (pass)	Met or exceeded the element requirements
2.0–2.5	Partially met (pass)	Met essential requirements of the element, but is deficient in some areas
< 2.0	Not met (fail)	Did not met essential requirements of the element
–	N/A	Not applicable

State-level ISCA review results

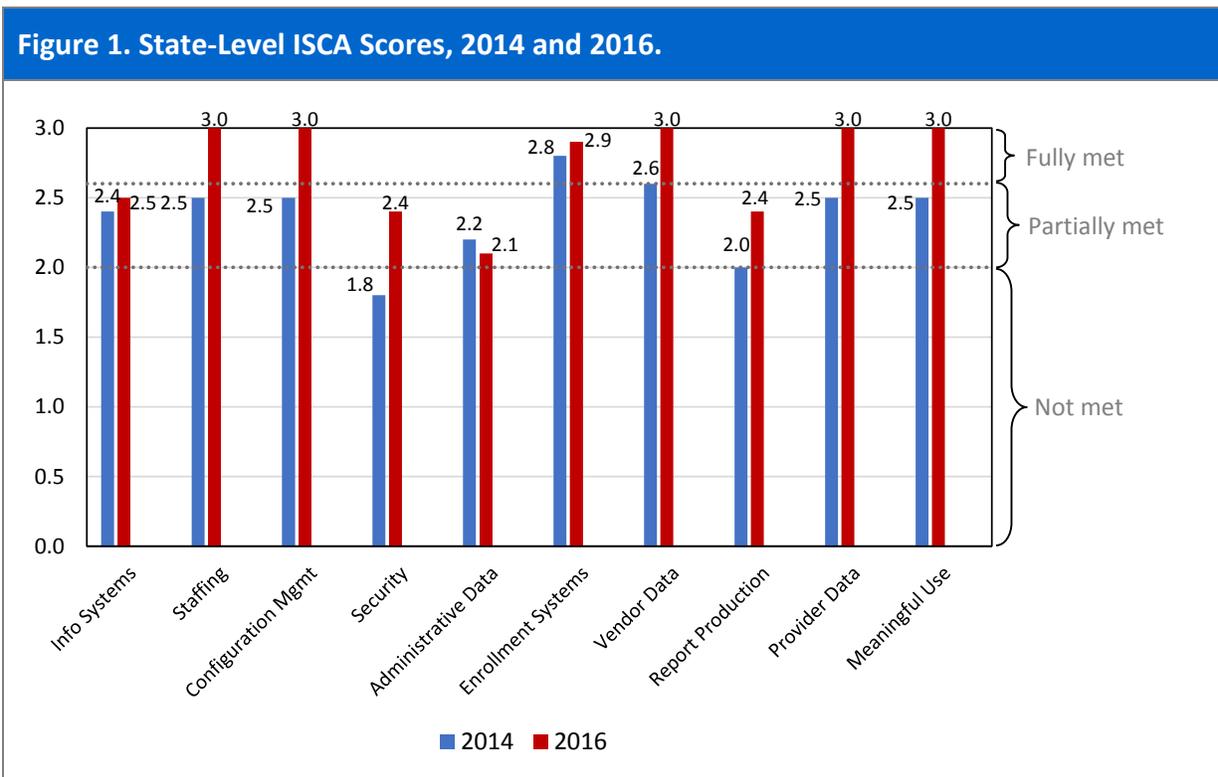
Figure 1 below shows OHA’s scores from the 2016 ISCA review, compared with scores from the 2014 review. As shown, the scores have improved in all review sections except Administrative Data, with all sections now rated either fully or partially met.

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. 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 a state-level business continuity/disaster recovery (BC/DR) plan to ensure the preservation of data in Medicaid information systems
- lack of a requirement for individual CCOs to maintain working BC/DR plans and to test the plans regularly
- non-performance of encounter data validation (EDV) to ensure accuracy and completeness of encounter data submitted by CCOs to OHA
- uncertainty as to whether CCOs are receiving notification of receipt of their data files and the transaction status of claims/encounters in the files

See Appendix C for additional details.



CCO-level ISCA review results

The CCO profiles in Appendix A summarize each CCO's ISCA results. High-level results are summarized below.

IT systems integration. Overall, the CCOs have made significant progress in integrating all required services and associated claims/encounter data into their IT systems. Most CCOs have successfully integrated mental health and dental data into their IT systems and reporting. Some CCOs have integrated NEMT data, while others continue to work toward that goal.

Less than complete integration of all services into the CCOs' IT systems has impeded the efficiency of CCO reporting as workloads have continued to expand. Many CCOs have collaborative relationships with multiple partner organizations, adding complexity to this task. The CCOs need to improve their understanding of service authorization processes, eligibility data flow and data validation for all services in order to perform appropriate monitoring and oversight of in-house and outsourced services.

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 and flow of encounter data. Some CCOs continue to work on enhancing their documentation and processes for certifying encounter data.

OHA needs to:

- clarify its expectation of requirements for certifying encounter data completeness, accuracy and truthfulness
- ensure that CCOs have appropriate documentation (such as a data flow diagram) to establish the sources of all types of encounter data

EDV. OHA does not require CCOs to validate their encounter data against clinical records, nor does OHA validate the submitted data. OHA should determine where in the claims life cycle this validation should occur and who should perform this activity.

OHA needs to:

- either conduct EDV or require the CCOs or a third party to conduct EDV, to ensure submission of complete and valid encounter data to OHA
- communicate its expectations of EDV performance to the CCOs

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 in monitoring the 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 reported that it does not have a contractual requirement for the CCOs to maintain BC/DR 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 have BC/DR plans that address all CCO activities and that the plans are tested annually or whenever a plan is updated
- 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 on the part of their partner organizations

Provider directories. The CCOs continue to work to develop integrated and accessible directories with practitioner-level details for all CCO services. Some CCOs need to make it easier for members to search for providers. Directories are required to include certain information for all types of providers (physical health, behavioral health and dental), including specialty, languages spoken and provider type. In addition, including the practitioner’s gender in directories would enable members to make more informed choices.

OHA should add language to the CCO contract to require provider directories to include each practitioner’s gender. OHA also should work with CCOs to:

- make it easier for members to search for all type of providers (physical health, behavioral health, and dental)
- ensure that provider directories present information on practitioners’ specialties, languages spoken, provider type and gender
- develop and implement formal processes for updating provider directories

Zero- and low-dollar claims. OHA reported that the CCOs are required to ensure that providers submit zero-dollar claims. The CCOs and OHA were not able to confirm that all providers were submitting all such claims. OHA should evaluate adding language to the CCO contract requiring CCOs to monitor providers for submission of zero-dollar claims.

OHA needs to work with CCOs to:

- ensure that all partner organizations understand that zero- and low-dollar claims must be submitted to OHA
- develop standards and policies for providers related to zero- and low-dollar claims
- continue to monitor for and resolve issues related to failure to submit zero-dollar claims

Table 4 lists major areas for improvement noted in the CCO ISCA reviews, with associated recommendations.

Table 4. CCO-Level ISCA: Major Areas for Improvement and Recommendations.	
Improvement Area	Recommendations
<p>CCO monitoring of delegates’ IT activities <i>OHP 410-141-0180(1)</i></p> <p>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.</p>	<ul style="list-style-type: none"> • CCOs should maintain written policies and procedures describing how they maintain the security of records as required by HIPAA and other federal regulations. • CCOs should communicate these policies and procedures to their delegates, partners, providers and third-party administrators. • CCOs should regularly monitor compliance with these policies and procedures and take corrective action where necessary.
<p>Encounter data validation (EDV)</p> <p>Almost all CCOs do not conduct EDV to verify the accuracy and completeness of encounter data against 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 captured and reported.</p>	<ul style="list-style-type: none"> • CCOs should work with their providers to ensure that all data submitted to OHA are accurately processed and included in the state data set. • CCOs should develop and implement processes 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.
<p>Monitoring of zero-dollar claims</p> <p>Most CCOs did not provide evidence of monitoring and oversight of partners’ and providers’ practices regarding submission of zero-dollar claims. Multiple provider and partner organizations reported that they did not report zero-dollar claims.</p>	<ul style="list-style-type: none"> • CCOs should work with partner and provider organizations to ensure that all Medicaid encounters are submitted to OHA, regardless of 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.
<p>Provider policies <i>OAR 943-120-0170(2)</i></p> <p>Most CCOs need to address security issues related to maintaining policies and procedures and monitoring the IT practices of provider and partner organizations.</p>	<ul style="list-style-type: none"> • CCOs should implement formal processes to regularly review and update their IT policies and procedures. • CCOs should monitor provider and partner organizations’ performance with regard to: <ul style="list-style-type: none"> ○ verifying eligibility at the time of service ○ data breach reporting strategies ○ updating and regularly testing BC/DR plans ○ password complexity standards, forced-change practices and multi-factor authentication processes in alignment with business standards ○ encrypting protected health information and/or portable media ○ hardware destruction and disposal

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 protocol. HealthInsight Oregon is responsible for facilitating and documenting the PIP. The CCOs are responsible for developing interventions that meet local community needs (Standard 8 of the PIP protocol) and for documenting the development and implementation of their interventions in quarterly reports to OHA.

In addition to the Statewide PIP, CCOs are required to conduct two PIPs and one focus project of their choice on topics from the list of seven QI focus areas. In 2016, HealthInsight Oregon began evaluating these CCO-specific projects and providing OHA with recommendations for follow-up.

Statewide PIP: Improving the Safety of Opioid Management

Discussions about topic selection for the second Statewide PIP were held at QHOC meetings in spring 2015. After reviewing CCOs' feedback about possible metrics and dosage thresholds, as well as data provided by the Office of Health Analytics, CCO QI directors selected the following PIP study metrics:

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

Percentage of Medicaid enrollees who filled prescriptions totaling ≥ 90 mg MED on at least one day within the measurement year

In addition to the study metric data, OHA collected and reported data on two supplemental metrics (percentage of Medicaid enrollees on dosages of ≥ 120 mg and on ≥ 90 mg MED for 30 or more consecutive days) to track progress on addressing this subpopulation at the state and CCO levels.

Technical assistance

HealthInsight Oregon continues to provide support and technical assistance to the CCOs in presentations at monthly QHOC meetings and in technical assistance meetings and calls with individual CCOs.

QHOC meeting topics have included development and implementation of non-opioid therapies, overview of medication-assisted treatment (MAT), elements of a successful MAT program, updates from Oregon researchers on opioid prescribing, general themes from CCO progress reports and revisions of the PIP quarterly report template.

From the inception of the Statewide PIP, HealthInsight Oregon has offered CCOs individualized technical assistance meetings quarterly or upon request. In 2016, HealthInsight Oregon met with representatives from all CCOs at least once, and most CCOs took part in several technical assistance meetings.

Standard 8 validation and scoring

Following the first remeasurement period (January 1–December 31, 2016), HealthInsight Oregon evaluated each CCO's Standard 8 Part 1 and January 2017 quarterly report submissions for the degree of completeness of each of the Standard 8 criteria (see Appendix B, Attachment G). Each CCO received a rating

of met, partially met or not met for each of the Standard 8 criteria and a summary of strengths and opportunities for improvement. All CCOs had the option of either accepting their initial evaluation or resubmitting their Standard 8 documentation for re-evaluation. Five of the 16 CCOs asked to be re-evaluated on their January 2017 quarterly reports.

Overall, CCOs did a good job of conducting data and barrier analyses linking their analyses to expected improvement in the study indicator, developing interventions to address aspects of the opioid problem and describing any barriers encountered in implementing those interventions. The areas of cultural and linguistic appropriateness and tracking and monitoring criteria were the most challenging for CCOs.

Following is a brief review of high-level themes drawn from the CCO quarterly reports. An extensive discussion of CCO interventions, barriers and next steps can be found in the Statewide PIP report, Appendix B.

Interventions. The CCOs developed interventions to address barriers and contributing factors identified from root cause and barrier analyses. All CCOs implemented prior-authorization processes and quantity limits as a first step in improving opioid safety, with many having done so before the start of this PIP. Other common interventions included:

- sending letters to providers and members about changes to opioid policies, community resources and alternative treatment options
- requiring taper plans for members with high opioid use
- conducting or sponsoring Pain/Opioid Summits and provider training
- identifying high opioid prescribers and providing education and problem-solving
- disseminating materials in different formats to the community about the risks of prescription opioids
- collaborating with other CCOs, local health departments and community-based organizations to coordinate efforts and prevent duplication

Almost all CCOs solicited the participation of substance use disorder organizations and staff in discussing strategies to increase access to MAT. Behavioral health staff were involved in training providers about substance use and how to have difficult conversations with members. A few CCOs conducted trainings for dental providers and included dental providers in the distribution of opioid use dashboards.

The most common barrier encountered in implementing the interventions was staff turnover. Other barriers included competing priorities, scheduling conflicts, difficulty coordinating with different departments, difficulty in developing accurate data reports, high costs of materials and inclement weather. Few CCOs reported having encountered provider resistance or noncompliance. In their progress reports, most CCOs described how they anticipated provider concerns and mitigated risks by implementing provider training and education.

Statewide PIP results

Study time periods.

- Baseline measurement: January 1–December 31, 2014
- First remeasurement: January 1–December 31, 2016
- Second remeasurement: January 1–December 31, 2017

CCOs, OHA and HealthInsight Oregon agreed on the date range for the first remeasurement period based on the expected date for many of the CCOs to begin implementing their interventions. A non-consecutive baseline measurement period was selected because a longer period of time would allow CCOs that had already worked on the study topic for several years more opportunity to demonstrate improvement in the study indicator.

At the time of this report, complete first remeasurement (calendar year 2016) results were not available due to lag in receipt of claims data.

Interpretation of results. The remeasurement period analyzed for the PIP report (December 1, 2015–November 30, 2016) is not strictly comparable to the baseline measurement period as it is not the 2016 calendar year. However, tentative conclusions can still be drawn about the data, as CCOs had not reported significant changes in interventions or barriers as of December 2016.

Data analyses showed that the percentage of enrollees aged 12 and older who filled opioid prescriptions for both ≥ 120 mg and ≥ 90 mg MED fell significantly ($p < .001$) between baseline and current remeasurement.

As shown in Figures 2 and 3, the study denominators for both metrics increased from December 2014 to March 2016 and then decreased steadily month-to-month through November 2016.

Figure 2. Aggregated Statewide Results for ≥ 120 mg MED Metric from Baseline to Remeasurement Period.

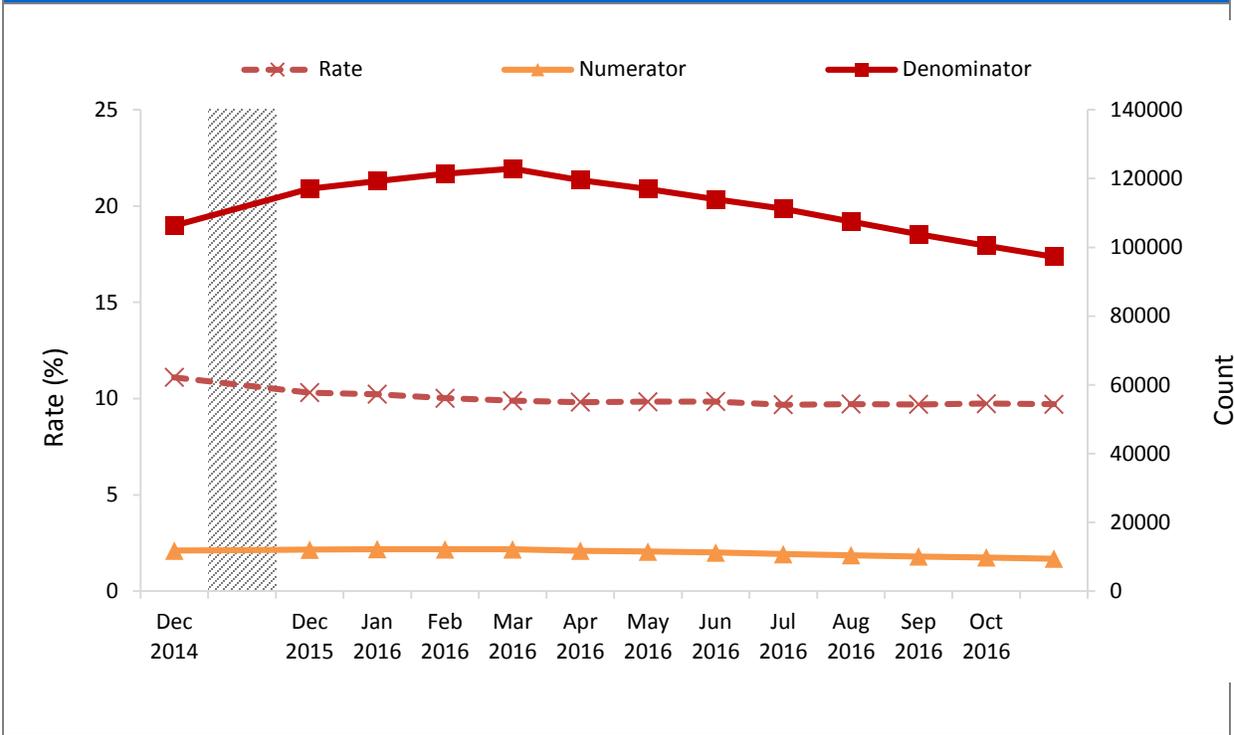
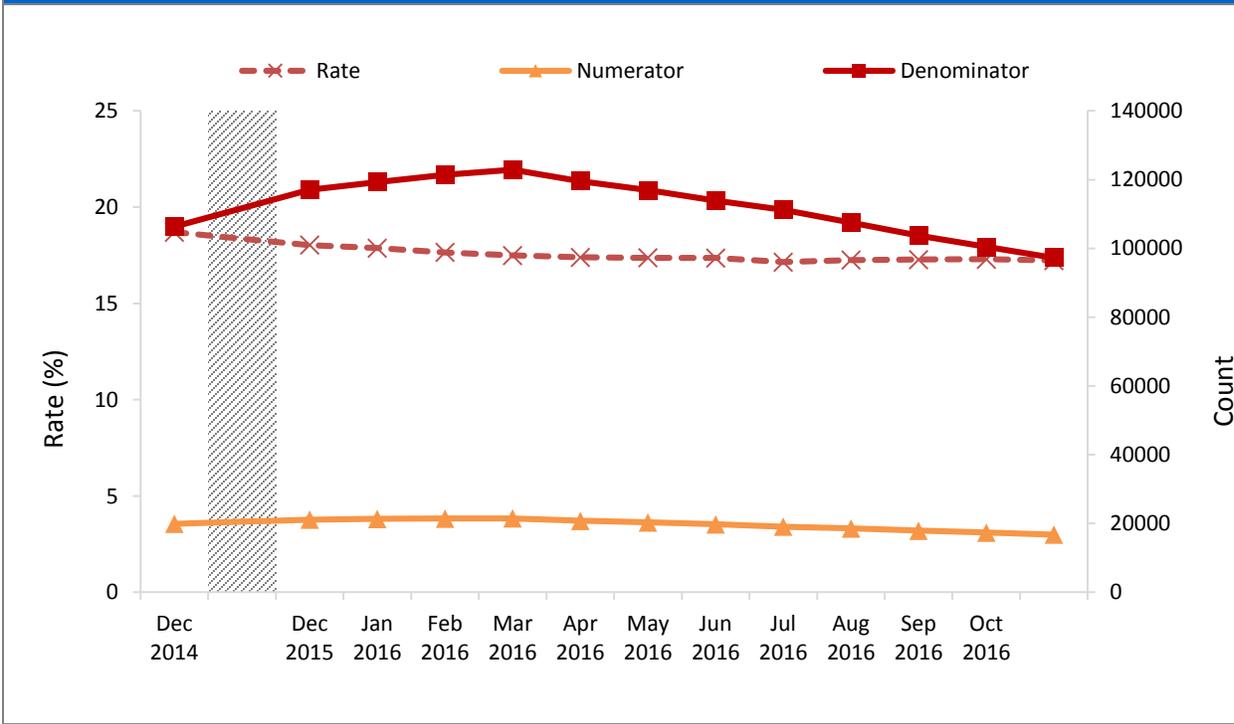


Figure 3. Aggregated Statewide Results for ≥ 90 mg MED Metric from Baseline to Remeasurement Period.



The increase in the aggregated study denominator from 2014 to 2015 can be accounted for by the increase in CCO enrollment and by the year-long (2015) incorporation of dental claims into CCO claims. It is not clear why the study denominator continued to increase until March 2016.

There was a notable decrease in the number of enrollees in the ≥ 120 mg MED and ≥ 90 mg MED aggregated study numerators from 2014 to 2015, followed by a very small monthly decrease through November 2016.

Data analyses of the two supplemental measures showed that the percentage of enrollees age 12 and older who filled opioid prescriptions for both ≥ 120 mg and ≥ 90 mg MED for consecutive 30 days or more fell significantly ($p < .001$) between baseline and current remeasurement. The supplemental measures displayed a trend similar to the study metrics, i.e., significant decrease in study denominator, slight decrease in the study numerators.

Because of the disproportionate decreases in the study denominator versus the numerators, it is important to examine both the counts as well as the rates when interpreting results, especially in the case of CCO-level data. For example, several CCOs saw a very small increase in both study metric rates from baseline to current measurement, yet data analyses showed a decrease in both the number of enrollees in their denominators and ≥ 120 mg MED and ≥ 90 mg MED numerators. The amount of opioids in circulation would be expected to decrease more quickly than the number of members being tapered off chronic doses of high opioids. A number of CCOs implemented taper plans of several months' duration that did not begin until late 2016, and the effect of those interventions might not be reflected in their rates until the second remeasurement year.

Additional analyses of the aggregated and CCO-level study data appear in the Statewide PIP report, Appendix B.

According to their January 2017 progress reports, most CCOs have succeeded in implementing interventions that address different aspects of the opioid problem in their communities. While it is reasonable to attribute improvement in the study indicators to CCO interventions, the degree to which CCO interventions are responsible for the change is not clear. Local, state and federal organizations have also implemented interventions as part of their own strategies to address opioid misuse and abuse, independent of the CCO-initiated interventions.

In addition to the effect of non-CCO interventions on study results, other limitations need to be considered. Medicaid claims do not capture cash payments by members for prescription opioids, and no readily available data exist for this subpopulation. Members might be included in the numerator because they appropriately received high doses of opioids for pain due to an active malignancy, but had not yet received exclusion diagnoses (e.g., palliative care). The study metrics address only a narrow aspect of the opioid problem (dosage thresholds and chronic high use) and do not reflect CCO progress on other and equally important opioid safety issues, such as co-prescribing with a benzodiazepine and the transition from naïve to chronic use.

Even taking the above limitations into account, the statistical tests, trends over time and individual CCO progress reports demonstrate improvement in the safety of opioid management at the state and CCO level. If CCOs continue to develop and implement intervention strategies as planned, improvement in both study indicators can be expected.

Future steps

1. HealthInsight Oregon will continue to offer technical assistance meetings to the CCOs on a quarterly basis or upon request.
2. HealthInsight Oregon will present Statewide PIP study results and facilitate a discussion of next steps at an upcoming QHOC meeting.
3. CCOs will continue to develop and modify interventions and to document progress in quarterly reports to OHA.
4. OHA will continue to provide each CCO with rolling monthly reports on both study indicators and the supplemental consecutive 30 days or more measures.

Recommendation

Based on the quarterly reports submitted by CCOs and the technical assistance meetings to date, HealthInsight Oregon recommends that OHA encourage CCOs to participate in technical assistance meetings with HealthInsight Oregon so that documentation issues, study modifications and/or problems with data can be addressed in a timely manner.

CCO-Specific PIPs and Focus Projects

Each CCO is required to provide quarterly reports on two additional PIPs and one focus project. In August 2016, HealthInsight began evaluating all CCO-specific PIPs and focus projects and providing assessments to OHA. OHA is responsible for providing direct technical assistance to CCOs.

Table 5 lists the topics of CCO-specific PIPs conducted in 2016, which sought to address various issues of health care access, timeliness and quality. The topics of these PIPs and of CCO focus projects are also shown in the individual CCO profiles in Appendix A.

Table 5. CCO-Specific PIP Topics and Objectives.

PIP Topic (CCO)	Objective
Addicted Newborns (UHA)	Increase the number of women receiving first trimester prenatal visits and drug screenings, and reduce the number of newborns born with substance issues.
Adolescent Well Care (PSCS-CG, PSCS-CO, YCCO, AllCare, JCC, EOCCO)	Increase the number of adolescents having an adolescent well-care visit during the measurement year. JCC is also measuring the number of adolescents receiving the alcohol and drug screening questionnaire.
Benzodiazepine and Opioid Co-Prescribing (WOAH)	Reduce the number of members receiving both opioid and benzodiazepine prescriptions.
COPD/Pulmonary Function Testing (CHA)	Increase the number of members with chronic obstructive pulmonary disease (COPD) who have had a pulmonary function test, a guideline requirement for this population.
Colorectal Cancer Screening (AllCare, PHJC)	Increase the number of members with a colorectal cancer screening test within the clinically recommended age group.
Dental Visit During Pregnancy (IHN, PSCS-CO, PSCS-CG)	Increase the percentage of pregnant members who have a dental visit.
Depression Screening (TCHP)	Increase identification and treatment of depression screening for adults in primary care by administering the PHQ-9 screening tool and tracking members with clinical-level results.
ED Utilization (UHA, WVCH, YCCO, IHN, JCC)	Reduce member use of the ED by increasing access to and use of primary care. YCCO is still at the stage of exploring reasons for high ED usage.
Effective Contraceptive Use (PSCS-CO, PSCS-CG, HSO, AllCare, WOAH)	Reduce unintended pregnancy in women of child-bearing age by increasing effective contraceptive use.
Foster Care/APC Collaborative (Health Share)	Design effective models of care for children in foster care so as to improve quality and utilization measures for these children.
Maternal and Perinatal Health (PHJC, EOCCO, JCC, FamilyCare, CHA)	Improve maternal and perinatal outcomes through case management, health education and outreach/incentives.
Mental Health 0–6 (EOCCO)	Increase the number of children age 0–6 who receive needed mental health services.
Patient-Centered Primary Care Home (WVCH, UHA, YCCO)	Increase the number of providers certified as PCPCHs and increase the percentage of enrollees affiliated with a PCPCH.
Reducing Hospital Readmissions (TCHP, WOAH, IHN)	Prevent inpatient readmission through improved discharge and transition planning and closer communication with primary care.
SBIRT (Adult)/CRAFT (Adolescent) Substance Use Disorder Screening (CPCCO)	Increase the number of members age 12 years or older who are screened for substance abuse and the number of those identified and referred to substance use treatment.

PIP Topic (CCO)	Objective
Serious and Persistent Mental Illness/Metabolic Screening (FamilyCare)	Continues topic of the first Statewide PIP to increase screening rates for hyperlipidemia and diabetes among members with serious and persistent mental illness who are prescribed two indicator mental illness medications.
Substance Use During Pregnancy (Health Share)	Improve outcomes for pregnant, substance-using women and their babies.
Tobacco Use/Cessation (TCHP, FamilyCare, CPCCO, WVCH)	Reduce tobacco use prevalence among CCO members by increasing the use of tobacco cessation programs.
Trauma-Informed Care (CPCCO)	Conduct provider training to increase the number of providers who practice trauma-informed care.

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 includes commissioners from Columbia, Umatilla and Union counties, plus provider and consumer representatives. Most MHO activities are delegated to the county mental health authorities, which receive a capitation payment to deliver services for enrollees.

Compliance follow-up review summary

In 2016, HealthInsight Oregon followed up on findings and recommendations of the 2014 and 2015 compliance reviews. The follow-up review found that GOBHI had made progress in addressing many findings that were carried over from 2012. Several findings from 2012 remained unresolved or only partially resolved. More work is needed to bring GOBHI into full compliance with its MHO contract and federal Medicaid regulations.

Delivery network

GOBHI lacks access to management reports to assess MHO enrollees' needs and expected service utilization. GOBHI submitted no documentation to demonstrate that it conducted assessments of network adequacy.

Policies and procedures

At the time of the 2015 review, many of GOBHI's policies and procedures were still in draft form. In 2016, GOBHI submitted many policies that were approved shortly before the follow-up review and had not yet been implemented. Only one of the policies submitted directly addressed MHO enrollees.

GOBHI reported that it had empowered its Quality Improvement Committee (QIC), rather than the MHO board of directors, to approve policies. The QIC's charter does not list approving policies and procedures among its duties. QIC minutes revealed that some policies discussed were actually EOCCO or CPCCO policies. The minutes documented that GOBHI staff had informed QIC members that GOBHI as an MHO is "held to the same standards."

- *GOBHI needs to review all policies to determine whether they apply to MHO enrollees.*

Tracking of second opinions, seclusion and restraint and access to interpretation and materials in alternative formats and languages

OHA requires managed care plans to track this information and use it to inform assessments of network adequacy. GOBHI submitted an Excel spreadsheet as documentation of its tracking of these items, but the spreadsheet contained no data on seclusion and restraint use, second assessment denials, member grievances or requests for information in alternative formats during 2014–2015. GOBHI appeared to be tracking grievance codes for some items for which there are no grievance codes.

- *GOBHI needs to develop effective mechanisms to track the required items for MHO enrollees.*

Oversight of delegated activities

GOBHI has created a delegation agreement for its providers to sign. This agreement refers to GOBHI’s MHO contract, but the Statement of Work refers exclusively to CCO-related requirements. The document does not specify the activities GOBHI has delegated to the CMHPs for MHO enrollees.

- *GOBHI needs to ensure that the CMHPs know what services are delegated, how GOBHI will track the CMHPs’ performance of those activities and the steps GOBHI will take if the CMHPs do meet the performance expectations in the agreement.*

GOBHI plans to de-delegate certain functions. However, at the time of the follow-up review, only a few functions had been centralized. The MHO has made little progress in the oversight of delegated activities.

- *GOBHI needs to conduct an annual evaluation of all delegated functions.*

Practice guidelines

GOBHI submitted a list of clinical practice guidelines that contained hyperlinks to websites. HealthInsight Oregon tested the links and found that many were broken or connected to a bookstore where one could buy the guideline. The title page for the recently adopted guideline for suicidality said the guideline “is more than 5 years old and has not yet been updated to ensure that it reflects

current knowledge and practice.” In accordance with national standards, this guideline can no longer be assumed to be current.

- *GOBHI is encouraged to review its practice guidelines to ensure that they are current, and implement a dissemination method.*

Oversight of quality management program

GOBHI’s QIC includes a representative of the board of directors. According to the QIC minutes submitted, this representative reported board activities to the QIC. However, no documentation was submitted to demonstrate that this representative reported QIC activities to the board.

Board minutes documented oversight of GOBHI’s CCO relationships, but not of the MHO contract or GOBHI’s MHO quality management program.

- *GOBHI needs to develop mechanisms that demonstrate oversight of the quality management activities of GOBHI as an MHO.*

Management data specific to MHO enrollees

GOBHI staff reported development of an information system that will produce performance reports. GOBHI lacks the ability to stratify its data to report on MHO enrollees. No data specific to MHO enrollees were submitted during the 2014 or 2015 reviews. GOBHI submitted one aggregate report of MHO grievances for the 2016 follow-up review.

At the time of review, GOBHI lacked data on access, utilization and quality of care delivered to MHO enrollees with SHCN.

- *GOBHI needs to ensure the quality and appropriateness of services delivered to MHO enrollees.*

PIP validation summary

OHA requires GOBHI to conduct two PIPs of its choosing each year, one clinical and one nonclinical.

Following the 2015 review, HealthInsight Oregon (then Acumentra Health) recommended that GOBHI select two new PIP topics for 2016 that would target a significant number of MHO enrollees and could significantly affect enrollee

health, functional status or satisfaction. In response, GOBHI analyzed its MHO-only member population and identified the new topics listed below.

As of the 2016 review, GOBHI had not developed either PIP beyond identifying and justifying the study topic (Standard 1 of the review protocol). By the time of the 2017 review, GOBHI is expected to have completed Standards 2–5 (study design) and 8 (improvement strategies) and to have supplied partial information for Standards 6 (study results) and 7 (interpretation of results).

1. Older Adult PIP

GOBHI's data review indicated underutilization of mental health services by adults over age 60. The MHO decided to focus this PIP on improving the service penetration rate for this population. GOBHI stated that its first step would be to identify the causes of low referrals and utilization. This topic clearly relates to quality of care for MHO enrollees since the target population does not appear to be receiving needed services. HealthInsight Oregon reviewed GOBHI's documentation and assigned a score of 85 (Substantially met) for Standard 1.

2. Children 0–6 Years Old Primary Care PIP

GOBHI's data review indicated underutilization of services by young Hispanic children (0–6 years of age). This PIP will focus on improving the service penetration rate for young Hispanic children in Umatilla and Malheur counties, the counties with the highest percentage of GOBHI's target population. GOBHI documented the importance of the topic, its relevance to the local MHO population and the topic prioritization process. The MHO identified a possible root cause for lower access by this population and briefly described its selected intervention. HealthInsight Oregon assigned a score of 100 (Fully met) for Standard 1.

ISCA summary

The ISCA review focused on processes related to GOBHI's MHO population. GOBHI uses similar IT practices for some CCO activities, which are covered in the individual CCO reviews.

GOBHI is working toward NCQA certification with a target review date of summer 2017. At the time of the ISCA review, GOBHI was formalizing and aligning its policies and procedures to NCQA standards.

GOBHI has struggled to remediate issues identified in the ISCA reviews from year to year. The MHO has taken steps to address some issues, but many have remained unresolved for several years.

GOBHI has increased its staffing in the past two years, adding a new IT director and several additional IT staff members who have responsibilities not only for the MHO, but for other GOBHI lines of business.

Summary of data systems

GOBHI outsources claims processing, encounter verification and data submission, enrollment verification and fee-for-service payments to PH Tech, a third-party administrator. The ISCA review reflected GOBHI's internal reporting, PH Tech's data processing and reporting procedures and GOBHI's oversight and monitoring of PH Tech-contracted services.

GOBHI's staff has begun making authorization decisions in PH Tech's Community Integration Manager. Previously, GOBHI's CMHPs performed service authorizations.

GOBHI provides and hosts email services for its provider network. Provider agencies can choose to have a GOBHI email address or to have their domain hosted by GOBHI.

Data certification and submission

GOBHI's encounter data liaison signs the certification of claims and encounter data. PH Tech submits mental health and addiction data to OHA, and GOBHI receives a copy of the submitted data.

Reporting data

GOBHI staff maintains an internal data warehouse for reporting data, loading the reporting data from PH Tech. GOBHI receives enrollment updates daily. Claims and encounter data are loaded when received, often weekly or more frequently. GOBHI staff maintains and write reports from this database. GOBHI has hired a new person to develop the reporting capabilities.

GOBHI is working with Arcadia Solutions to implement a new data warehouse. GOBHI intends to supplement in-house reporting capabilities with Arcadia; this solution is not meant to replace the internal reporting capabilities. This hosted solution will receive data from GOBHI, PH Tech and GOBHI provider agencies.

GOBHI intends for this data warehouse to include not only claims and encounter data, but clinical data stored in the providers' EHR systems. GOBHI hopes this data warehouse will enhance capabilities to verify completeness of encounters and perform more timely clinical interventions or record reviews.

GOBHI's profile in Appendix A presents the MHO's scores on each section of the ISCA review protocol.

DISCUSSION AND OVERALL RECOMMENDATIONS

HealthInsight Oregon and the CCOs have completed the first three-year cycle of EQR reviews since the CCOs were formed. In total, the reviews have covered the CCOs' compliance with state and federal standards for Enrollee Rights, Grievance Systems, Certifications and Program Integrity and QA/PI; validation of CCO performance measures adopted by the state, including two full ISCA reviews of OHA and CCO information systems; and work the CCOs have performed as part of two Statewide PIPs.

These reviews have revealed many successes and challenges as the CCOs strive to transform the delivery of health care for a greatly expanded population of Medicaid recipients. Following the 2016 review, HealthInsight Oregon offers the following recommendations for OHA to help the CCOs address the program areas in greatest need of improvement.

Ongoing Service Integration

The overarching need for ongoing improvement is to finish integrating the required services into the CCO benefit package and delivery systems. CCOs have made substantial progress with mental health service integration and need to continue those efforts. Integration of substance abuse disorder treatment, dental and NEMT services is less complete.

The CCOs have made progress in integrating data on physical, behavioral and dental health services. However, more work is needed to ensure that CCOs can use the data to manage care for enrollees, including those with SHCN.

Moving forward, the CCOs need to continue to work on integrating all required services at the administrative and service delivery levels, and on integrating these services into the CCOs' electronic clinical data systems. CCOs should ensure that all providers and delegates are aware of the expectations for care integration, and that services delivered across the entire network are aligned with the CCOs' policies and procedures.

- *OHA needs to continue to support the CCOs in developing integrated policies and procedures, data systems, network and capacity planning and care coordination for all required services.*

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

Access to Care

During 2016, most CCOs did not monitor contractual requirements for provider network access. Some CCOs lacked system-wide mechanisms to monitor network capacity in order to identify service gaps or disparities. Few CCOs' policies and procedures for providing direct access to specialists addressed access to behavioral health and dental care specialists.

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. Although avoidable ED utilization has declined, most CCOs reported an increase in overall ED utilization from 2015 to mid-2016.

More work is needed to improve access to care in rural areas, and to improve processes for identifying and coordinating care for members with SHCN.

- *OHA needs to provide the CCOs with clear direction on monitoring their provider network capacity to ensure timely access to required services for all members.*

Oversight of Delegated Functions

Though CCOs may subcontract many activities to outside entities, the CCO is responsible for all duties and responsibilities included in the managed care contract, and must monitor subcontractors' performance. Many CCOs lack mechanisms to monitor certain activities that are delegated to partners and providers. Continuing work is needed to ensure that delegated functions such as utilization management, care coordination and provider credentialing are performed as required by contract.

HealthInsight Oregon observed that the CCOs and their delegates handle and monitor physical health and mental health grievances inconsistently. In many instances the CCO's grievance policies and procedures had not been updated to apply to mental health and dental services. CCOs need to continue to work with their partners and delegates to ensure that the grievance system is implemented consistently across all service types.

- *OHA needs to provide guidance to the CCOs on handling and monitoring of member grievances to ensure that grievances are gathered and reported consistently as expected.*

Most CCOs did not provide evidence of monitoring and overseeing their contracted or partner organizations' practices for encounter data submission and IT security.

- *OHA needs to encourage the CCOs to develop processes for monitoring their providers to enforce contractual requirements for timely data submission, IT security and business continuity planning.*

Program Integrity

Many CCOs have effective compliance programs in place for monitoring internal and external risks. However, some CCOs incur significant risk by not screening key personnel monthly for exclusion from federal health care programs, not performing criminal background checks and not monitoring gifts, gratuities and vendor compensations and relationships.

- *OHA needs to clarify its expectations for CCOs to screen key personnel for exclusion from federal health care programs, conduct criminal background checks and monitor for conflicts of interest to reduce CCOs' overall risk.*

Performance Measures

OHA has made substantial improvements in resolving concerns about the integrity and completeness of encounter data. However, HealthInsight Oregon remains concerned about the validity of the data OHA uses to calculate the CCO performance measures.

- *OHA needs to clearly document the performance measure calculation process, including steps to ensure a complete data set, data flow among separate systems and the roles and responsibilities of external partners.*
- *OHA should either conduct an EDV or require the CCOs or a third party to conduct an EDV, to ensure submission of complete and valid encounter data to OHA.*

Incentive measures are now reported according to member race and ethnicity as identified on the Medicaid enrollment forms. This is a positive step forward in addressing health equity. However, member race and ethnicity are not required

fields on the enrollment forms, so information is missing for a large proportion of Medicaid enrollees, rendering the stratified results unreliable.

- *OHA should require race and ethnicity fields to be completed on Medicaid enrollment forms, and should require the CCOs to determine and report members' racial/ethnicity data as part of encounter data.*

Many CCOs lack adequate understanding of documentation of the different sources and flow of encounter data. Some CCOs continue to work on enhancing their documentation and processes for certifying encounter data.

- *OHA needs to ensure that the CCOs implement a certification process to ensure the completeness, accuracy and truthfulness of all encounter data submitted by providers.*

Information System Security

OHA continues to expand and enhance its business continuity/disaster recovery (BC/DR) plan for the Medicaid Management Information System, which was still in draft form at the time of the ISCA review.

- *OHA needs to implement its strategy to recover data in the event of a disaster. OHA should monitor and verify that the plan is tested at least every other year, reviewed at least every two years and updated when significant changes occur.*

OHA does not require the CCOs by contract to maintain BC/DR plans, without which the CCOs risk being unable to fulfill their contractual obligations. OHA noted that CMS has made a rule change requiring Medicare/Medicaid cost centers to conduct more effective BC/DR planning.

- *OHA needs to ensure that:*
 - *CCOs and their delegates have BC/DR plans in place that address all CCO activities and that the plans are tested annually or whenever a plan is updated*
 - *the CCOs review and update their data security policies and procedures, and those of their delegates, at least every two years*

Provider Directories

CCOs continue working to develop integrated and accessible directories with practitioner-level details for all services. Many CCOs have posted directories on their websites, but the online directories often are incomplete, particularly for mental health and dental services. OHA requires directories to include certain information for all types of providers, including specialty, languages spoken and provider type. In addition, including the practitioner's gender in directories would improve members' ability to make informed choices.

- *OHA needs to provide direction to the CCOs on ensuring that their provider directories are easily searchable and contain the required practitioner-level details.*
- *OHA should modify the managed care contract to require CCO provider directories to include each practitioner's gender.*

APPENDIX A. CCO PROFILES

These profiles briefly describe each CCO's organizational structure and summarize the CCO's performance in the review areas covered by the 2016 EQR:

- Follow-up review of compliance with regulatory and contractual standards
- Statewide and CCO-specific performance improvement projects (PIPs)
- Information Systems Capabilities Assessment (ISCA)

High-level results are extracted from the reports of individual health plan reviews that HealthInsight Oregon delivered to OHA throughout 2016. HealthInsight Oregon calculated the scores for these activities using methodology based on the Centers for Medicare & Medicaid Services review protocols and approved by OHA.

Profiles are presented for the 16 CCOs and one managed mental health organization (GOBHI) that served Oregon Health Plan enrollees during 2016.

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AllCare Health Plan	
<p>Mid Rogue Independent Physician Association, doing business as AllCare Health Plan, contracts with OHA to provide physical, dental and behavioral health services for OHP members in Jackson, Josephine, Curry and Douglas counties. AllCare delegates mental health service delivery to Jackson County Mental Health, Curry Community Health and Options for Southern Oregon. The CCO delegates alcohol and drug treatment service delivery to OnTrack and Addictions Recovery Center; dental service delivery to Advantage Dental, Capitol Dental Care, Willamette Dental Group, Moda Health and La Clinica; non-emergent medical transportation (NEMT) to Ready Ride; provider credentialing to PrimeCare and NW Rehab Alliance; and encounter data processing to PH Tech.</p>	
Compliance with Regulatory and Contractual Standards	
<p>During 2016, HealthInsight Oregon followed up with AllCare regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.</p> <ul style="list-style-type: none"> • The CCO resolved 2 and partially resolved 2 of the 4 findings from 2014. • Of 20 recommendations in 2014, 6 were resolved, 10 were partially resolved and 4 were not resolved. • The CCO resolved both of the 2 findings from 2015. • Of 20 recommendations in 2015, 3 were resolved, 15 were partially resolved and 2 were not resolved. 	
Performance Improvement Projects (PIPs)	
Statewide PIP on Opioid Safety	
<p>Interventions:</p> <ul style="list-style-type: none"> • Mailed co-branded letters (with logos of all CCOs in the letterhead) to all providers about the opioid policy guidelines • Mailed co-branded letters and taper forms to providers with patients on high opioid doses about the need to develop taper plans • Developing co-branded educational materials, including a video for staff education and a provider toolkit • Developing co-branded letters and other materials to mail to members 	<p>Barriers:</p> <ul style="list-style-type: none"> • There was uncertainty as to who would own the rights to the co-branded video. It was decided that the Oregon Pain Guidance group would take ownership. • Differences about how the toolkit would be distributed delayed implementation.
<p>Next steps:</p> <ul style="list-style-type: none"> • Continue member education. • Complete the staff educational video and begin dissemination. • Continue to send taper agreement letters and track the number of plans received. 	
CCO-Specific Project Topics	
<p>CCO-Specific PIPs:</p> <ul style="list-style-type: none"> • Increasing the percentage of referrals of pregnant women to community substance abuse programs • Increasing the percentage of member advance directives or Physician Orders for Life-Sustaining Treatment (POLST) 	<p>CCO Focus Area:</p> <ul style="list-style-type: none"> • Increasing PCPCH enrollment

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Fully met (2.9)	Enrollment Systems	Fully met (3.0)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (2.8)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Fully met (2.7)
Security	Partially met (2.1)	Provider Data	Not met (1.8)
Administrative Data	Partially met (2.3)	Meaningful Use of EHRs	Fully met (3.0)
Key Findings and Areas for Improvement			
Finding #1: CCO monitoring of delegated IT activities			
<p>AllCare has developed a new delegation oversight and audit process to monitor IT security practices, policies and procedures of its delegates and partners. The process does not clearly define relationships between the IT and business sides of AllCare, nor the roles and responsibilities for different monitoring activities. AllCare expected the monitoring of delegates' and partners' IT security practices, policies and procedures to be in regular production rotation by late 2016. Through the delegation oversight and audit process, AllCare identified a business partner that lacked formal IT policies, procedures and processes. The business partner reported working to develop and formalize its IT policies, procedures and processes.</p>			
Finding #2: Business continuity/disaster recovery (BC/DR) plans and testing plans			
<p>AllCare reported that it was developing a CCO-level BC/DR plan and planned to create a testing strategy. The CCO has identified an alternate recovery site and is working to document this as part of its project to construct a new office building. Curry Community Health reported that it is working with a contractor to develop and implement a BC/DR plan and a testing plan. Development of this plan was expected to be completed in early 2017.</p> <p>AllCare's provider agencies reported varied stages of BC/DR planning. One agency reported having an informal BC/DR plan but had not developed a testing plan or identified a recovery site. Another provider agency reported having a BC/DR plan but had not developed a testing plan.</p>			
Finding #3: Zero- and low-dollar claims expectations and monitoring process			
<p>AllCare reported that it does not monitor to ensure that all Medicaid claims are submitted to OHA. The CCO has begun educating providers on its expectations regarding zero- and low-dollar claims. PH Tech worked to clarify requirements to match the state expectations. At least one provider agency reported that it does not submit these type of claims or encounters. Curry Community Health reported that it monitors for zero-dollar claims but does not submit such claims.</p>			
Finding #4: Unclear if AllCare is notified when provider leaves Curry Community Health			
<p>Curry Community Health reported that it does not notify AllCare when a provider leaves the agency. AllCare has an informal process of reviewing the credentials of all providers listed in the CCO's provider directory, but the credential review would not ensure the accuracy of the provider directory.</p>			

Cascade Health Alliance (CHA)

CHA, a wholly owned subsidiary of Cascade Comprehensive Care, LLC (CCC), contracts with OHA to provide physical, behavioral and dental health services for OHP members in Klamath County. CCC, a local physician-owned organization, performs all administrative functions for the CCO. Dental care delivery for enrollees is delegated to Advantage Dental and Capitol Dental Care. CHA contracts with Klamath Basin Behavioral Health, Lutheran Community Services, Transformation Wellness Center and individual mental health practitioners to provide mental health and substance use disorder treatment. NEMT service management is delegated to TransLink.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with CHA regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- CHA resolved 1 of the 6 findings from 2014 and partially resolved the other 5.
- The CCO resolved 7, partially resolved 8 and did not resolve 10 of the 25 recommendations from 2014.
- CHA resolved 2, partially resolved 1 and did not resolve 5 of the 8 findings from 2015.
- The CCO resolved 6, partially resolved 11 and did not resolve 23 of the 40 recommendations from 2015.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Integrate CHA’s Pain Committee with Sky Lakes Medical Center to improve efficiency and reduce duplication
- Develop point-of-sale prior authorization guidelines for opioid prescriptions \geq 90 mg MED
- Add non-opioid treatment options to formulary
- Add alternative treatment providers to network

Barriers:

- Lack of a full-time pharmacist has delayed integration efforts
- Difficulty finding alternative treatment providers to sign long-term contracts

Next steps:

- Once pain committees have been integrated, begin tracking pain contracts and tapering plans for members on \geq 90 mg MED.
- Begin implementing point-of-sale prior authorization guidelines at Klamath Basin pharmacies.
- Negotiate short-term contracts with alternative service providers.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improve timeliness of prenatal care
- Increase percentage of members with chronic obstructive pulmonary disease who receive a pulmonary function test

CCO Focus Area:

- Improve patient access at the clinic level by reducing no-show appointments

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially met with a finding (2.7)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (3.0)	Vendor Data Integration	Partially met (2.4)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.9)
Security	Not met (1.7)	Provider Data	Fully met (2.8)
Administrative Data	Partially met (2.5)	Meaningful Use of EHRs	Fully met (2.8)
Key Findings and Areas for Improvement			
<p>Finding #1: Data-flow diagrams and documentation</p> <p>CHA uses multiple data repositories to house claims and encounter data received from multiple partners. CHA sends eligibility data to Advantage Dental and Capitol Dental Care. The CCO uses multiple software packages in processing, authorizing, reporting and submitting claims/encounters to OHA. In the ISCA interview, CHA described sending all claims and encounter data to OHA, but the data-flow diagram CHA submitted did not confirm that process.</p>			
<p>Finding #2: Monitoring</p> <p>CHA lacked a formal process to monitor IT activities of its delegates or partners. Relationships between the IT and business sides of CHA were unclear; roles and responsibilities were not clearly defined for different monitoring activities. CHA has begun to determine how to monitor the security policies and practices of partners and delegates, and is evaluating how to conduct a review of a partner/delegate’s IT security policies and practices before contracting with the partner/delegate. CHA is exploring how to expand its Admin Audit Tool and Dental Compliance and Delegated Activity Review documents and processes to monitor the IT security policies and practices of partners and delegates.</p>			
<p>Finding #3: Business continuity/disaster recovery (BC/DR) plan</p> <p>CHA has developed a BC/DR plan and continues to refine it. It was unclear whether this plan covers all CCO functions and services. CHA reported that it has not yet developed a testing plan.</p>			

Columbia Pacific CCO (CPCCO)

CPCCO, a wholly owned subsidiary of CareOregon, provides physical, behavioral and dental health services for OHP members in Columbia, Clatsop and Tillamook counties. The CCO has a management agreement with CareOregon to provide administrative and risk-associated services. CPCCO delegates behavioral health service delivery to GOBHI, which subcontracts with Tillamook Family Counseling Center, Clatsop Behavioral Healthcare and Columbia Community Mental Health Services. CPCCO contracts for dental services with Moda Health, Capitol Dental Care, Advantage Dental and Willamette Dental Group. CPCCO’s utilization management functions are shared among CareOregon, GOBHI and the four dental organizations.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with CPCCO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 8 and partially resolved 5 of the 13 findings from 2014.
- Of 44 recommendations in 2014, 12 were resolved, 27 were partially resolved and 5 were not resolved.
- The CCO resolved 1 and did not resolve 2 of the 3 findings from 2015.
- Of 29 recommendations in 2015, 8 were resolved, 20 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- **Intervention #1:** Expanded the CCO’s pain clinic model into each county served (total of 119 graduates)
- **Intervention #2:** Changing the prescribing patterns of local providers through clinician education and cultivation of a shared vision
- **Intervention #3:** Conducted North Coast Opioid Summit in April 2016. Participants represented regional clinics, local hospitals, drug courts, police departments, school staff and the community.

Barriers:

- Difficulty filling available pain clinic openings; CPCCO is working with private insurers to cover pain clinic services for all members.

Next steps:

- Continue with the pain clinic model, but work on raising community awareness about the service and identifying barriers to member participation.
- Continue developing or implementing the different strategies listed under Intervention #2.
- Evaluate the recent Opioid Summit and make decisions about next steps.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Tobacco cessation
- Timeliness of prenatal care

CCO Focus Area:

- Adverse childhood experiences/trauma informed care

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially met (2.0)	Enrollment Systems	Fully met (2.6)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Partially met (2.3)
Security	Not met (1.5)	Provider Data	Partially met (2.4)
Administrative Data	Not met (1.9)	Meaningful Use of EHRs	Partially met (2.4)
Key Findings and Areas for Improvement			
Finding #1: Encounter data certification			
<p>CareOregon handles data submission for CPCCO. It was unclear how the data received from partner organizations would be monitored to ensure completeness and accuracy. CareOregon has some processes to check for expected/estimated volume and trends. It was unclear if those processes are used in the certification process. Currently, CareOregon staff sign the certification for the CCO.</p>			
Finding #2: CCO monitoring of delegated IT activities			
<p>CPCCO did not provide evidence of monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. During the interview, it was unclear who held the contracts and how many contracts were in place. The CCO provided no evidence of a process to monitor provider agencies' activities related to information systems. It was unclear how this function would be split between CCO staff and the CareOregon delegation team.</p> <p>CareOregon's delegation team has conducted monitoring of some delegates' IT activities, but did not have a process for monitoring provider agencies. CareOregon reported that it is defining IT monitoring activities.</p>			
Finding #3: Lack of business continuity/disaster recovery (BC/DR) plan			
<p>CareOregon hired a disaster recovery expert to work on its disaster recovery plan, and had an early draft of the plan. CareOregon planned to continue working on this plan and develop a testing strategy during 2016.</p> <p>Neither CPCCO nor CareOregon maintained a CCO-level BC/DR plan.</p>			
Finding #4: Provider directory			
<p>CPCCO has updated its provider directory since the previous review. However, the directory lists only facility-level information for mental health providers and does not provide practitioner details. It is unclear how a member would request non-emergent medical transportation services by using the CCO website.</p> <p>CPCCO's website includes links to dental partners' websites. It appeared that most sites had practitioner-level details, but not all websites listed genders and languages spoken. Some websites may have had additional details, but links to individual practitioner information may have been broken. This process may be difficult for members to navigate.</p>			

Eastern Oregon CCO (EOCCO)	
<p>EOCCO provides physical, behavioral and dental health services to OHP members in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler counties. The CCO’s daily operations are administered by GOBHI and Moda Health. GOBHI provides mental health services through contracts with providers, most of which are community mental health programs in its service area. Moda Health provides physical health, chemical dependency and vision services. EOCCO provides dental services through contracts with Advantage Dental, ODS Community Health and Capitol Dental Care. GOBHI administers the contract with Mid-Columbia Council of Governments for NEMT services.</p>	
Compliance with Regulatory and Contractual Standards	
<p>During 2016, HealthInsight Oregon followed up with EOCCO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.</p> <ul style="list-style-type: none"> • The CCO resolved 3 and partially resolved 4 of the 7 findings from 2014. • Of 27 recommendations in 2014, 15 were resolved, 8 were partially resolved and 4 were not resolved. • The CCO resolved all 3 findings from 2015. • Of 16 recommendations in 2015, 4 were resolved, 11 were partially resolved and 1 was not resolved. 	
Performance Improvement Projects (PIPs)	
Statewide PIP on Opioid Safety	
<p>Interventions:</p> <ul style="list-style-type: none"> • Community education: The Regional Opioid Prescribing Group (ROPG) will conduct forums in Hermiston, Pendleton, Ontario and John Day, and plans to develop a patient resource library. • Community health worker (CHW) activities: ROPG is developing ways to integrate opioid management into CHW training. • Provider education: Deliver best-practice information and referral resources to help providers intervene with members on high opioid doses. Track buprenorphine rates to demonstrate changing prescribing practices and effectiveness of provider education. 	<p>Barriers:</p> <ul style="list-style-type: none"> • Changes in data analytics staffing; EOCCO is working with pharmacy to resolve the gap. • Providers lack information and resources needed to manage chronic opioid users. EOCCO, through the ROPG, is developing interventions to address this barrier.
<p>Next steps:</p> <ul style="list-style-type: none"> • Promote May 2016 pain management conference in Medford to the provider network. • Distribute materials developed by Grande Ronde Regional and Baker City Saint Alphonsus clinics. • Develop a list of regional pain schools and non-pharmacologic resource materials for providers. • Recruit a non-physician behaviorist and a physical therapist representative to the ROPG. • Provide education about buprenorphine to providers. 	
CCO-Specific Project Topics	
<p>CCO-Specific PIPs:</p> <ul style="list-style-type: none"> • Increase adolescent well visits • Improve maternity and child health outcomes 	<p>CCO Focus Area:</p> <ul style="list-style-type: none"> • Increase rates of development screening for children 0–6 years old

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially met (2.5)	Enrollment Systems	Fully met (2.7)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.9)
Security	Partially met (2.1)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Partially met (2.4)
Key Findings and Areas for Improvement			
<p>Finding #1: Business continuity/disaster recovery (BC/DR) plan</p> <p>Moda Health has done some BC/DR planning but is reworking its activities. Testing was planned for summer 2016. There appears to be limited planning for loss of the key data center, but there are offsite data replicas. It was unclear if any BC/DR planning has occurred that includes the CCO partners or all CCO services.</p> <p>GOBHI has a contingency policy in place, but it is high-level and focused on IT. GOBHI staff who assisted in testing this policy have a lot of historical knowledge, but the policy lacks sufficient information to enable other personnel without that knowledge to perform recovery tasks. GOBHI conducted a test scenario in August 2015; the plan was not updated after that test.</p> <p>It was unclear how data flows through GOBHI’s information systems and in what order information systems need to be restored in the event of a disaster to facilitate recovery of business operations.</p> <p>GOBHI has many outsourced or cloud-based solutions. GOBHI’s recovery strategy may need to document contact information and items needed to use those services.</p>			
<p>Finding #2: Monitoring</p> <p>GOBHI and Moda Health are developing a process for monitoring contracted and partner organizations’ policies, procedures and practices related to information systems. GOBHI expected to implement monitoring by summer 2016. At the time of the review, GOBHI was hiring a person to work with contracted or partner organizations on compliance with contract requirements and security best practices.</p>			
<p>Finding #3: Provider payment and updates process</p> <p>GOBHI staff perform credentialing decisions for new provider contracts, and inform PH Tech of necessary updates and contracting rates. GOBHI has instructed PH Tech to track payment based on the facility’s contracted rates. It was unclear if PH Tech could pay for an encounter conducted by a practitioner who has not completed GOBHI’s credentialing process.</p>			

FamilyCare CCO

FamilyCare, Inc., a 501(c)(4) public benefit corporation, contracts with OHA to provide physical, behavioral and dental health services to OHP members in Multnomah, Clackamas, Washington and Marion counties. FamilyCare contracts with eight dental plans. FamilyCare contracts with CVS Caremark as its pharmacy benefit manager and with Access2Care for NEMT.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with FamilyCare regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 7 and partially resolved 5 of the 12 findings from 2014.
- Of 11 recommendations in 2014, 5 were resolved, 5 were partially resolved and 1 was not resolved.
- The CCO resolved all 3 findings from 2015.
- Of 11 recommendations in 2015, 1 was resolved and 10 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Provider outreach: Initiated educational program with dental prescribers.
- Comprehensive/alternative pain services
- Provider education
- Conducted on-site visits to top prescribing clinics by medical directors
- Existing interventions: Continued to implement prior authorization and quantity limits policies and procedures
- Internal data development

Barriers:

- Mailing had been planned to begin earlier but was delayed by timing of internal staff education. Training has now been completed.
- Data needed to facilitate pilot programs were incomplete. FamilyCare is building dashboards to support data requests.
- On-site visits are time-consuming to plan, implement and follow up.
- Staffing changes in provider services create a barrier to on-site visits.
- Difficult to achieve clinic-oriented outreach when many providers are non-contracted and there is no clinic affiliation information.

Next steps:

- Begin mailing notifications to top prescribers. Continue providing reports to clinics, adapting elements of the reports to meet individual clinic needs. Increase the number of clinics to receive reports.
- Try to recruit a community provider to participate in a Project ECHO-like program.
- Analyze acute prescribing of high-dose opioids, focusing on urgent care, emergency department and post-surgical prescribing. Initial data suggest that acute prescribing might be more problematic for the CCO.
- Opioid workgroup will develop a program for alternative treatments for chronic pain management.
- Conduct data analyses of metric and interventions to determine effectiveness.
- Implement MED-based coding by 4th quarter 2016.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Increasing colorectal cancer screening
- Increasing adolescent well-child visits

CCO Focus Area:

- Improving chronic conditions in the serious and persistent mentally ill population

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Fully met (2.8)	Enrollment Systems	Fully met (2.6)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Fully met (2.8)
Security	Partially met (2.3)	Provider Data	Fully met (2.7)
Administrative Data	Partially met (2.4)	Meaningful Use of EHRs	Fully met (3.0)
Key Findings and Areas for Improvement			
<p>Finding #1: CCO monitoring of delegated IT activities</p> <p>FamilyCare reported that it does not conduct monitoring and oversight of contracted or partner organizations’ IT systems, policies and procedures. FamilyCare has developed a Provider Office Site Review Checklist that includes reviewing the IT systems and policies and procedures used by a provider or other type of partner organization. The CCO submitted the new checklist for review after the ISCA interview.</p> <p>FamilyCare plans to phase the new checklist into operations during regularly scheduled site visits to provider offices in late 2016 and 2017.</p>			
<p>Finding #2 : Encounter data certification</p> <p>PH Tech handles data submission for FamilyCare. PH Tech submits a copy of the CIM database, provider master database and various tables once a month. It was unclear if FamilyCare receives copies of the 837 files that PH Tech submits to OHA. FamilyCare is developing additional reports and processes to augment the current certification process used by the Claims Department assistant manager to sign the encounter data certification for the CCO.</p>			

Greater Oregon Behavioral Health, Inc. (GOBHI)

GOBHI, a managed mental health organization (MHO), manages the OHP mental health benefit in 22 rural Oregon counties and provides services through local community mental health programs. GOBHI's governing board includes county commissioners of Columbia, Umatilla and Union counties, provider network representatives and consumers. Most MHO activities are delegated to the county mental health authorities, which receive a capitation payment to deliver services for enrollees.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with GOBHI regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews. GOBHI had made progress in addressing many findings that were carried over from 2012, though several findings remained unresolved or only partially resolved. More work is needed to bring GOBHI into full compliance with its MHO contract and federal Medicaid regulations in the following areas:

- Delivery network
- Policies and procedures
- Tracking of second opinions, seclusion and restraint and access to interpretation and materials in alternative formats and languages
- Oversight of delegated activities
- Oversight of quality management program
- Practice guidelines
- Management data specific to MHO enrollees

Performance Improvement Projects (PIPs)

As of the 2016 review, GOBHI had not developed either PIP beyond identifying and justifying the study topic (Standard 1 of the review protocol). By the time of the 2017 review, GOBHI is expected to have completed Standards 2–5 (study design) and 8 (improvement strategies) and to have supplied partial information for Standards 6 (study results) and 7 (interpretation of results).

Older Adult PIP (score = 14 out of 85, Not met)

GOBHI's data review indicated underutilization of mental health services by adults over age 60. The MHO decided to focus this PIP on improving the service penetration rate for older adults. GOBHI stated that its first step would be to identify the causes of low referrals and utilization. This topic clearly relates to quality of care for MHO enrollees since the target population does not appear to be receiving needed services. HealthInsight Oregon reviewed GOBHI's documentation and assigned a score of 85 (Substantially met) for Standard 1.

Children 0–6 Years Old Primary Care PIP (score = 17 out of 85, Not met)

GOBHI's data review indicated underutilization of services by young Hispanic children (0–6 years of age). This PIP will focus on improving the service penetration rate for young Hispanic children in Umatilla and Malheur counties, the counties with the highest percentage of GOBHI's target population. GOBHI documented the importance of the topic, its relevance to the local population and the topic prioritization process. The MHO identified a possible root cause for lower access by this population and briefly described its selected intervention. HealthInsight Oregon assigned a score of 100 (Fully met) for Standard 1.

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially met (2.2)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (2.6)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.7)
Security	Not met (1.9)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.1)	Meaningful Use of EHRs	Partially met (2.4)
Key Findings and Areas for Improvement			
Finding #1: Encounter data certification			
<p>PH Tech handles data submission for GOBHI, sending reports to GOBHI of what the providers submit. GOBHI is using these reports in a specialized cleanup process and is trying to determine how to use these data and reports on an ongoing basis. GOBHI is working to evolve its processes to ensure data completeness and accuracy.</p> <p>GOBHI signs the attestation that data are accurate based on PH Tech’s data submission to OHA. GOBHI is working with PH Tech and providers on processes to ensure the completeness and timeliness of the data.</p>			
Finding #2: Monitoring			
<p>GOBHI is developing a process for monitoring contracted and partner organizations’ policies, procedures and practices related to information systems. GOBHI expected to implement monitoring by summer 2016. At the time of the review, GOBHI was hiring a person to work with contracted or partner organizations on compliance with contract requirements and security best practices.</p>			
Finding #3: Provider payment and updates process			
<p>GOBHI staff perform credentialing decisions for new provider contracts that are added. Staff members inform PH Tech of necessary updates and contracting rates. GOBHI has instructed PH Tech to track payment based on the facility’s contracted rates.</p> <p>It was unclear if PH Tech could pay for an encounter with a practitioner who has not completed the GOBHI credentialing process. It was unclear if this process would need to change in March 2016 when NPI numbers for the rendering practitioner must be used. It was unclear how additional practitioners would be added to the provider directory.</p>			

Health Share of Oregon

Health Share contracts with OHA to provide physical, behavioral and dental health services to OHP members in Multnomah, Washington and Clackamas counties. The CCO contracts with 16 risk-accepting entities (RAEs). Activities delegated to RAEs include network planning, monitoring and maintaining access, credentialing, care coordination/case management, pharmacy benefit management, claims payment, customer service and utilization management. The CCO has workgroups and committees charged with fully integrating behavioral and physical health and dental services. The CCO retains adjudication of final appeals and oversight of QI activities.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with Health Share regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved all 4 findings from 2014.
- The CCO resolved all 20 recommendations from 2014.
- No findings arose from Health Share’s 2015 compliance review.
- Of 12 recommendations in 2015, 10 were resolved and 2 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Patient education and engagement—distribute materials to members about the new opioid prescribing policy and need for tapering plans
- Provider education and engagement (e.g., learning collaborative, pain conference, continuing medical education)
- Expand access to effective alternatives (e.g., acupuncture, physical therapy, aqua therapy)
- Implement new opioid prescribing limits
- Increase actionable data
- Increase leadership priority and buy-in

Barriers:

- Kaiser Permanente (KP) nurses lacked tools or knowledge to hold difficult conversations with members. The nurses are receiving appropriate training.
- KP members have filed complaints about changes to the opioid prescribing guidelines.
- Challenging to develop a process of working with high opioid-prescribing providers and clinics that is sustainable and not punitive.
- Tuality Health Alliance (THA) is not receiving accurate pharmacy data.

Next steps:

- Health plan partners will continue existing interventions.
- One of Kaiser’s clinics will test a review board model for new opioid starts.
- Providence Health Plan will reevaluate its Pathways to Treat provider tool, develop a regional case review process and reschedule the pain symposium.
- THA will meet face to face with providers about back pain coverage and opioid prescribing practices.
- Health Share will develop a dashboard to provide to each of its RAEs on a monthly basis.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving maternal and infant outcomes using a new model of care (Project Nurture)
- Designing and implementing foster care medical home models of care

CCO Focus Area:

- Improving rate of effective contraception use

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Fully met (3.0)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (2.8)	Vendor Data Integration	Partially met with a finding (2.6)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Fully met (3.0)
Security	Not met (1.8)	Provider Data	Partially met with a finding (2.8)
Administrative Data	Partially met (2.5)	Meaningful Use of EHRs	Partially met (2.4)
Key Findings and Areas for Improvement			
<p>Finding #1: Business continuity/disaster recovery (BC/DR) plan</p> <p>Health Share is developing a CCO-level BC/DR plan; CCO management was reviewing a draft plan at the time of the ISCA interview. CCO management expects to continue to define critical functions, systems and resources that need to be maintained in the event of a disaster.</p> <p>Health Share reported that it has developed a plan for supporting the phone systems and network infrastructure during a disaster. The CCO is evaluating how the use of virtual workstations could facilitate disaster recovery and business continuity plans.</p>			
<p>Finding #2: Monitoring of business partners and PH Tech</p> <p>Health Share did not provide evidence of monitoring and oversight of PH Tech for processing of claims and encounter data.</p> <p>Several of Health Share’s business partners contract with PH Tech to process claims and encounter data. PH Tech submits claims and encounter data to Health Share on behalf of those business partners. It was unclear if Health Share would be able to ensure the completeness and accuracy of business partners’ data submitted to the CCO by PH Tech based on the current level of monitoring.</p>			

InterCommunity Health Network (IHN)

IHN, a wholly owned subsidiary of Samaritan Health Services, contracts with OHA to provide physical, behavioral and dental health services for OHP members in Benton, Lincoln and Linn counties. IHN is managed by Samaritan Health Plan Operations (SHPO), and all CCO staff members are SHPO employees. IHN contracts with the three counties for behavioral health services, and with Advantage Dental, Capitol Dental Care, ODS Community Health and Willamette Dental Group to provide dental care for members.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with IHN regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 3 and partially resolved 4 of the 7 findings from 2014.
- Of 29 recommendations in 2014, 11 were resolved, 10 were partially resolved and 8 were not resolved.
- The CCO resolved 2 and partially resolved 2 of the 4 findings from 2015.
- Of 29 recommendations in 2015, 13 were resolved, 15 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Conduct general public and provider education
 - 16 urgent care providers received education from IHN’s chief medical officer (CMO)
 - 57 providers were educated through the regional task force
 - 8 providers on Pharmacy and Therapeutics Committee received education
 - 151 providers attended the continuing medical education offering
 - 20 leaders attended training in managing chronic conditions
 - 70 members received direct education through a class led by the CMO
- Implement prescription opioid limits
 - 87 providers and 964 members were sent letters about the new policy

Barriers:

- None

Next steps:

- Continue current interventions.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Reducing preventable hospitalizations
- Deploying care teams to reduce emergency department utilization

CCO Focus Area:

- Improving the oral health of pregnant women

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Fully met (2.8)	Enrollment Systems	Partially met (2.5)
Staffing	Fully met (3.0)	Vendor Data Integration	Partially met (2.4)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.0)
Security	Not met (1.8)	Provider Data	Partially met (2.4)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Fully met (3.0)
Key Findings and Areas for Improvement			
Finding #1: Lack of business continuity/disaster recovery (BC/DR) plan			
IHN did not maintain a CCO-level BC/DR plan, though IHN’s parent organization has a draft plan. IHN has a pilot project underway to develop a CCO-level plan based on the parent organization’s plan. IHN planned to continue working on this plan and developing a testing strategy during 2016.			
Finding #2: Historical gaps in mental health data			
In September 2013, IHN began receiving mental health encounters directly from providers and county mental health facilities. The CCO no longer contracts with PH Tech to administer mental health data. Mental health claims and encounters from the first three to four months of CCO operations were not migrated into IHN’s Facets system due to data integrity issues. At the time of the ISCA review, these data were not in a database and not available for reporting.			

Jackson Care Connect (JCC)

JCC, a wholly owned subsidiary of CareOregon, contracts with OHA to provide physical, behavioral and dental health services for OHP members in Jackson County. JCC has an agreement with Jackson County Health and Human Services (JCHHS) to provide mental health services, and CareOregon provides physical health services. CareOregon performs many administrative and operational activities on the CCO’s behalf. JCC delegates dental service delivery to Willamette Dental Group, Capitol Dental Care, Moda Health and Advantage Dental; and NEMT services to TransLink.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with JCC regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 5, partially resolved 5 and did not resolve 5 of the 15 findings from 2014.
- Of 45 recommendations in 2014, 12 were resolved, 16 were partially resolved and 17 were not resolved.
- The CCO resolved 1, partially resolved 2 and did not resolve 1 of the 4 findings from 2015.
- Of 25 recommendations in 2015, 11 were resolved, 12 were partially resolved and 2 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- JCC-specific interventions
 - Use claims data to identify subgroups of opiate users and refine outreach to providers based on users’ primary characteristics
 - Communicate to providers about lowering the medication limit; offer technical assistance by behavioral health and CCO medical director
- Joint interventions with regional collaborative: With other southern Oregon CCOs, develop joint strategies around community education, provider education, pain management modalities and medication-assisted treatment

Barriers:

- Inconsistencies between internal and OHA study metric data make it difficult to identify and understand the study population.
- Large number of pain specialists in the area is a disincentive for primary care providers to manage their own patients. Treatment of chronic pain by a specialist increases the fragmentation of patient care.
- Collaboration among CCOs has been difficult due to lack of time, physical distance between organizations, different operating structures.

Next steps:

- Continue to distribute quarterly reports on high opioid users to providers.
- JCC’s behavioral health team, pharmacist and medical director will continue to reach out to providers and clinics with the most patients on a quarterly basis.
- JCC’s pharmacist will begin to incorporate additional actionable data (patient lists) as they are received. Pharmacist will begin retrospective review of members previously identified as achieving MED goal, and will begin to provide tapering technical assistance to providers.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving prenatal and perinatal care
- Adolescent well care and behavioral health integration

CCO Focus Area:

- Focus on high utilizers

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially met (2.1)	Enrollment Systems	Partially met (2.4)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Partially met (2.4)
Security	Not met (1.6)	Provider Data	Partially met (2.4)
Administrative Data	Not met (1.9)	Meaningful Use of EHRs	Partially met (2.4)
Key Findings and Areas for Improvement			
<p>Finding #1: Encounter data certification</p> <p>CareOregon handles data submission for JCC. It was unclear how JCC would monitor data received from partner organizations to ensure completeness and accuracy. CareOregon has some processes to check for expected/estimated volume and trends, but it was unclear if those processes are used in certification. Currently, CareOregon staff sign the certification for the CCO. The CCO is transitioning this function to CCO staff.</p>			
<p>Finding #2: Monitoring</p> <p>JCC did not provide evidence of monitoring and oversight of contracted or partner organizations’ IT systems, policies and procedures. The 2015 Jackson County Utilization Management Team (JC-UMT) delegation oversight review included a health information system corrective action plan that has been completed. During the ISCA interview, it was unclear who held the contracts and how many contracts were in place. It was unclear how monitoring would be divided between CCO staff and the CareOregon team. CareOregon’s delegation oversight unit conducted a review of JC-UMT but was in the process of adding organizations and IT monitoring.</p>			
<p>Finding #3: Lack of business continuity/disaster recovery (BC/DR) plan</p> <p>JCC did not maintain a CCO-level BC/DR plan. CareOregon hired a disaster recovery expert to work on its disaster recovery plan. CareOregon planned to continue working on this plan and developing a testing strategy in 2016.</p>			
<p>Finding #4: JC-UMT enrollment checks</p> <p>JC-UMT relies on providers to check eligibility before delivering services. JC-UMT checks eligibility at the time of authorization but not at the time of the claims payment. The JC-UMT profiler system does not have access to 834 enrollment data. There may be post-payment mechanisms that could reconcile some of these payments.</p>			
<p>Finding #5: Provider directory</p> <p>JCC has updated its provider directory since the previous review. JCC has a directory of physical health providers, but not of mental health or dental practitioners in Jackson County. It was unclear how a member might find mental health provider-level detail. Also, some views of the physical provider directory do not display gender or specialty, but those items are searchable.</p> <p>JCC’s provider directory shows dental agencies without practitioner-level information or DCO assignment information. The portal may confuse members because they can obtain practitioner-level information from the website, but then they must follow a link located in a separate area of the website for each contracted DCO.</p>			

PacificSource Central Oregon (PSCS-CO)	
<p>PacificSource Community Solutions, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-CO and PSCS-Columbia Gorge. PSCS-CO serves OHP members in Deschutes, Jefferson and Crook counties. Each CCO has its own governing council with oversight from a subsidiary board of directors. PacificSource contracts with Deschutes County Health Services for mental health services and substance use disorders; with Caremark for pharmacy benefit management; and with Advantage Dental, Capitol Dental Care, Willamette Dental Group and Moda Health for dental services.</p>	
Compliance with Regulatory and Contractual Standards	
<p>During 2016, HealthInsight Oregon followed up with PSCS-CO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.</p> <ul style="list-style-type: none"> • The CCO partially resolved both of the 2 findings from 2014. • Of 20 recommendations in 2014, 14 were resolved, 5 were partially resolved and 1 was not resolved. • The CCO partially resolved all 4 findings from 2015. • Of 22 recommendations in 2015, 9 were resolved, 11 were partially resolved and 2 were not resolved. 	
Performance Improvement Projects (PIPs)	
Statewide PIP on Opioid Safety	
<p>Interventions:</p> <ul style="list-style-type: none"> • Promote safer prescribing practices <ul style="list-style-type: none"> ○ Limit opioid dosing threshold to <120 mg MED ○ Reduce co-prescribing of opioids and benzodiazepines • Increase prescription drug monitoring program (PDMP) enrollment and usage <ul style="list-style-type: none"> ○ Continue to implement pharmacy prior authorization process that requires attestation of PDMP enrollment 	<p>Barriers:</p> <ul style="list-style-type: none"> • Definition of target population is delayed as the issue of whether or not to include members on buprenorphine has not been decided. • Creation of mailing processes has taken longer than expected due to multiple pre-approval processes and the need to create processes to accommodate new technology. • Need to coordinate efforts of multiple entities around the PDMP to avoid burdening providers with multiple requests for their time.
<p>Next steps:</p> <ul style="list-style-type: none"> • Finalize data analysis process and begin distributing accurate lists of members on ≥120 mg MED, regenerating old reports if revisions are necessary. • Develop process to identify members who are co-prescribed opiates and benzodiazepines; provide lists of these members to providers on a monthly basis. • Conduct PDMP training in May 2016. • If Deschutes County receives grant to improve PDMP usage, work collaboratively with grant project staff. 	
CCO-Specific Project Topics	
<p>CCO-Specific PIPs:</p> <ul style="list-style-type: none"> • Improving post-partum care • Integrating chronic pain management into primary care 	<p>CCO Focus Area:</p> <ul style="list-style-type: none"> • Increasing preventive care to members with serious and persistent mental illness

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially met (2.4)	Enrollment Systems	Partially met (2.5)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.4)
Security	Partially met (2.0)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Partially met (2.4)
Key Findings and Areas for Improvement			
<p>Finding #1: Encounter data certification</p> <p>PH Tech is submitting final data directly to OHA, and PSCS-CO is not receiving a copy of the submitted data. The CCO stated it continues to monitor trends related to the encounter and claims data and is developing additional reports to more completely reflect all CCO services. After the PH Tech transition, PSCS-CO worked to determine what additional reports were needed to monitor the data submission process. These new and existing reports are being used to support the CCO’s attestation process.</p>			

PacificSource Columbia Gorge (PSCS-CG)

PacificSource Community Solutions, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-CG and PSCS-Central Oregon. PSCS-CG serves OHP members in Hood River and Wasco counties. Each CCO has its own governing council with oversight from a subsidiary board of directors. PacificSource contracts with Mid-Columbia Center for Living for mental health services and substance use disorders; with Caremark for pharmacy benefit management; and with Advantage Dental, Capitol Dental Care, and Moda Health for dental services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with PSCS-CG regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO partially resolved both of the 2 findings from 2014.
- Of 21 recommendations in 2014, 14 were resolved, 6 were partially resolved and 1 was not resolved.
- The CCO resolved all 4 findings from 2015.
- Of 18 recommendations in 2015, 8 were resolved, 9 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Charter a Pain and Opioid Treatment Work Group to advise the CCO’s Clinical Advisory Panel and disseminate recommendations to providers and members
- Promote safer prescribing practices
 - Adherence to a ≥ 120 mg MED opiate limit
 - Avoidance of polypharmacy
- Increase prescription drug monitoring program (PDMP) enrollment and usage
 - CCO is developing a PDMP training

Barriers:

- Barriers to a successful community strategy:
 - Limited access to Suboxone prescribers
 - Limited treatment options for chronic pain members with “below the line” diagnoses
 - Competing demands and priorities for PCPs affects participation in workgroup
 - Strong member resistance to decreasing opioid limits
 - Providers lack experience with difficult patient conversations

Next steps:

- Pain and Opioid Treatment Work Group will meet monthly and develop interventions in accordance with their charter, including PDMP education and assistance to providers.
- Develop process to identify members who are co-prescribed opiates and benzodiazepines; provide lists of these members to providers on a monthly basis.
- Conduct PDMP training in May 2016.
- Continue to refine data analysis process.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving postpartum care
- Integrating chronic pain management into primary care

CCO Focus Area:

- Increasing preventive care to members with serious and persistent mental illness

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially Met (2.4)	Enrollment Systems	Partially met (2.5)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.4)
Security	Partially met (2.0)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Partially met (2.4)
Key Findings and Areas for Improvement			
<p>Finding #1: Encounter data certification</p> <p>PH Tech is submitting final data directly to OHA, and PSCS-CG is not receiving a copy of the data. The CCO stated that it continues to monitor trends related to encounter and claims data and is developing additional reports to more completely reflect all CCO services. After the PH Tech transition, PSCS-CG worked to determine which additional reports were needed to monitor the data submission process. These new and existing reports are being used to support the CCO’s attestation process.</p>			

Primary Health of Josephine County (PHJC)

PHJC, owned by Oregon Health Management Services (OHMS), provides physical, behavioral and dental health services for OHP members in Josephine County. OHMS sub-delegates mental health service delivery to Options for Southern Oregon; dental services to Capitol Dental Care, Advantage Dental, Willamette Dental Group, and Moda Health; and NEMT to TransLink.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with PHJC regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 5, partially resolved 4 and did not resolve 1 of the 10 findings from 2014.
- Of 18 recommendations in 2014, 7 were resolved, 10 were partially resolved and 1 was not resolved.
- The CCO resolved 5 and partially resolved 2 of the 7 findings from 2015.
- Of 22 recommendations in 2015, 18 were resolved, 4 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Community education
- Support and assist providers in reducing prescription opioids
- Pain management modalities
 - CCO helped sponsor chronic pain group classes in Josephine County.
- Medication-Assisted Treatment (MAT)
 - CCO is working with Choices Counseling Center to open a MAT clinic.

Barriers:

- New limits might be a challenge and burden to PCPs that serve chronic pain patients
- Lack of alignment among CCOs regarding chronic pain management
- Previous pain resiliency pilot program lost funding due to low patient participation, low provider engagement and poor coordination with other resources
- Very few providers of buprenorphine in Josephine County

Next steps:

- Develop an educational video, culturally and linguistically appropriate member education materials and other messaging (social media, public service announcements, etc.).
- Develop small toolkit (including tapering agreement, schedule, letters and materials) primarily focused on benefit changes. Collaborate with drug detail representative to spread the policy message.
- Develop community-based meetings to discuss benefit changes and distribute toolkits.
- After review and analyses, recommend a model of care to inform Center of Excellence development.
- Collect data and information on the Josephine County pain classes and share with the larger group.
- Open MAT clinic in Grants Pass.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Design and implement a local medical maternal health home
- Reduce emergency department utilization by moderate utilizers

CCO Focus Area:

- Implement Mental Health First Aid in the community

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Fully met (2.9)	Enrollment Systems	Fully met (3.0)
Staffing	Fully met (3.0)	Vendor Data Integration	Partially met with a finding (2.6)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.7)
Security	Partially met with a finding (2.6)	Provider Data	Fully met (2.9)
Administrative Data	Partially met (2.4)	Meaningful Use of EHRs	Fully met (3.0)
Key Findings and Areas for Improvement			
<p>Finding #1: Lack of integrated business continuity/disaster recovery (BC/DR) plan</p> <p>PHJC developed a draft BC/DR plan and continues to refine it. PHJC is updating the plan to support virtualization of production servers. It was unclear whether this plan covers all CCO functions and services. PHJC has scheduled plan testing for 2017.</p>			
<p>Finding #2: Informal process for monitoring data flow to ensure submission of all data</p> <p>PHJC uses an informal process to monitor encounter trends for CCO services. The CCO should devote attention to capitated services due to the lack of incentive for an agency or partner organization to supply encounter data for these services. Monitoring for over- or underutilization of anticipated services will allow the CCO to address any issues early and minimize potential negative impacts on actuarial rates and performance measure calculations.</p>			
<p>Finding #3: Monitoring IT policies and procedures of providers and other partner organizations</p> <p>Intelligenz, on behalf of PHJC, has contracted with Amazon Web Services and PeHS for key production IT services and functions. Intelligenz submitted some IT policies and procedures, but it was unclear whether Intelligenz has developed or expanded its current policies, procedures and practices sufficiently to cover these new IT services and functions.</p> <p>PHJC has developed a process for monitoring contracted and partner organizations' policies and procedures related to information systems. The CCO expected this monitoring process to be in full use sometime in 2017.</p>			
<p>Finding #4: NEMT data not being submitted to OHA</p> <p>As of the interview date, PHJC had not successfully submitted NEMT claims and encounter data to the state. PHJC is working with TransLink, its NEMT service provider, to resolve issues with submission of the 837 data.</p>			

Trillium Community Health Plan (TCHP)

TCHP, a wholly owned subsidiary of Centene Corp., contracts with OHA to provide physical, behavioral and dental health services for OHP members in Lane County and portions of other counties. Trillium Behavioral Health (TBH) provides behavioral health services for TCHP members. TCHP delegates to TBH the responsibility to establish and maintain the provider network needed to support behavioral services, utilization management, credentialing for behavioral health services and care coordination. TCHP provides dental services through contracts with Willamette Dental Group, Advantage Dental, Capitol Dental Care and Moda Health. NEMT services are delegated to RideSource.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with TCHP regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 3, partially resolved 1 and did not resolve 1 of the 5 findings from 2014.
- Of 25 recommendations in 2014, 10 were resolved, 10 were partially resolved and 5 were not resolved.
- The CCO partially resolved 1 and did not resolve 2 of the 3 findings from 2015.
- Of 18 recommendations in 2015, 5 were resolved, 7 were partially resolved and 6 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Clinical Advisory Panel adopted the Centers for Disease Control and Prevention (CDC) guidelines on opioid prescribing.
- Disseminate CDC guidelines to providers on laminated reference sheets.
- Conduct Living Well with Chronic Pain classes.

Barriers:

- Lack of staff delayed implementation of interventions.

Next steps:

- Once staff is hired and trained, implement interventions to offer and increase access to physical therapy or acupuncture and to behavioral health for managing chronic pain.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Reducing preventable hospital readmissions
- Improving depression screening

CCO Focus Area:

- Decreasing tobacco use during pregnancy

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Fully met (3.0)	Enrollment Systems	Fully met (3.0)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.8)	Report Production/PM Reports	Fully met (2.9)
Security	Not met (1.9)	Provider Data	Fully met (2.8)
Administrative Data	Not met (1.6)	Meaningful Use of EHRs	Fully met (3.0)
Key Findings and Areas for Improvement			
Finding #1: Business continuity/disaster recovery (BC/DR) plan			
<p>TCHP’s BC/DR plan was being updated at the time of the ISCA review. Centene, the parent organization, has a BC/DR plan for its enterprise data center. TCHP plans to continue working on this plan and developing a testing strategy during 2016. TCHP submitted additional documentation detailing plans for updating the BC/DR plan and the expectation of testing the updated plan in the second quarter of 2017.</p>			
Finding #2: Monitoring			
<p>Centene is developing a new vendor oversight program that TCHP expects to use for monitoring and oversight of contracted and partner organizations’ IT and security practices, procedures and policies. Centene is evaluating who will be the business owner for this process. It was unclear how TCHP will implement this program and communicate it to providers and other partner organizations.</p>			
Finding #3: Attestation process			
<p>It was unclear how TCHP monitors the submission of claims and encounter data by provider agencies. TCHP was not sure how the CCO and/or Centene would know if the volume of claims being submitted by providers was within expected norms. The onsite interview revealed that the TCHP staff member tasked with monitoring of data submission trends was unaware that NEMT claims and encounters had not been successfully submitted to OHA in several months.</p>			
Finding #4: NEMT data not monitored or submitted to OHA			
<p>TCHP contracts with RideSource (Lane Transit District) to provide NEMT services. TCHP reported that as of mid-September 2016, NEMT claims and encounter data had not been successfully submitted to OHA since the CCO’s IT operations were migrated to Centene’s corporate data center in June. Centene and TCHP were attempting to resolve these issues, resume regular submission of NEMT claims and encounter data to OHA and ensure that the backlogged claims are processed and submitted.</p> <p>TCHP has not yet determined a strategy to monitor NEMT data for completeness. The ride vendor is responsible for ensuring that the transportation request has an associated appointment. The CCO needs to determine appropriate monitoring activities to ensure that transportation services have a corresponding encounter (e.g., a physician office visit).</p>			

Umpqua Health Alliance (UHA)	
Douglas County Independent Practice Association <i>dba</i> UHA is the CCO for Douglas County. UHA contracts with Community Health Alliance (CHA) to provide mental health outpatient services; with ADAPT to provide substance use disorder treatment; with GOBHI to manage access to inpatient psychiatric services; with MedInsight for pharmacy benefits management; and with Advantage Dental and Willamette Dental Group for dental services.	
Compliance with Regulatory and Contractual Standards	
During 2016, HealthInsight Oregon followed up with UHA regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.	
<ul style="list-style-type: none"> • The CCO resolved 5, partially resolved 5 and did not resolve 3 of the 13 findings from 2014. • Of 35 recommendations in 2014, 9 were resolved, 6 were partially resolved and 20 were not resolved. • The CCO partially resolved 3 and did not resolve 2 of the 5 findings from 2015. • Of 26 recommendations in 2015, 2 were resolved, 11 were partially resolved and 13 were not resolved. 	
Performance Improvement Projects (PIPs)	
Statewide PIP on Opioid Safety	
Interventions: <ul style="list-style-type: none"> • Monitoring of opioid policy, guidelines and adherence by CCO’s Pain Committee • Ongoing implementation of the prior authorization process • Ongoing implementation of new opioid medication guidelines • Ongoing provision of education and CME • Ongoing case reviews conducted as needed • Ongoing support for providers and clinics that have large drug-seeking patient populations 	Barriers: <ul style="list-style-type: none"> • Provider compliance with opioid policy guidelines: The Pain Committee chair and CCO pharmacist meet with individual providers who are “reticent to change.”
Next steps: <ul style="list-style-type: none"> • Continue existing interventions 	
CCO-Specific Project Topics	
CCO-Specific PIPs: <ul style="list-style-type: none"> • Identification of addiction issues in pregnancy • Decreasing utilization of the emergency department 	CCO Focus Area: <ul style="list-style-type: none"> • Increasing PCPCH enrollment

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially met with a finding (2.7)	Enrollment Systems	Partially met (2.4)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met with a finding (2.6)
Security	Partially met (2.1)	Provider Data	Fully met (2.9)
Administrative Data	Partially met (2.5)	Meaningful Use of EHRs	Fully met (3.0)
Key Findings and Areas for Improvement			
Finding #1: Attestation sign-off			
UHA receives reports of the claims and encounter data that ABCT submits to OHA. UHA performs attestation based on those reports. It was unclear who would monitor data received from partner organizations to ensure data completeness and accuracy.			
Finding #2: Disaster recovery planning			
UHA has developed a business continuity/disaster recovery plan and continues to refine it. It was unclear whether this plan covers all CCO functions and services. UHA reported that it had not yet developed a testing plan.			
Finding #3: Provider monitoring			
No documentation was submitted showing that the delegate was monitoring providers. The CCO performs only limited monitoring of GOBHI's IT functions. The CCO lacked a formal process to monitor IT activities of its delegates or partners. Relationships between the IT and business sides of the CCO were unclear; roles and responsibilities were not clearly defined for different monitoring activities.			
Finding #4: Provider is not verifying enrollment at time of service			
One provider agency stated that it checks eligibility only when billing for the claim/encounter.			
Finding #5: Enrollment data components received from OHA "unloadable" in Plexis CM			
The daily 834 file received from OHA contained components that were unloadable into the Plexis CM system. It was unclear what UHA and ABCT were doing to resolve this situation.			
Finding #6: Reconciliation issues due to full capitation payment not being received by CHA			
CHA reported problems reconciling capitation payment for UHA members assigned to CHA. CHA reported that it receives a capitation payment without information on which member services the payment covers. UHA reduces CHA's capitation payment when a CHA-assigned member receives care from a non-CHA provider.			

Western Oregon Advanced Health (WOAH)

Based in Coos Bay, WOAH provides physical, behavioral and dental health services to OHP members in Coos and Curry counties. Behavioral health services are delegated to Coos Health and Wellness, Curry Community Health and ADAPT. Advantage Dental is delegated to provide dental services, manage the dental network, conduct utilization review and provide training, credentialing and oversight of dental care providers. WOAH contracts with TransLink to provide NEMT services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with WOAH regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 7 and partially resolved 2 of the 9 findings from 2014.
- Of 34 recommendations in 2014, 26 were resolved, 5 were partially resolved and 3 were not resolved.
- The CCO resolved 3 and partially resolved 1 of the 4 findings from 2015.
- Of 18 recommendations in 2015, 9 were resolved and 9 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Participated in a Heroin Town Hall organized by law enforcement in May 2016.
- Supporting the opening of an Opioid Treatment Program (OTP) in 2017; supporting the local Federally Qualified Health Center in developing its own office-based OTP.
- Working with Lines for Life to present an Opioid Summit in fall 2016.
- Facilitated regular meetings of a Community Opioid Guidance Group to promote communication and coordination among community partners and providers.
- Supported North Bend Medical Center (NBMC) to conduct quarterly education programs for providers in Coos and Curry counties.

Barriers:

- Provider resistance: Some providers feel the CDC opioid guidelines are not appropriate; others do not want to change treatment that appears to be “working” for their patients.
- Lack of prescribing providers: Patients report difficulty in finding providers willing to treat people on chronic opioids.
- Delay in receiving member-specific data has delayed member and provider outreach.
- Medication-Assisted Treatment access: The OTP will not be functional until early 2017.

Next steps:

- Continue to support NBMC quarterly education events.
- Begin planned regional collaborative interventions in October 2016.
- Conduct an Opioid Summit in fall 2016.
- Conduct a care manager conference to train care managers in motivational interviewing techniques and difficult conversation skills.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Reducing preventable hospital readmissions
- Reducing co-prescribing of benzodiazepines and opioids

CCO Focus Area:

- One Key Question implementation

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Fully met (2.7)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Partially met (2.4)	Report Production/PM Reports	Fully met (2.7)
Security	Partially met (2.1)	Provider Data	Partially met with a finding (2.8)
Administrative Data	Not met (1.9)	Meaningful Use of EHRs	Fully met (3.0)
Key Findings and Areas for Improvement			
<p>Finding #1: Remote access</p> <p>DOCS employees have remote user access when sharing hardware, saving data to local storage devices and remote printing. WOAHA employees do not often handle protected health information (PHI) and other confidential data while working. Remote access that allows local printing and/or saving data to local storage increases the potential and associated risk of a breach of either PHI or confidential company data by allowing these data to be printed on devices that are not properly secured.</p>			
<p>Finding #2: Lack of current policies and procedures</p> <p>WOAHA is developing a strategy to work with delegates and partners to create, maintain and update policies. The CCO will determine if some policies can be CCO-level and may not need to be duplicated by partners. WOAHA has some policies in draft format, and delegates have some draft policies and policies in need of updates. WOAHA plans to purchase, install and implement policy tracking software to better enable the CCO to maintain policies.</p>			
<p>Finding #3: CCO monitoring of delegated IT activities</p> <p>WOAHA did not provide evidence of monitoring and oversight of contracted or partner organizations’ IT systems, policies and procedures. Also, WOAHA provided no evidence of processes to monitor provider agencies’ activities related to information systems.</p>			
<p>Finding #4: NEMT monitoring and data submission to OHA</p> <p>As of the ISCA interview, NEMT encounter data had not yet been submitted to state. WOAHA later reported that all backlogged NEMT encounter data were submitted to the state as required.</p> <p>WOAHA has not yet determined policies and procedures for monitoring NEMT data. The ride vendor is responsible for monitoring that the transportation request has an associated appointment. The CCO needs to determine monitoring practices and/or reports to ensure that transportation services have a corresponding service that has been delivered (e.g., a physician office visit).</p>			
<p>Finding #5: Provider directory</p> <p>WOAHA has contracted with a new vendor to redesign and support its website. Members can now search on multiple provider attributes, but cannot search for specific types of behavioral health providers. Members are redirected to the dental provider network (DPN) websites for dental provider information, but members cannot search for specific types of dental health providers on the DPN websites. WOAHA uses informal processes for adding providers to or removing providers from the provider directory.</p>			

Willamette Valley Community Health (WVCH)

WVCH contracts with OHA to provide physical, behavioral and dental health services for OHP members in Marion and Polk counties. WVCH delegates many day-to-day operational activities to Willamette Valley Provider Health Authority, such as utilization and medical management, care management, disease management and credentialing. WVCH delegates behavioral health service delivery to Mid-Valley Behavioral Care Network; customer service, claims processing and information systems to PH Tech; dental services to Moda Health, Capitol Dental Care, Advantage Dental and Willamette Dental Group; pharmacy services to MedImpact; and NEMT services to the Salem-Keizer Transit District.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with WVCH regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 7 and partially resolved 2 of the 9 findings from 2014.
- Of 32 recommendations in 2014, 19 were resolved, 11 were partially resolved and 2 were not resolved.
- The CCO resolved 2, partially resolved 2 and did not resolve 1 of the 5 findings from 2015.
- Of 27 recommendations in 2015, 15 were resolved, 10 were partially resolved and 2 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Revise the CCO’s preauthorization process with new criteria for prescribing opioids at >120 mg MED/day for new non-cancer pain
- Quantity and duration limits/tapering program: members on >120 mg; six-month taper for long-acting opioids, two-month taper for short-acting opioids
- Remove preauthorization criteria for physical and occupational therapy for members tapering off opioids and receiving an evaluation from pain management specialists

Barriers:

- Resistance by some physicians to using a pain contract. WVCH’s Pharmacy and Therapeutics Committee will develop strategies to address this barrier.

Next steps:

- Continue the current interventions without changes.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Tobacco cessation and prevention
- Deploying care teams to improve care and reduce preventable or unnecessary utilization by “super users”

CCO Focus Area:

- Increasing the percentage of members assigned to a PCPCH

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Partially met (2.1)	Enrollment Systems	Fully met (2.6)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.2)
Security	Not met (1.4)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.2)	Meaningful Use of EHRs	Fully met (3.0)
Key Findings and Areas for Improvement			
Finding #1: Encounter data certification			
<p>PH Tech is contracted to submit encounter data on behalf of WVCH. WVCH has increased the contractual expectations of PH Tech’s role in this process. WVCH does not appear to be receiving copies of the 837 data submitted on its behalf. It was unclear how WVCH would monitor data received from partner organizations to ensure completeness and accuracy of the data. PH Tech has some processes to check for expected/estimated volume and trends. WVCH staff sign the certification documentation.</p>			
Finding #2: Business continuity/disaster recovery plan			
<p>WVCH has added to PH Tech’s contract that it will participate in a recovery exercise later in 2016 to train all delegates regarding CIM and what to do if CIM is unavailable.</p> <p>Many of the delegates have plans in draft form. WVCH is working to develop a strategy for the different plans and how they would interact or work together.</p>			
Finding #3: CCO monitoring of delegated IT activities			
<p>WVCH has begun the delegate monitoring process by understanding and augmenting contracted relationships. As part of this process, WVCH has started holding additional meetings to help communicate issues and work through roles and responsibilities. WVCH is planning to conduct additional oversight and monitoring in the future. WVCH has hired additional staff and is determining strategy and processes.</p>			
Finding #4: Provider directory			
<p>WVCH has updated its provider directory since the previous review. The CCO’s website contains agency-level information for many types of services such as dental or mental health. WVCH has included updated information on how to access transportation services.</p>			

Yamhill Community Care Organization (YCCO)

YCCO, located in McMinnville, is a private not-for-profit organization, formerly a subsidiary of CareOregon. The CCO provides physical, dental and behavioral health services for OHP members in Yamhill County and parts of Polk, Marion and Washington counties. YCCO subcontracts with Yamhill County Health and Human Services to manage behavioral health services; with CareOregon to administer physical health services and provide administrative and management support; with Advantage Dental, Capitol Dental Care, and ODS Community Health for dental services; and with First Transit for NEMT services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with YCCO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 6, partially resolved 4 and did not resolve 2 of the 12 findings from 2014.
- Of 45 recommendations in 2014, 31 were resolved, 9 were partially resolved and 5 were not resolved.
- The CCO resolved 4, partially resolved 5 and did not resolve 2 of the 11 findings from 2015.
- Of 38 recommendations in 2015, 14 were resolved, 14 were partially resolved and 10 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Share CCO and provider-level trending data on opioid prescribing and ED utilization
- Implement community prescribing guidelines/ provider education on system resources, including prescription drug monitoring program (PDMP) registration, work flow, etc.
- Implement alternative payment model (APM), with add-on payments for practices with no members on >120 mg MED
- Community coordination/education
 - Created a Controlled Substance Quality Oversight Committee to assist providers
 - Community health workers conduct Living Well with Chronic Disease classes

Barriers:

- Little ability to access the PDMP program data. The CCO reached out to providers and asked them to report on their enrollment and use in day-to-day practice.

Next steps:

- Continue site visits and sharing data on chronic users and breakdown of various MED levels.
- Disseminate updated guidelines to providers; analyze data on the adoption of the guidelines.
- Explore how to promote the PDMP among providers not using the tool.
- Continue to evaluate APM strategies on a quarterly basis.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Increase PCPCH enrollment
- Increase/improve adolescent well-care visits

CCO Focus Area:

- Reduce emergency department utilization

Information Systems Capabilities Assessment (ISCA)			
Section	Score (out of 3.0)	Section	Score (out of 3.0)
Information Systems	Fully met (2.8)	Enrollment Systems	Fully met (2.9)
Staffing	Partially met (2.4)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.5)
Security	Not met (1.7)	Provider Data	Fully met (2.8)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Fully met (3.0)
Key Findings and Areas for Improvement			
<p>Finding #1: Backup media improperly handled</p> <p>YCCO is not encrypting backup media. The backup media are connected to a server in a small closet during the week. YCCO uses two USB external drives as backup media. Each Friday, a staff member brings the USB external drive back into YCCO’s office and exchanges it with the external drive currently connected to the server. This staff member then takes the USB external drive removed from the server to staff member’s personal residence.</p>			
<p>Finding #2: Monitoring</p> <p>YCCO did not provide evidence of monitoring and oversight of contracted or partner organizations’ IT systems, policies and procedures. YCCO provided no evidence of a process to monitor provider agencies’ activities related to information systems. It was unclear how this function would be split between CCO staff and the CareOregon delegation team.</p>			

Appendix B: Oregon Statewide Performance Improvement Project (PIP) on Opioid Safety: Reducing Prescribing of High Morphine Equivalent Doses

Prepared by HealthInsight Oregon

Standard 1: Study Topic

Standard 1 establishes the importance of the study topic in general; presents local data to demonstrate that the topic applies to a large or high-risk portion of the Medicaid population and will have a significant impact on enrollee health, functional status, or satisfaction; and demonstrates that a systematic selection and prioritization process, that includes opportunities for input by enrollees and providers, was used in choosing the topic.

Status of PIPs in Oregon

OHA's contract with coordinated care organizations (CCOs), as negotiated with the Centers for Medicare & Medicaid Services, requires CCOs to conduct three PIPs and one focus study that target improving care in at least four of seven quality improvement (QI) areas. OHA determined that one of the PIPs would be conducted as a statewide collaborative on the integration of physical health and behavioral health, and in accordance with the 2012 CMS PIP protocol. The first Statewide PIP (2013–2015) addressed monitoring for diabetes in people with schizophrenia or bipolar disorder. The second Statewide PIP focuses on improving the safety of prescription opioid management.

HealthInsight Oregon, the state's external quality review organization, is responsible for facilitating and documenting the 10 PIP validation standards adapted from federal guidelines. The CCOs are responsible for developing interventions that meet the needs of their local communities and documenting their efforts in quarterly reports to OHA.

Topic Overview

Opioid abuse and misuse is a major public health problem in the United States. Federal and state health agencies, medical provider organizations, health care researchers and the Veterans Administration have been galvanized to address the opioid epidemic in response to public testimonies, provider concerns and alarming national statistics. The United States accounts for only 4.6% of the world's population, yet the country uses 99% of the world's supply of hydrocodone and 83% of the world's oxycodone.¹

¹ Report of the International Narcotics Control Board for 2007. https://www.incb.org/documents/Publications/AnnualReports/AR2007/AR_07_English.pdf. Accessed January 12, 2016.

Data collected at a national level reveal that from 1999 through 2006, opioid-analgesic deaths increased about 18% on average. The rate stabilized from 2006 to 2011, then began to decline in 2012.² A recent report by the Centers for Disease Control and Prevention (CDC) indicates that the decline has not been sustained. Data show that although overdose deaths due to natural and semisynthetic opioids (which include most of the prescribed opioid pain relievers) remained similar from 2012 to 2013, there was a 9% increase from 2013 to 2014.³

Overdose and death are not the only adverse effects of the abuse and misuse of prescription opioids. CDC estimated that prescription opioid abuse costs (e.g., lost workplace productivity, medical treatment and criminal justice costs), totaled about \$55.7 billion in 2007.⁴

Studies by Washington State and New York State demonstrated that the Medicaid population is disproportionately affected by the opioid epidemic. In Washington, a Medicaid enrollee was 5.7 times more likely to die due to prescription opioid overdose than a person not enrolled in Medicaid.⁵ A similar increased death rate among Medicaid enrollees was observed in New York from 2003 to 2012.⁶ In response to the particular vulnerability of the Medicaid population, CMS issued a bulletin describing Medicaid pharmacy benefit management and naloxone provision strategies states could employ to reduce opioid-related overdose deaths.⁷

As part of a national initiative to address the opioid problem, CDC awarded 16 states (including Oregon) grants to assist those states in their efforts to prevent opioid misuse and overdose. In addition, CDC issued opioid prescribing guidelines for primary care providers in early 2016. Although state, regional and professional guidelines and resource guides have been published, the CDC guidelines are the first set of standards

² Chen LH, Hedegaard H, Warner M. Drug-poisoning Deaths Involving Opioid Analgesics: United States, 1999–2011. NCHS Data Brief No. 166, September 2014.

<http://www.cdc.gov/nchs/data/databriefs/db166.pdf>.

³ Centers for Disease Control and Prevention. Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. *MMWR*, December 18, 2015.

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm64e1218a1.htm?s_cid=mm64e1218a1_e. Accessed January 12, 2016.

⁴ Centers for Disease Control and Prevention. Injury Prevention & Control: Prescription Drug Overdose. <http://www.cdc.gov/drugoverdose/data/overdose.html>. Accessed February 17, 2016.

⁵ Coolen P, Lima A, Savel J, et al. Overdose deaths involving prescription opioids among Medicaid enrollees—Washington, 2004-2007. *MMWR*. 2009; 58:1171-1175.

⁶ Sharp MJ, Melnik TA. Poisoning deaths involving opioid analgesics-New York State, 2003–2012. *MMWR*. 2015; 64:377–380.

⁷ Centers for Medicare & Medicaid Services. CMS Informational Bulletin: Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction. <https://www.medicare.gov/federal-policy-guidance/downloads/CIB-02-02-16.pdf>. Accessed February 17, 2016.

on prescription opioids from a federal agency. Among other recommendations, CDC proposed that providers should avoid increasing opioid dosages to ≥ 90 mg/day morphine milligram equivalent (MME)/day and “carefully reassess benefits and risks” when increasing opioid dosages to ≥ 50 MME⁸. Other guidelines (Washington State, Medicare) have established a target of < 120 mg/day MED.

In March 2016, President Obama addressed the National Prescription Drug Abuse and Heroin Summit in Atlanta and announced a series of public and private sector initiatives aimed at stemming prescription opioid abuse and the heroin epidemic. Among other actions, the federal government will increase the number of patients for whom a provider can prescribe buprenorphine from 100 to 200; award funding to 271 community health centers and 11 states to expand access to medication-assisted treatment (MAT); provide funding for states to buy and distribute naloxone, a drug used to reverse opioid overdose, and to train first-responders in its use; and create a federal interagency task force on mental health and substance use disorder parity.⁹

Oregon

Statewide, Oregon had the highest rate of nonmedical use of prescription opioids for people age 18 years and older in 2011–2012, according to the National Survey on Drug Use Health. Oregon tied for second place in 2012–2013.¹⁰

Data collected by state and federal agencies reveal the extent of the opioid epidemic in Oregon:

- In 2013, the number of deaths due to drug overdose exceeded that of motor vehicles among people 25 to 64 years of age. Half of the drug overdose deaths were related to prescription drugs, and more than 70% of the prescription drug overdoses involved opioids.¹¹
- The rate of opioid hospitalizations in Oregon increased from 2.6 per 100,000 in 2000 to 10.0 per 100,000 in 2013, according to the Oregon Public Health Division (PHD).¹²

⁸ Centers for Disease Control and Prevention. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. *MMWR*, March 18, 2016. Accessed at: <http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>.

⁹ White House press release: Fact Sheet: Obama Administration Announces Additional Actions to Address the Prescription Opioid Abuse and Heroin Epidemic. March 29, 2016. Accessed at: <https://www.whitehouse.gov/the-press-office/2016/03/29/fact-sheet-obama-administration-announces-additional-actions-address>.

¹⁰ National Survey on Drug Use Health. Available at www.icpsr.umich.edu/icpsrweb/ICPSR/series/64.

¹¹ Oregon Health Authority, Public Health Division. Injury and Violence Prevention Program. Prescription Drug Poisoning/Overdose in Oregon. http://www.orpdmp.com/PDO_2015v04242015.pdf. Accessed February 17, 2016.

¹² See note 9 above.

- Unintentional and undetermined prescription opioid poisoning death rates followed a similar trend, increasing from 1.4 per 100,000 in 2000 to 6.5 per 100,000 in 2006. In 2012, the rate was 4.2 per 100,000.¹³
- The PHD reported that while the prescription drug poisoning/overdose death rates in 2013 and 2014 had declined to about 4.0 per 100,000, the 2013 rate was still 2.8 times higher than in 2000.¹⁴
- Recent CDC data showed an increase in all drug overdose deaths in Oregon: from 11.3 deaths per 100,000 persons in 2013 to 12.8 deaths per 100,000 persons in 2014. Since the CDC data do not distinguish between deaths due to heroin and those due to natural and semisynthetic opioids (associated with the more commonly prescribed opioid pain relievers), further analyses are needed to determine if there is consistency between the national and state data.

In terms of the Medicaid population, an exploratory data analysis for this PIP by OHA's Office of Health Analytics demonstrated that of 170,000 adults age 18 years or older on Medicaid, 35,749 (21% of the total population) received six or more prescriptions for opioid pain relievers in calendar year 2014. The percentage of the CCO adult population receiving six or more prescriptions ranged from 8.0% to 31.1% per CCO.

Recognizing the alarming trend in prescription opioid misuse and abuse, the State of Oregon and health professionals and organizations have taken steps to address the problem, including but not limited to the following initiatives.

- The Oregon Legislature established a Prescription Drug Monitoring Program (PDMP) in 2009. The PDMP, which became operational in 2011, is intended to assist health care providers in providing better patient care by helping providers identify risks associated with controlled drug dispensing and use.
- In 2011, a managed care organization, Doctors of the Oregon Coast South (DOCS), selected the topic of opioid prescribing for a PIP after reviewing alarming pharmacy data. Opioid prescribing continued to be a focus for improvement even after DOCS merged with other partners to create the Western Oregon Advanced Health CCO.
- In 2011, Dr. Jim Shames, medical director of Jackson County Health and Human Services, along with several CCOs (AllCare, Jackson Care Connect) and

¹³ Oregon Health Authority, Center for Prevention & Health Prevention. Injury & Violence Prevention section. Drug Overdose Deaths, Hospitalizations, Abuse & Dependency among Oregonians. <http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/oregon-drug-overdose-report.pdf>. Accessed February 17, 2016.

¹⁴ Oregon Health Authority, Public Health Division. Injury and Violence Prevention Program. Prescription Drug Poisoning/Overdose in Oregon. http://www.orpdmp.com/PDO_2015v04242015.pdf. Accessed February 17, 2016.

interested health care professionals, formed the Oregon Pain Group (OPG) to address the growing negative impact of prescription opioids in southern Oregon. OPG has identified and developed patient and provider materials and guides (including an Opioid Prescribers Guideline), hosts annual pain conferences and maintains a website for health care professionals and patients (<http://www.oregonpainguidance.com/>).

- In 2012 and 2013, the Prescription Drug Task Force, appointed by Governor John Kitzhaber, hosted meetings for stakeholders interested in developing and implementing a prescription drug strategy. Interested stakeholders formed the Oregon Coalition for Responsible Use of Meds, whose mission is to “prevent overdose, misuse and abuse of amphetamines and opioids, both prescription and illicit.”¹⁵
- In 2014, the Healthy Columbia Willamette Collaborative convened a workgroup to develop opioid prescribing standards. The workgroup represented four Portland area public health departments (Clackamas, Multnomah and Washington counties, OR, and Clark County, WA), safety net clinics, two CCOs (FamilyCare and Health Share of Oregon), local hospitals and professional organizations. After nearly a year’s work, the workgroup released the Portland Metro Regional Safe Opioid Prescribing Standards in December 2015.
- After reviewing the existing research on back pain treatments, including surgery and opioids, OHA’s Health Evidence Research Commission presented a revised back pain guideline to the Quality and Health Outcomes Committee (QHOC) meeting in February 2015. Key changes in the treatment of back pain included limiting coverage on the prescription of opioids and adding coverage for non-opioid therapies such as physical therapy, chiropractic, acupuncture and massage. The new guidelines were scheduled for implementation on January 1, 2016, but implementation was delayed until July 2016.
- In 2015, the PHD received a Prescription Drug Overdose Prevention for States grant from CDC. The purpose of the grant was to help states enhance their PDMPs and work with communities, health systems and providers to develop and implement interventions to prevent prescription drug overdose. As part of this effort, the PHD developed a toolkit to help CCOs develop a more comprehensive approach to reducing opioid overdose and misuse (<https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Documents/reducing-opioid-overdose-cco-guide.pdf>).

¹⁵ Oregon Coalition for Responsible Use of Meds. <http://orcrm.org>. Accessed January 12, 2016.

- In November 2016, the Oregon Opioid Prescribing Guidelines Task Force, representing the PHD, CCOs, physical health, mental health, oral health and addiction medicine professional organizations, pharmacists, federally qualified health centers and other opioid task forces, adopted the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain as “the foundation for opioid prescribing for Oregon” and provided additional recommendations to address Oregon-specific issues.¹⁶

Topic Selection and Prioritization

At the April 2015 QHOC meeting, QI directors and managers divided into small groups to begin preliminary discussions about topics for the second Statewide PIP (start date July 1, 2015). The following topics garnered the most support: opioid management, maternal medical home, tobacco prevalence and cessation, effective contraceptive care and assessments for children in DHS custody. Following the discussion, Lisa Bui, OHA’s QI director, sent an online survey to all CCOs asking them to rank the above list according to their top three preferences.

HealthInsight Oregon encouraged, but did not require, CCOs to solicit stakeholder input. It is not clear what, if any, influence enrollees had in prioritizing the topic. The overwhelming majority of CCOs selected the topic of opioid management as their first preference. The selection of opioid management as a topic for the second Statewide PIP received final approval by the OHA Quality Council in June 2015.

Standard 2: Study Question

Standard 2 presents a study question that provides a clear framework for data collection, analysis, and interpretation. The study question should refer to the proposed intervention, a study population (denominator), what is being measured (a numerator), a metric (e.g., average, percentage), and a direction of desired change.

All participating CCOs conduct the PIP with the same topic, indicators and objectives, but may have different interventions. Consequently, the interventions are not defined in the study questions.

Two study questions were developed after finalization of the study metric:

Study question #1: Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥ 120 mg MED on at least one day within the measurement year?

¹⁶ Oregon Opioid Prescribing Guidelines: Recommendations for the Safe Use of Opioid Medications. <https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf>. Accessed on January 30, 2017.

Study question #2: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥ 90 mg MED on at least one day within the measurement year?*

Standard 3: Study Population

Standard 3 provides a brief description of the study population; lists all inclusion and exclusion criteria for the study population, including enrollment criteria; and provides definitions and data sources, including codes and calculations. If a sample is selected, the sampling methods will be described.

This PIP targets adult and adolescent OHP members who have at least one prescription for an opioid pain reliever filled within the measurement year. The study includes all qualified members and does not require sampling.

Study Population (Denominator) Inclusion Criteria and Definitions

- *OHP enrollment (Medicaid/CHIP-enrolled):* Enrolled in Medicaid or CHIP at the time of service. The study population includes enrollees with dual eligibility in Medicaid and Medicare and enrollees in CHIP who meet the rest of the study criteria.
- *Continuous enrollment:* The 2015 HEDIS specifications define enrollment as continuous enrollment with only one enrollment gap allowed of no more than 45 days during the measurement year.
- *Adults and adolescents:* Medicaid enrollees ≥ 12 years of age on the final day of the measurement year. Data will be analyzed and reported according to the following stratifications: 12–17, 18+ and total.
- *Opioid pain reliever:* All medications covered under the OHA therapeutic class 40: narcotic analgesics. Using the therapeutic class to define opioids allows for year-to-year variation as NDC codes and medication formulations change. Cough and cold medications are “under the line” (i.e., not covered by OHA) and are not included in the definition. A table of the individual codes for drugs in this class is available as a separate document from HealthInsight Oregon or tOHA’s Office of Health Analytics.

Denominator Exclusion Criteria

- *Neoplasm-related pain/end of life care/palliative care/hospice:* The use of high doses of opioids under these circumstances is appropriate, and members who are identified as meeting this criterion according to relevant medical claim codes will be excluded from the study denominator.

According to the Washington State Agency Medical Directors' Group, "In the absence of 'red flags' for malignancy, simple exacerbations of chronic pain in the [cancer] survivor may be treated in a manner similar to chronic non-cancer pain."¹⁷ A cancer diagnosis is not considered to be an exclusion criterion. As "red flags" cannot be identified through claims data, it is likely there will be a small number of members with active malignancy who have a cancer diagnosis but have not yet received an end of life/palliative care/hospice diagnosis.

See Attachment A for a list of the relevant denominator exclusion codes.

- *Buprenorphine*: Buprenorphine, alone or in combination with naloxone, is a semi-synthetic partial opioid agonist. The U.S. Food and Drug Administration has approved transmucosal, film and sublingual buprenorphine products for the treatment of opioid use disorder (MAT). MAT drugs are excluded from the therapeutic class 40 narcotic analgesic drug list, so members on these medications ONLY are excluded from the denominator as they do not need to be targeted for MME reduction interventions.

Buprenorphine transdermal patches and injections are not approved for use in MAT, and are included in the therapeutic class 40 narcotic analgesic drug list. OHA data analysis from July 2016 revealed that 0.04% of opioid medication claims for the study population were for buprenorphine, and those claims were for transdermal buprenorphine patches (Butrans®).

Standard 4: Study Indicator

Standard 4 provides a definition of the numerator (what is being measured) and the denominator; defines key terms; describes the target goal; discusses the basis for adopting the indicator as a valid proxy for enrollee outcomes, satisfaction, or quality of care; lists all inclusion and exclusion criteria for the numerator (what is being measured), including enrollment criteria; and provides definitions and data sources, including codes and calculations.

Statewide PIP metric: Percentage of OHP enrollees age 12 years and older who filled prescriptions for opioid pain relievers of ≥ 120 mg MED on at least one day, and the percentage of enrollees with ≥ 90 mg MED on at least one day during the measurement year.

¹⁷ Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain. 3rd Edition, June 2015.

<http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>.

Metric Selection

Following the topic confirmation, HealthInsight Oregon conducted a literature review and identified a list of potential metrics for a Statewide PIP on the management of opioid prescription drugs. The list was reviewed by the Office of Health Analytics, several members of the HealthInsight Oregon PDMP research team and the Healthy Columbia Willamette Collaborative opioid monitoring workgroup. The documents were discussed by the medical directors at the July 2015 QHOC meeting, and were evaluated in more depth by the Quality and Performance Improvement (QPI) workgroup in the afternoon QHOC session. The QPI workgroup selected the following three metrics for further consideration:

1. Percentage of individuals on opioid doses ≥ 120 mg MED per day
2. Proportion of individuals with overlapping prescriptions for opioids and benzodiazepines
3. Percentage of adolescents and adults, previously naïve to opioid pain reliever utilization, who became chronic users of opioid pain relievers (this metric is used by the Minnesota Department of Human Services and is referenced in this report as “the Minnesota metric”)¹⁸

Following the QPI workgroup, HealthInsight Oregon, OHA and the Office of Health Analytics met to discuss the metric specifications for each of the three metrics, and developed a list of clarifications that needed to be presented to the larger group for final decisions. A handout of issues needing clarification, along with a table of individuals with opioid prescriptions for calendar year 2014 (analyzed according to CCO, age and 6+ prescriptions), was distributed at the September 2015 QHOC meeting. Discussions at the medical director or QPI sessions produced no consensus on metric selection. Copies of the three metric technical specifications, along with a list of pros/cons gathered from past discussions, were emailed to CCO medical directors and QI managers, along with a survey asking each of the 16 CCOs to submit a single vote for one of the three metrics. These are the survey results:

- Metric #1 – 9 votes
- Metric #2 – 2 votes
- Metric #3 – 5 votes

This information, along with feedback from the PHD and the CCO Pharmacy Directors workgroup, was presented to OHA leadership. At OHA’s request, the Office of Health Analytics conducted data analyses of each CCO’s Medicaid populations using the

¹⁸ Schiff, J. Analysis of Opioid Utilization CYs 2011–2014. Minnesota Department of Human Services, Office of the Medical Director. August 20, 2015.

Minnesota metric eligibility criteria to determine the metric's feasibility. The analyses demonstrated that four CCOs had numerators of less than 40, and another two CCOs had numerators less than 50. Although OHA leadership was interested in the Minnesota metric, the small study populations presented a barrier to implementation, as was demonstrated in the first Statewide PIP on diabetes monitoring in the SPMI population. Instead, OHA leadership selected the ≥ 120 mg MED metric as the Statewide PIP metric and decided to investigate other avenues for a metric focused on naïve to chronic users, such as review by the OHA Scoring and Metrics Committee.

Once a decision was made to monitor the management of opioid pain relievers by measuring a dosing threshold, concerns were raised about the dosing threshold level itself. While experts agree that there is a dose-related risk for overdose and adverse effects,¹⁹ at the time the PIP metric definitions were discussed at QHOC, they had not achieved consensus on a dosage limit performance measure. During that time, CDC had invited subject matter experts and the public to review and comment on a draft Guideline for Prescribing Opioids for Chronic Pain. The draft CDC guidelines recommended a dosing threshold of ≤ 90 mg MED per day.²⁰ The 2015 edition of the Washington State Interagency Guideline on Prescribing Opioids for Pain included a recommendation from the 2010 edition that prescribers avoid prescribing opioids > 120 mg/day MED without first consulting with a trained pain specialist. Citing studies from the literature,^{21,22} the Washington guideline emphasized that “there is no completely safe opioid dose.”²³

Data provided by the Office of Health Analytics revealed that CCOs that had worked on opioid prescribing issues for several years had significantly lower percentages of members on ≥ 120 mg MED per day than did organizations just beginning work in this area. Experienced CCOs expressed concern that given the lower percentages, it would be difficult to demonstrate improvement over a short period of time. After discussion of additional pros and cons of different dosage levels at the November QHOC meeting, HealthInsight Oregon surveyed CCOs as to their study metric dosage threshold preference. Each of the 16 CCOs was asked to select only one option. The results of the

¹⁹ Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain. 3rd Edition, June 2015.

<http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>.

²⁰ Centers for Disease Control and Prevention. Draft CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. <http://www.regulations.gov/#!documentDetail;D=CDC-2015-0112-0002>. Accessed January 12, 2016.

²¹ Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med*. 2010.

²² Fulton-Kehoe D, Garg RK, Turner JA, et al. Opioid poisonings and opioid adverse effects in workers in Washington State. *Am J Ind Med*. 2013.

²³ See note 15.

survey are as follows (PacificSource–Central Oregon and PacificSource–Columbia Gorge voted as a single CCO):

- ≥ 90 mg MED – 7
- ≥ 100 mg MED – 1
- ≥ 120 mg MED – 7

Several CCOs that supported the ≥ 120 mg MED threshold noted that they had already begun educating providers and implementing interventions based on that threshold assumption. The survey results, along with CCO comments, were presented to a OHA Quality Directors Committee meeting. The committee decided that this PIP should measure both the 90 mg and the 120 mg thresholds.

While data will be collected on both numerators (≥ 120 mg and ≥ 90 mg MED/day) at the statewide level, CCOs have the option of collecting data internally on either or both of the metrics. Because CCOs differ significantly in terms of study baseline rates (percentage of members with opioid doses ≥ 120 mg MED/day or ≥ 90 mg MED/day) and existing implementation strategies, target goals will be established at the CCO level.

Study Numerators

Numerator inclusion criteria and definitions:

- Study eligible (meet the denominator definitions)
- *90 mg and 120 mg MED per day*: Daily MED is calculated as drug strength multiplied by quantity divided by days' supply, multiplied by the conversion factor identified by CDC (the table of morphine equivalent conversion factors is available as a separate document from the Office of Health Analytics). MED will be calculated per filled prescription, applied to the date range according to the fill date and days' supply and then summed for patient total. Any overlapping prescriptions should be summed on each day of overlap.

Any enrollee in the denominator who filled prescriptions for opioid pain relievers of ≥ 120 mg MED or ≥ 90 mg MED for one day during the measurement year will be included in the numerators.

Standard 5: Data Collection and Data Analysis Plan

Standard 5 describes data collection and data validation procedures, including a plan for addressing errors and missing data, and presents a clear data analysis plan, including time frames for the measurement and intervention periods and an appropriate statistical test to measure differences between the baseline and remeasurement periods.

Data Collection

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

From MMIS, data are transferred to the Decision Support Surveillance and Utilization Review System (DSSURS), where it is organized to facilitate reporting and other data extraction. The Office of Health Analytics pulls data from DSSURS, applies the continuous enrollment and exclusion criteria and then calculates the study indicators for the measurement periods and for monthly reports to each CCO. Data are reported to the CCOs in a rolling 12-month format and according to age group (12–17, 18+ and both age groups).

In addition to study indicator data, OHA analyzes and reports the number and percentage of the members in the study denominator who have opioid prescriptions of 90 mg MED and 120 mg MED for at least 30 consecutive days. A report on consecutive 30-day opioid use at 90 mg MED and 120 mg MED was generated at the beginning of this PIP to alleviate CCO concerns that the study numerator results were artificially inflated due to technicalities, such as overlapping prescriptions.

CCOs are expected to track the study indicators internally. OHA has offered all CCOs technical assistance for collecting data and applying the technical metric specifications.

Data Verification and Validation

At the end of the remeasurement period, OHA allows for a 90-day period to receive all CCO claims (a 90-day period to collect and process claims is routine practice). OHA then calculates the study data and posts member-level data on each CCO's secure FTP site. CCOs are asked to review the information and send any revisions/questions to the designated OHA contact, who works with the Office of Health Analytics to evaluate the CCO queries.

Quality management personnel at each CCO are responsible for reviewing and comparing OHA monthly reports against their own data reports to reconcile any discrepancies. Before submitting data to the state, CCOs perform automated edits and

validation checks to ensure completeness and correctness of submitted claims. Currently, there is no contractual requirement for the CCOs to perform encounter data validation in accordance with the CMS standards for that activity.

Study Time Periods

- **Baseline measurement:** January 1–December 31, 2014
- **First remeasurement:** January 1–December 31, 2016
- **Second remeasurement:** January 1–December 31, 2017

CCOs, OHA and HealthInsight Oregon agreed on the date range for the first remeasurement period based on the expected date for many of the CCOs to begin implementing their interventions. A non-consecutive baseline measurement period was selected because a longer period of time would allow those CCOs that had worked on the study topic for several years more opportunity to demonstrate improvement in the study indicator.

The study results for each study indicator at the statewide level will be tested for a statistically significant difference between baseline and remeasurement periods using a one-tailed chi-square test (appropriate for categorical data with a directional hypothesis) with a probability level of $p \leq .05$.

Standard 6: Study Results

Standard 6 presents results according to the data analysis plan, including the study indicator, the original data used to compute the indicator, and a statistical test to measure differences between the baseline and remeasurement periods; and discusses any other data analyses for factors that may affect the study results.

Study results are reported according to study metric threshold and in the following order.

- Aggregated statewide numerator, denominator and calculated indicator for baseline and current measurement
- Results of statistical tests
- Table of aggregated statewide numerator by age
- Graph of the aggregated statewide numerators, denominators and rates from 2014 (baseline) to the current measurement period
- Graph of the individual CCO rates from 2014 to the current measurement period

≥120 mg MED Metric Results

Table 1 shows the baseline and last remeasurement period results for the ≥120 mg MED metric.

Table 1. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥120 mg MED on at least one day during the measurement year.		
Study indicator	Baseline January 1–December 31, 2014	Current December 1, 2015– November 30, 2016
Numerator	11,945	9518
Denominator	112,768	101,800
Calculated indicator	10.6%	9.3%

The chi-square test yielded a result of 91.8 with 1 degree of freedom, with a one-tailed p value of <0.001, indicating a statistically significant difference between the percentage of enrollees age 12 years and older who filled opioid prescriptions for at least ≥120mg MED at baseline and current remeasurement.

Table 1a shows the 120 mg study metric data according to age group

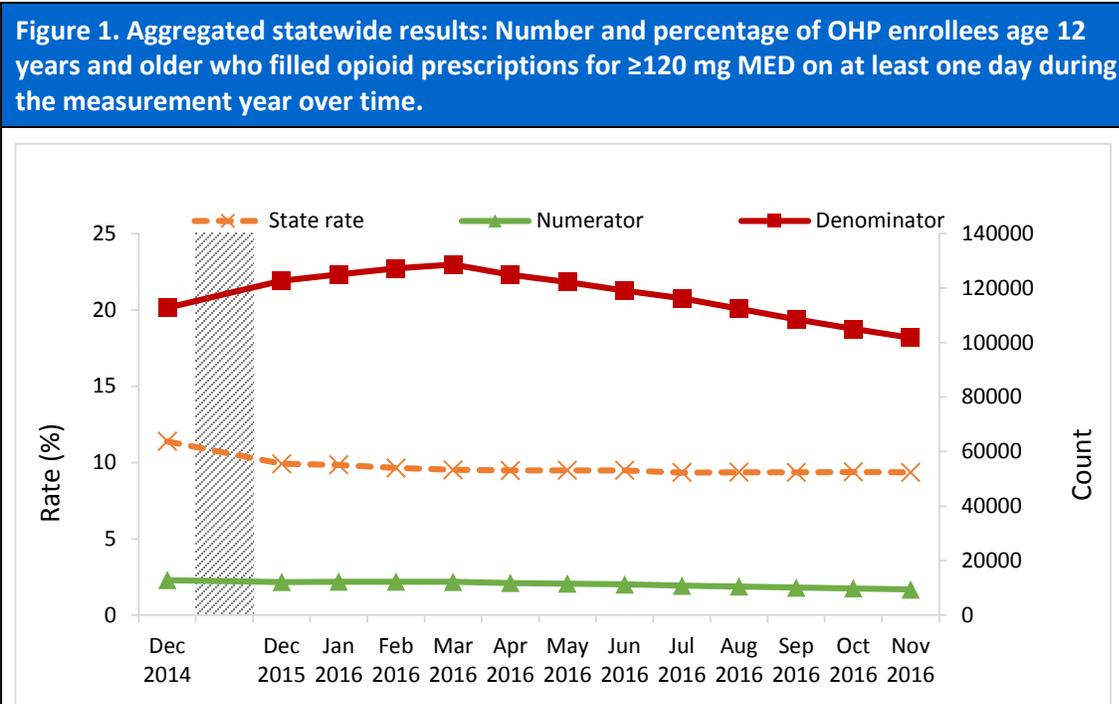
Table 1a. Aggregated statewide results: Number of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥120 mg MED on at least one day during the measurement year according to age group		
Age group	Baseline January 1–December 31, 2014	Current December 1, 2015– November 30, 2016
12–17 years	142	77
18+ years	11803	9441
Total	11945	9518

The number of enrollees age 12–17 who filled an opioid prescription ≥120mg MED on at least one day during the measurement period decreased by approximately 50% from baseline to current remeasurement, compared to the 18+ age group, which decreased by 20% in the same period.

The graphs of the statewide and CCO study results include calendar year 2015, even though that year is not included as a measurement period in the data analysis plan. Study indicator data from January 1 to December 31, 2015, are presented in order to

better analyze trends and understand the relationship between CCO interventions and the study results.

Figure 1 shows the aggregated statewide results for the 120mg MED metric over time.

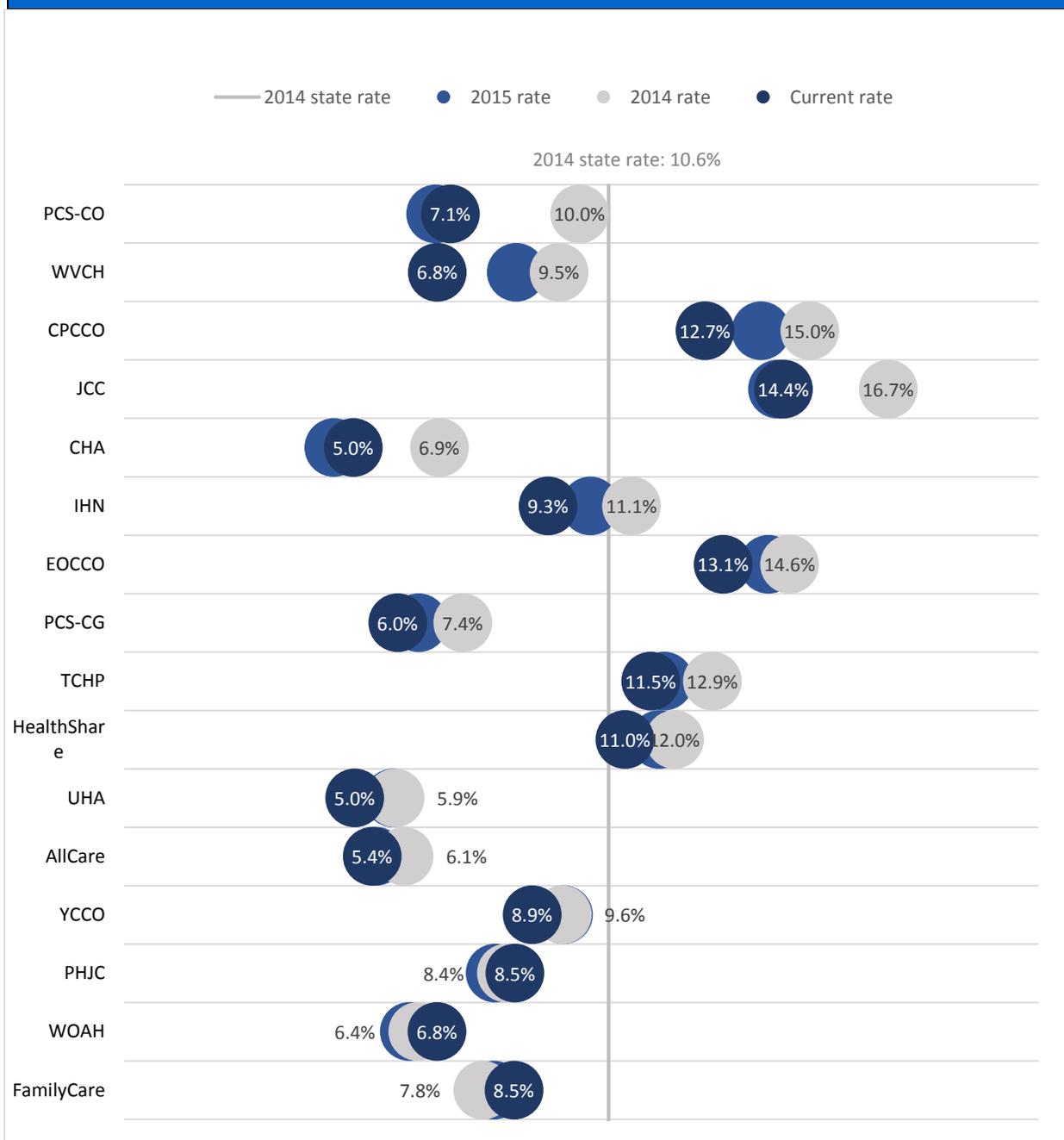


The study denominator increased over time until March 2016, when it dropped steadily until the current measurement. Although difficult to discern because of the scale of the graph, the study numerator also increased from 2014 to 2015, then decreased slightly and steadily over time. The statewide rate showed an initial decrease from 2014 (10.6%) to 2015 (9.9%) and then continued to decrease slightly over 2016.

The above tables and graphs provide information on the aggregated study results. It is important to examine CCO-level as well as statewide results to get a more accurate understanding of the prescription opioid problem in Oregon.

Figure 2 shows CCO progress on the 120 mg MED metric over time. CCOs are ordered from top to bottom according to the amount of progress from baseline to current measurement. Note: the figure does not display 2015 rate data labels.

Figure 2. CCO progress on ≥120 mg MED study metric from baseline to current remeasurement.



≥90 mg MED Metric Results

Table 2 shows the baseline and last remeasurement results for the ≥90 mg MED metric.

Table 2. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥90 mg MED on at least one day during the measurement year.		
Study indicator	Baseline January 1–December 31, 2014	Current December 1, 2015– November 30, 2016
Numerator	20,235	16,974
Denominator	112,768	101,800
Calculated indicator	17.9%	16.7%

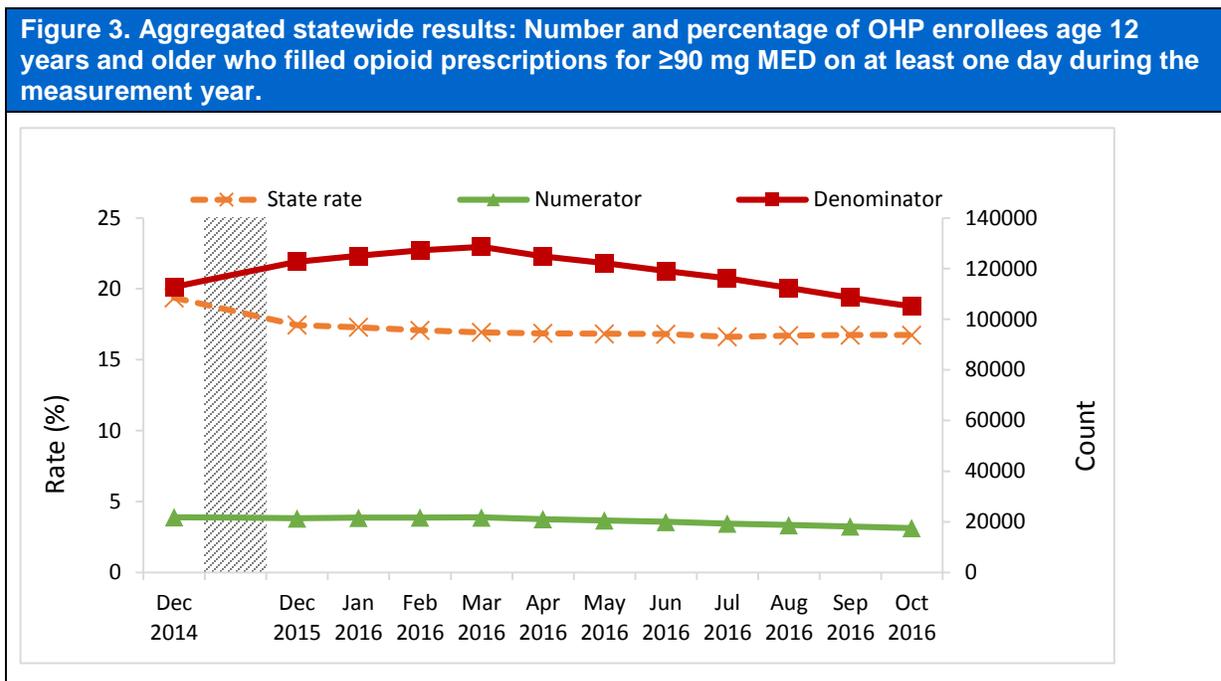
The chi-square test yielded a result of 78.4 with 1 degree of freedom, with a one-tailed *p* value of <0.001, indicating a statistically significant difference between the percentage of enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 mg MED at baseline and current remeasurement

Table 2a shows the 90 mg study metric data according to age group

Table 2a. Aggregated statewide results: Number of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥90 mg MED on at least one day during the measurement year according to age group.		
Age group	Baseline January 1–December 31, 2014	Current December 1, 2015– November 30, 2016
12–17 years	354	220
18+ years	19,881	16,754
Total	20,235	16,794

As with the 120mg metric, the 12–17 year old group showed more improvement over time than the older group in reducing the numbers of enrollees with opioid prescriptions of ≥90 mg MED for any day in the measurement period. Compared to the 120 mg metric results, the decreases were not as large (approximately 40% for the 12–17 year old group; approximately 15% for the 18+ year old group).

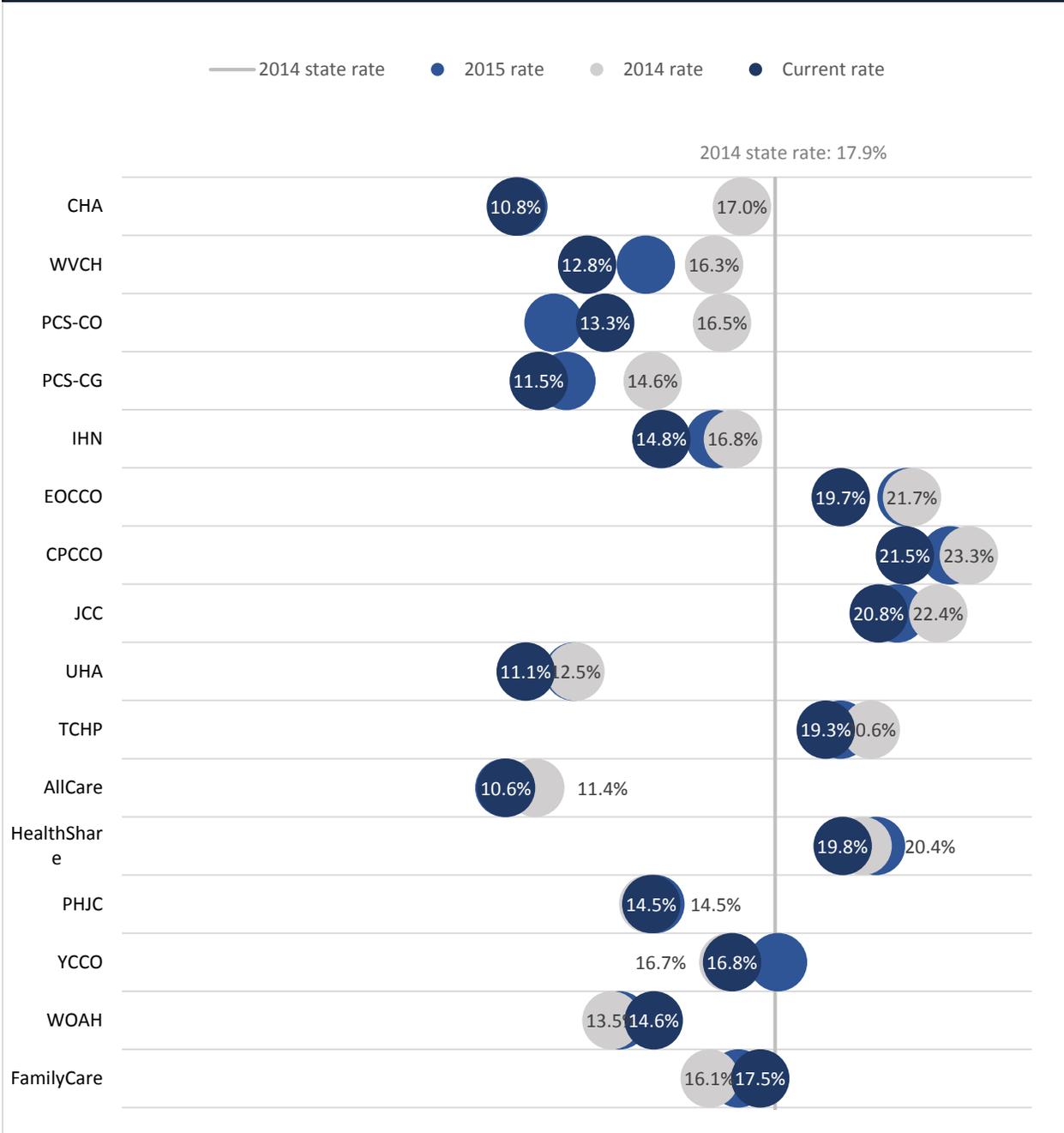
Figure 3 shows the aggregated statewide results for the 90 mg MED metric over time.



As with the 120 mg MED metric results, the study numerator and rate decreased slightly from baseline to current measurement.

Figure 4 shows CCO progress on the 90 mg MED metric over time. CCOs are ordered from top to bottom according to the amount of progress from baseline to current measurement. Note: the figure does not display 2015 rate data labels.

Figure 4. CCO progress on ≥90 mg MED study metric from baseline to current remeasurement.



Additional Analyses

Demographic analyses of the statewide study baseline denominator and chronic high user numerator populations indicate that Latino/Hispanic, Asian and Race/ethnicity unknown enrollees are underrepresented in the numerator, while Caucasian/white enrollees are overrepresented. The complete analysis appears in Attachment E.

OHA provided CCOs with data on the percentage of OHP members on ≥ 120 mg and ≥ 90 mg for 30 or more consecutive days. The additional analyses were provided to help CCOs identify their chronic user populations.

Tables 3 and 4 compare baseline and remeasurement results for high chronic users.

Table 3. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥ 120 mg MED for consecutive 30 days or more within the measurement year.

Study indicator	Baseline	Current remeasurement
	January 1–December 31, 2014	December 1, 2015–November 30, 2016
Numerator	3,129	2,019
Denominator	112,768	101,800
Calculated indicator	2.8%	2.0%

Table 4. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥ 90 mg MED for consecutive 30 days or more within the measurement year.

Study indicator	Baseline	Current remeasurement
	January 1–December 31, 2014	December 1, 2015–November 30, 2016
Numerator	4,448	3,239
Denominator	112,768	101,800
Calculated indicator	3.9%	3.2%

Statistical tests indicate a statistically significant difference between the percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least 120 mg and 90 mg MED for 30 consecutive days or more at baseline and at current remeasurement.

Figures 5 and 6 show CCO progress over time on the supplemental measures. Note: the figures do not display 2015 rate data labels.

Figure 5. ≥120 mg MED for consecutive 30 days metric by CCO over time.

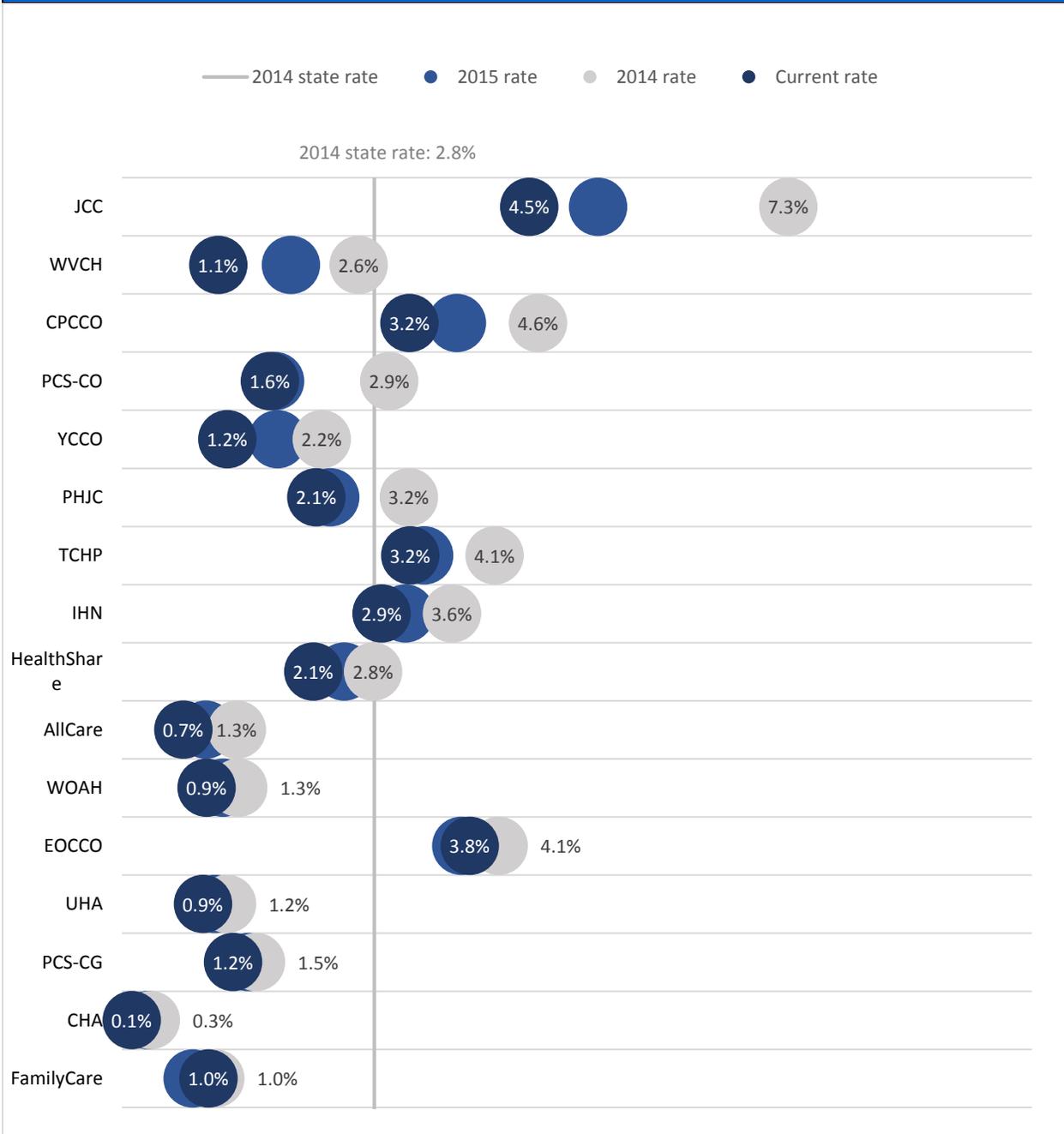
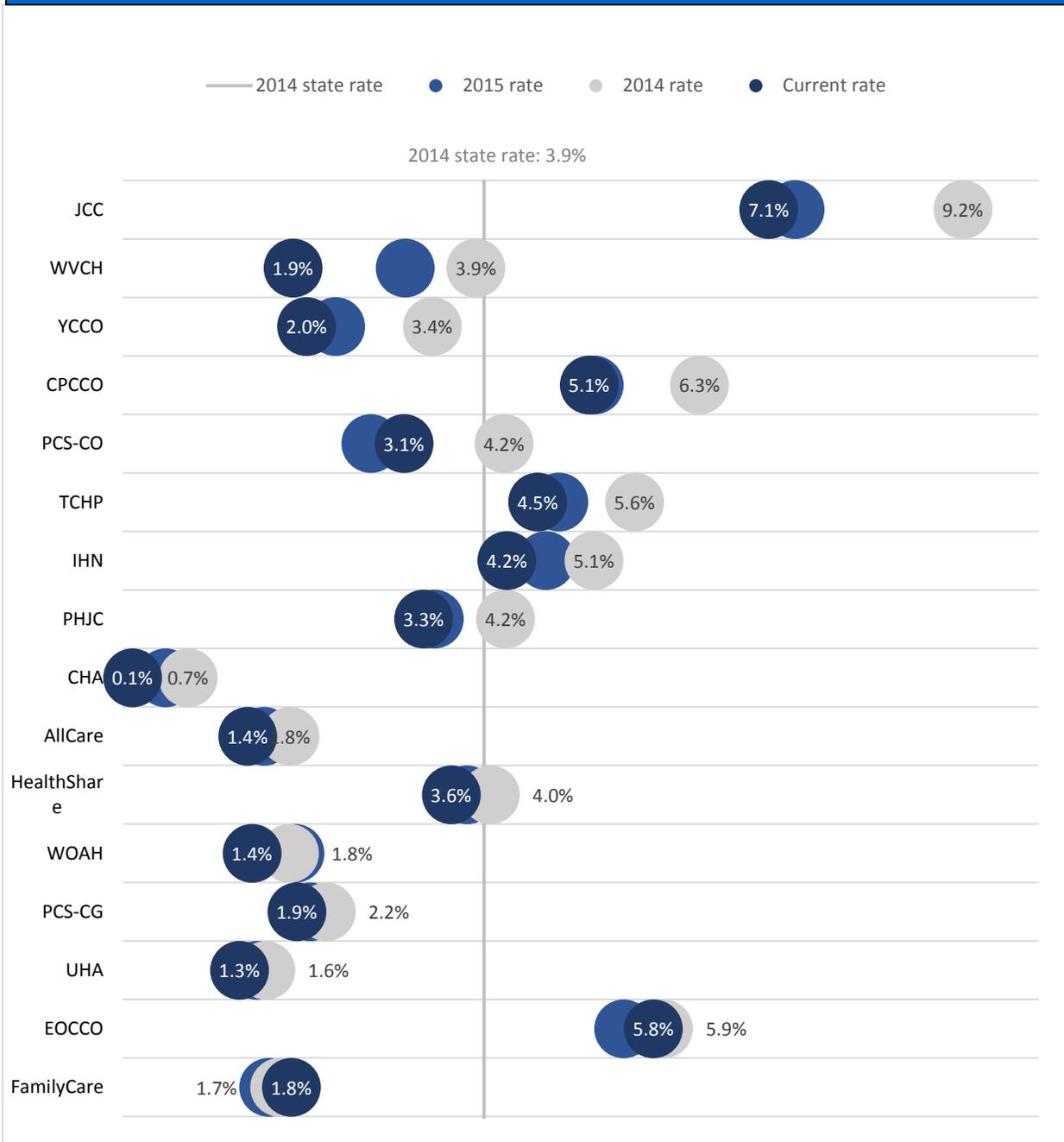


Figure 6. ≥90 mg MED for consecutive 30 days metric by CCO over time.



Standard 7: Interpretation of Results

Standard 7 lists any changes to the study design and discusses the effect of those changes on the comparability of data and interpretation of results; describes any factors that threaten the internal or external validity of the study; discusses whether the intervention was implemented as planned; describes any improvement in enrollee health, functional status, or satisfaction and accomplishment of target goals; discusses how the intervention influenced the results; discusses lessons learned during the PIP process; draws a conclusion about the study results based on the above factors; and describes next steps for the study.

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

The following factors need to be considered when interpreting the study results.

Data validity and limitations:

- At the time of this report, OHA was only able to provide study data through November 30, 2016, due to a 90-day claims lag. The current measurement period (December 1, 2015–November 30, 2016) overlaps the previous measurement period (calendar year 2015) by one month and omits data from the month of December 2016. Discussions with CCOs revealed no major events in December 2016 that would significantly reverse the trends of the previous 11 months. While the current measurement is not strictly comparable to the baseline measurement period (calendar year 2014), tentative conclusions can be drawn.
- The baseline (calendar year 2014) and first remeasurement period (calendar year 2016) are not contiguous, leaving calendar year 2015 unaccounted for. However, this project is not a strictly before-after comparison, as at least four CCOs had implemented prior authorization and quantity limits for opioids and provider education for several years prior to the study baseline. Collection and analyses of an additional data point (calendar year 2015) will better demonstrate any trends and help rule out statistical regression as a threat to validity.
- The study data are aggregated across 16 CCOs, but as noted above, a number of CCOs had implemented interventions aimed at improving the opioid problem in their communities, resulting in significantly lower than average study metrics at baseline. To gain a better understanding of the actual progress on this measure, it will be necessary to analyze the individual CCO study results alongside the aggregated study indicators.
- Although patients with a diagnosis for palliative care, hospice or end-of-life care are excluded from the denominator, patients with a diagnosis of cancer are not. It is likely that a small number of members with active malignancy who had not yet received an exclusion diagnosis will be included in the numerator.

- The single end-of-measurement period data do not reflect ongoing improvement efforts. Members who were tapered off of high-dose opioids during the measurement year still appear in the numerator, and the intervention success will not be evident until the following measurement year data collection. However, OHA is analyzing and reporting study indicator data on a rolling 12-month basis, and displaying the data in time-series graphs more accurately reflects the effect of intervention strategies.
- Members might be included in the numerator for administrative reasons (one-day overlap in prescriptions) that do not reflect the member's ongoing opioid use. However, this PIP is focused on opioid safety, and even one day at 120 mg MED or 90 mg MED puts members at risk. Their inclusion in the numerator, therefore, is appropriate.
- CCO Medicaid claims do not capture cash payments by members for prescription opioids. It is not clear to what extent the exclusion of cash purchases of opioids affect the study numerators and denominator. At least one CCO (Cascade Health Alliance) has identified the cash purchase of opioids as a significant contributing factor to its local opioid problem.
- The topic of opioid safety is complex, and the study metrics address only one safety aspect (high dosages and chronic high use). CCO efforts around other and equally important opioid safety issues, such as co-prescribing and the transition from naïve to chronic use, are not reflected in the study metrics.

Possible confounding factors:

- Other local and state organizations (see Standard 1) have implemented interventions as part of their own strategies to address opioid misuse and abuse, independent of the CCO-initiated interventions, which could have contributed to a decrease in the remeasurement study indicator results. Nationally, CDC released its final Guideline for Prescribing Opioids for Chronic Pain in March 2016. These guidelines and the media attention surrounding their release could have influenced provider prescribing practices, separate from any local CCO-initiated interventions.
- The delay in the implementation of OHA's back and spine policy guidelines (originally scheduled to begin January 1, 2016, but implemented July 1, 2016) disrupted CCOs' plans to develop and fund non-opioid therapies, and could have had a negative impact on improvement in the study indicators in the first remeasurement period. However, the restrictions on opioid treatment for enrollees with newly diagnosed back and spine conditions (seven days'

medication at a time, no medication coverage after 90 days), might have had an effect on the number of opioids in circulation (study denominator).

Results of the statistical analyses showed statistically significant differences between baseline and current remeasurement periods for both study indicators as well as for the supplemental consecutive 30 day measures.

Analysis of performance by percentage without taking frequencies into account provides an incomplete picture. As shown in the Standard 6 graphs and tables, the number of enrollees in the statewide and CCO study denominators decreased at a more rapid rate than the study numerators (see Attachment D for CCO-level data). Even though their numbers decreased, some CCOs saw little change or even an increase in their study metric rates over time. The amount of opioids in circulation would be expected to decrease more quickly than the number of members being tapered off chronic doses of high opioids. A number of CCOs implemented taper plans of several months' duration that did not begin until late 2016. It is not clear whether or not the decrease in opioids in circulation is appropriate. CCOs have reported that they plan to monitor provider refusals to prescribe opioids. No quantitative or qualitative results regarding this topic were documented in quarterly progress reports.

There was a notable increase in the total (both age groups) statewide and CCO study denominators from 2014 to 2015, with a smaller increase in both numerators. However, in the 12–17 year old group, there was a consistent decrease in the denominator from 2014 to 2015 and from 2015 to 2016 (see Attachment C). The increase in the adult denominators and numerators can be accounted for by the increase in CCO enrollment (from 707,458 as of 1/15/14 to 916,127 as of 1/15/15)²⁴ and by the complete incorporation of dental claims into CCO claims report (CCOs began incorporating dental claims at different times throughout 2014; 2015 was the first entire year of integrated claims). It is not clear why the overall denominators and numerators increased to their highest point in March 2016, and then began to decrease.

As seen in Figures 2 and 4, baseline study metrics varied widely among CCOs. For the 120 mg MED metric, baseline rates ranged from 5.9% (Umpqua Health Alliance) to 16.7% (Jackson Care Connect). For the 90 mg MED metric, baseline rates ranged from 11.4% (AllCare) to 23.3% (Columbia Pacific CCO).

CCOs also varied as to their percentages of high chronic users (enrollees in the study denominator on 30 consecutive days or more of opioid dosages ≥ 120 mg MED or ≥ 90 mg MED) at baseline and in their progress over time.

²⁴ Accessed at:

<https://www.oregon.gov/oha/healthplan/DataReportsDocs/April%202016%20Mental%20Health%20Service%20Delivery%20by%20Rate%20Group.pdf>.

Tracking and monitoring of data from CCO progress reports demonstrates successful implementation of interventions. CCOs are continuing to develop and implement interventions around pain management and buprenorphine prescribing training for providers, opioid risks and alternative pain treatment education for members and the community, increasing access to MAT and increasing member utilization of non-opioid treatments and services, including pain programs/classes. Although local, state and federal organizations have implemented interventions as part of their own strategies to address opioid misuse and abuse, independent of the CCO-initiated interventions, it is reasonable to attribute some, if not most, of the improvement in the study indicator to CCO efforts. If the CCOs continue to develop and implement their intervention strategies as planned, improvement in both study indicators (continued downward trend as demonstrated in the graphs) can be expected.

In the process of working on this project, CCOs have realized other benefits. The four CCOs that formed the regional collaborative developed a model of collaboration that could be used to address other common problems and gaps. Participation by community-based groups, public health and law enforcement in the development and implementation of PIP strategies has strengthened those relationships. Siloes between physical health, behavioral health and oral health continue to be breached through interventions (such as Meet and Greet and Community of Practice dinner events), utilization of behavioral health staff in educating providers and collaboration with substance use organizations (in increasing access to MAT).

A few CCOs that have achieved and maintained lower rates of enrollees on high doses of prescription opioids have expanded their efforts to address opioid use by pregnant women and co-prescribing of opioids and benzodiazepines.

Standard 8: Improvement Strategies

Standard 8 describes and documents the implementation of the intervention(s) and discusses the basis for adopting the intervention; how the intervention can be reasonably expected to result in measurable improvement; the cultural and linguistic appropriateness of the intervention; a tracking and monitoring plan (providing evidence of how the intervention was or will be implemented as planned); barriers encountered during implementation of the intervention and how they were addressed; and how the intervention will be adapted, adopted, or abandoned.

Each CCO has been tasked with developing, implementing and documenting an improvement strategy to address the statewide study topic of improving the safety of opioid management. Because they differ significantly in terms of geography, level of integration of physical, mental and oral health systems, previous attempts in addressing this topic and population size, the CCOs were advised to develop strategies for this PIP in a manner that met the needs of their local communities. HealthInsight Oregon

provided the CCOs with the criteria and scoring matrix for this standard, as well as ongoing technical assistance.

OHA required that CCOs submit quarterly reports documenting their progress on the Statewide PIP, beginning with the January 2016 quarterly report. Following completion of the first remeasurement period (12/31/16) and based on their January 31, 2016, quarterly report submission, each CCO received an evaluation (met/partially met/not met) for the degree of completeness, clarity and consistency in addressing each of the Standard 8 criteria. See Attachment F for an explanation of the Standard 8 criteria. HealthInsight Oregon developed evaluation reports and sent them to the CCOs for review. All CCOs had the option of either accepting their initial evaluation or resubmitting their Standard 8 documentation for re-evaluation. See Attachment G for the final overall Standard 8 criteria evaluations for each CCO.

Following is a summary of CCO documentation of each of the Standard 8 criteria.

a. Root cause analysis or QI process used to select the intervention

As one of their first steps in the QI process, CCOs participated in or developed opioid/pain taskforces or workgroups. These groups included different internal representatives (leadership, providers, QI improvement and behavioral staff) and representatives from community organizations, public health departments, addiction and drug treatment centers, law enforcement and Community Advisory Councils. Soliciting the input from such a diverse group of involved stakeholders helped CCOs develop a thorough understanding of the barriers and contributing factors to the opioid problem in their communities. Many CCOs also conducted data analyses of their study population, looking at factors such as race, ethnicity, gender, age, location and prescription opioid dosage.

Root cause barriers to improving/factors contributing to the opioid problem described by CCOs were associated with the following categories.

Member factors:

- ignorance of the risks of prescription opioids and pain management options
- lack of available non-opioid alternative treatments
- manipulation of providers and CCO processes in order to obtain opioids.

Provider factors:

- confusion about CCO prescription opioid guidelines
- lack of knowledge about prescription opioid risks, MAT and non-opioid treatment options
- underutilization of the PDMP
- reluctance to engage members in difficult conversations

Organizational factors:

- absence of formal pharmacy benefits/prescribing guidelines
- lack of alternative non-opioid treatments and service policies and processes
- lack of resources to assist providers in managing chronic pain patients

In addition, several CCOs identified contributing factors specific to their situation. Four southern Oregon CCOs, whose coverage areas and contracted providers overlap with each other, formed a regional collaborative to address “CCO shopping” by members seeking desired benefits and frustration by providers over multiple different guidelines and processes. The proliferation of non-contracted pain clinics in one small area in southern Oregon resulted in a significant number of members in both the covering and adjacent CCO receiving opioids from providers resistant to CCO policies and processes.

Rating: All 16 CCOs received a “met” rating for this criterion.

b. Brief description of the intervention(s)

In their reports, CCOs described interventions developed and implemented by their CCO alone, in collaboration with other CCOs and with other organizations (clinics, law enforcement and community-based organizations).

Prior to the start of the first remeasurement period (January 1, 2016), almost all CCOs had implemented prior authorization (PA) processes and quantity limit (QL) guidelines to address the opioid problem in their communities. Fourteen CCOs defined quantity limits by dosage, while two CCOs limited prescribers as to number of capsules/tablets. Most CCOs’ PA criteria included documentation of a pain contract/agreement and a tapering plan. One CCO required providers to sign a certificate attesting to their agreement with CCO policy and fulfillment of mandated criteria. Following CDC’s recommendation to limit opioid dosages to less than 90 mg MED and the adoption of that recommendation by the Oregon Opioid Prescribing Guidelines Task Force, most CCOs revised, or at the time of this report were in the process of revising, their PA and QL guidelines to align with this threshold.

Other common intervention themes included:

- Provider training/education: Education about opioid-related topics was provided at clinic site visits, hospital grand rounds, clinic continuing medical education and Pain/Opioid Summits. The topics covered CCO policy and guidelines, current literature on opioid risks, alternative non-

opioid treatments, available resources, MAT, how to use the PDMP and how to have difficult conversations with patients about opioids. CCOs also informed providers about PA process and guideline changes through individual letters and provider newsletters. Many CCOs had developed opioid dashboards (including an overview of prescribing patterns, member demographics, etc.) that were distributed to all primary care providers or clinics.

- Member education: Members were educated about the risks of opioids and CCO policies and guidelines through individual letters, newsletter articles, videos in clinic and hospital waiting rooms and community forums.
- Targeted interventions with members and providers: Most CCOs analyzed data to identify top opioid prescribers and members receiving ≥ 120 mg MED or ≥ 90 mg MED. Top prescribers received a letter (with information about guidelines and resources) and often a visit by the medical director and/or pharmacist to determine how the provider could achieve compliance. CCOs sent letters to members on high doses of opioids about CCO policies and guidelines, the need to develop a taper plan with their provider and the availability of alternative non-opioid treatments and resources.
- Alternative therapies: CCO strategies regarding alternative non-opioid treatments and services focused on alternative or complementary services, non-opioid pain medication and pain management programs.

While a few CCOs had offered alternative treatment (acupuncture, chiropractic, massage) and behavioral health services to members with chronic pain, most plans delayed implementation of this intervention until final approval of OHA's Guideline note 60 in July 2016. Guideline note 60 encourages the use of non-opioid treatments for back and spine pain by providing coverage for up to 30 visits per year of any combination of physical/occupational therapies, chiropractic or osteopathic manipulation and acupuncture, cognitive behavioral therapy and non-opioid medications. At the time of this report, CCOs were still refining their benefit policies, developing credentialing procedures for non-licensed providers, organizing lists of available local alternative providers and negotiating contracts for service.

In addition to treatment services, most CCOs documented efforts to expand pharmacy benefit coverage to cover non-opioid medications, such as gabapentin, non-steroidal anti-inflammatories, lidocaine, etc.

Another non-opioid pain management resource promoted to both providers and members was pain management classes/programs. Some CCOs developed and conducted their own programs, while others made referrals to existing community programs.

- Medication-assisted treatment (MAT): All CCOs were either developing or had implemented strategies to increase access to MAT, including provider education about the role of MAT, provider training on acquiring the license necessary to prescribe MAT, identifying MAT providers in the community, working with other organizations to implement opioid treatment programs and developing a hub-and-spoke MAT model.
- Collaboration with community organizations: Several CCOs reported working with local law enforcement or community organizations on initiatives to increase medication disposal sites and with local pharmacists to increase prescribing of naloxone. CCOs also collaborated with community organizations in sponsoring community education events

Four CCOs (AllCare, Jackson Care Connect, PrimaryHealth of Josephine County, and Western Oregon Advanced Health), formed a regional collaborative and created an umbrella advisory PIP group and multiple workgroups to address common concerns in an organized and consistent manner. To date, the collaborative has developed standardized member and provider letters (which included all four CCO logos in the header and signed by all four CCO medical directors), member and staff educational materials and tapering forms and a staff/provider training video.

In terms of the integration of physical, behavioral and oral health, almost all CCOs solicited the participation of substance use disorder organizations and staff in discussing strategies to increase access to MAT. Behavioral health staff were involved in training providers about substance use and how to have difficult conversations with members. A few CCOs conducted trainings for dental providers and included dental providers when distributing opioid use dashboards.

Rating: Twelve CCOs received a “met” and four CCOs received a “partially met” rating for this criterion. CCOs that received a partially met rating did not provide clear and complete documentation of interventions.

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

CCOs responded to this question by using narrative, diagrams or cross-references to explain and illustrate how the interventions addressed factors identified in their root cause analyses. A few CCOs provided details as to how some interventions were evidence-based or implemented standard-of-care practices.

Rating: Fifteen CCOs received a “met” and one CCO received a “partially met.” The CCO that received a partially met rating did not clearly link interventions to root cause barriers and factors.

d. Cultural and linguistic appropriateness of the intervention

CCOs described their local study populations as majority Caucasian and English-speaking, and many noted that their demographics reflected national statistics. CCOs highlighted factors that they had identified in their root cause analyses: mental illness/substance use, location (urban/rural/frontier) and lower socioeconomic status/illiteracy.

In discussing this topic, almost all CCOs mentioned the existence of general organizational policies and procedures regarding equity, such as the availability of interpreters, staff training in diversity, etc. Some CCOs provided specific examples of how interventions were modified to address study population characteristics, e.g., conducting pain programs in different locations to lessen the burden on rural members, soliciting input from Hispanic organizations on how best to engage Hispanic members, including chronic disease management or information on mental illness in training modules.

Rating: Nine CCOs received a “met” and seven CCOs received a “partially met” rating for this criterion. CCOs that received a partially met rating discussed cultural and linguistic appropriateness only from an organizational level and were asked to provide examples specific to the PIP study population.

e. Tracking and monitoring plans and results

By the end of the first remeasurement period, CCOs were expected to have not only developed tracking and monitoring plans, but also to have produced and presented the results of those plans.

CCOs were given the option of reporting on either or both of the study indicators. Four CCOs chose to report on the 90 mg MED metric, six CCOs reported on the 120 mg MED metric and five CCOs reported data for both metrics. One CCO provided no data for either study metric. About half of the

CCOs presented measurement plans that included internally derived study indicator data as well as other CCO-selected performance measures.

In terms of tracking the effective implementation of interventions, CCOs presented data on summit/grand rounds/training program attendance, number of mailings to providers and members, number of received taper plans, number of clinic/site visits, number of providers licensed to prescribe buprenorphine, number of opioid treatment programs and number of clinics receiving additional payments for meeting performance thresholds. Some CCOs also described plans to link medical director or pharmacy director visits to high prescribers or to link training attendance to changes in prescribing patterns. HealthInsight Oregon has encouraged CCOs to link the effective implementation of interventions to changes in prescribing or member dosages.

In general, CCOs were less successful at providing results to demonstrate the effectiveness of alternative therapy interventions. One CCO was working with Oregon State University to assess all of its pain management strategies, but at the time of this report, had not yet received its evaluation. Another CCO provided data on pain program referrals, attendance and graduation rates over the past year. No CCO reported on the number of members who received alternative services (chiropractic, acupuncture, massage, etc.) or any changes in opioid dosage or use following treatment.

In situations where CCOs did not have direct responsibility for intervention implementation (e.g., community-based interventions), tracking and monitoring results were often not available.

Rating: Seven CCOs received a “met,” eight CCOs received a “partially met” and one CCO received a “not met” rating for this criterion. CCOs that received a partially met rating did not provide a specific metric improvement target or complete metric data. One CCO did not provide any study metric data and received a rating of not met.

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

Overall, the CCOs did a good job of documenting the barriers they encountered during implementation of their interventions. A number of CCOs continued to experience turnover of leadership, QI and data analytic staff, resulting in delayed development and implementation of intervention strategies and in lack of available study indicator or intervention effectiveness data.

Reported barriers also included competing priorities, scheduling conflicts, difficulty coordinating with different departments, difficulty in developing accurate data reports, high costs of materials and inclement weather.

Very few CCOs reported provider resistance or noncompliance as a barrier. Most CCOs anticipated provider concerns and mitigated risks by implementing multiple interventions focused on provider training and education.

Rating: Fifteen CCOs received a “met” and one CCO received a “partially met” rating. The CCO that did not identify or fully identify as barriers the problems described in progress reports received a lower rating.

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

Most CCOs had a well-established vision of the next steps for their intervention strategies. All CCOs were continuing with the interventions described in their intervention strategies table, sometimes with some minor modifications. The four CCOs in the regional collaborative are continuing to explore how they can best pool their resources.

Rating: Fifteen CCOs received a “met” and one CCO received a “partially met” rating for this criterion. The CCO that did not fully capture next steps that were alluded to in the intervention strategies and tracking monitoring sections of their reports received a lower rating.

Strengths and Opportunities for Improvement

Generally, HealthInsight Oregon has seen improvement in the CCOs’ documentation of the Standard 8 criteria and their understanding of QI concepts since the implementation of the previous Statewide PIP. Most CCOs did a good job of conducting data and barrier analyses linking the analyses to expected improvement in the study indicator, developing interventions to address aspects of the opioid problem and describing any barriers encountered in the implementation of those interventions.

Regarding individual Standard 8 criteria, the cultural and linguistic appropriateness and tracking and monitoring criteria were the most challenging for CCOs. In their initial submissions, almost all CCOs described general CCO-level linguistic and health disparity policies and processes, but few provided examples of how interventions were developed or modified to meet the specific needs of the study population. About half of the CCOs either did not provide an improvement target for their selected study metric or did not provide baseline and quarterly data for one of the study metrics. It is possible that the lower ratings for these two criteria reflect lack of documentation rather than lack of actual implementation.

Standard 9: Repeated Measurement of the Study Indicator

Standard 9 provides study results for two measurement periods, including the study indicator, original data used to compute the indicator, and a statistical test of group differences; provides any other data analyses for factors that may affect the study results; and discusses how the intervention, consistency of methodology, and any confounding factors affected the study results in the second remeasurement period.

This standard will not be completed until after the second remeasurement.

Standard 10: Sustained Improvement

Standard 10 discusses whether or not goals were met and sustained; whether improvement in the study indicator, as well as in enrollee health, functional status, or satisfaction was achieved; discusses lessons learned for the PIP and the system as a whole; and reports next steps.

This standard will not be completed until after the second remeasurement.

Statewide PIP, Attachment A: Denominator Exclusion Codes

Diagnoses and CPT codes related to end-of-life care, palliative care or hospice care		
DX		
V66	Convalescence and palliative care	
V667	Encounter for palliative care	
Z515	Encounter for palliative care	
CPT		
4350F	CnsIng Provided Symp Mngmnt	Counseling Provided On Symptom Management, End Of Life Decisions, And Palliation (Dem)
4553F	Pt Asst Re End Life Issues	Patient Offered Assistance In Planning For End Of Life Issues (Als)
99377	Hospice Care Supervision	Physician Supervision Of Patient Hospice Services, 15-29 Minutes Per Month
99378	Hospice Care Supervision	Physician Supervision Of Patient Hospice Services, 30 Minutes Or More Per Month
D9110	Tx Dental Pain Minor Proc	Palliative (Emergency) Treatment Of Dental Pain-Minor Procedures
G0065	Physician Supervision Of A Hospice Patient	Physician Supervision Of A Hospice Patient
G0151	Hhcp-Serv Of Pt,Ea 15 Min	Services Performed By A Qualified Physical Therapist In The Home Health Or Hospice Setting, Each 15 minutes
G0152	Hhcp-Serv Of Ot,Ea 15 Min	Services Performed By A Qualified Occupational Therapist In The Home Health Or Hospice Setting, Each
G0153	Hhcp-Svs Of S/L Path,Ea 15mn	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Or Hospice Setting,
G0154	Hhcp-Svs Of Rn,Ea 15 Min	Direct Skilled Nursing Services Of A Licensed Nurse (Lpn Or Rn) In The Home Health Or Hospice Setting

Diagnoses and CPT codes related to end-of-life care, palliative care or hospice care		
G0155	Hhcp-Svs Of Csw,Ea 15 Min	Services Of Clinical Social Worker In Home Health Or Hospice Settings, Each 15 Minutes
G0156	Hhcp-Svs Of Aide,Ea 15 Min	Services Of Home Health/Hospice Aide In Home Health Or Hospice Settings, Each 15 Minutes
G0157	Hhc Pt Assistant Ea 15	Services Performed By A Qualified Physical Therapist Assistant In The Home Health Or Hospice Setting
G0158	Hhc Ot Assistant Ea 15	Services Performed By A Qualified Occupational Therapist Assistant In The Home Health Or Hospice Set
G0182	Hospice Care Supervision	Physician Supervision Of A Patient Under A Medicare-Approved Hospice (Patient Not Present) Requiring
G0337	Hospice Evaluation Preelecti	Hospice Evaluation And Counseling Services, Pre-Election
G8768	Doc Med Reas No Lipid Profile	Documentation Of Medical Reason(S) For Not Performing Lipid Profile (E.G., Patients With Palliative
G8892	Doc Med Reas No Ldl-C Test	Documentation Of Medical Reason(S) For Not Performing Ldl-C Test (E.G. Patients With Palliative Goal
G9380	Off Assis Eol Iss	Patient Offered Assistance With End Of Life Issues During The Measurement Period
G9381	Doc Med Reas No Offer Eol	Documentation Of Medical Reason(S) For Not Offering Assistance With End Of Life Issues (Eg, Patient
G9382	No Off Assis Eol	Patient Not Offered Assistance With End Of Life Issues During The Measurement Period
G9433	Death, Nhres, Hospice	Death, Permanent Nursing Home Resident Or Receiving Hospice Or Palliative Care Any Time During The M
G9433	Death, Nhres, Hospice	Death, Permanent Nursing Home Resident Or Receiving Hospice Or Palliative Care Any Time During The M
HC100	Omap: Nf Hospice Care	Omap: Nf Hospice Care
Q5001	Hospice Or Home Hlth In Home	Hospice Or Home Health Care Provided In Patient'S Home/Residence

Diagnoses and CPT codes related to end-of-life care, palliative care or hospice care		
Q5002	Hospice/Home Hlth In Asst Lv	Hospice Or Home Health Care Provided In Assisted Living Facility
Q5003	Hospice In Lt/Non-Skilled Nf	Hospice Care Provided In Nursing Long Term Care Facility (Ltc) Or Non-Skilled Nursing Facility (Nf)
Q5004	Hospice In Snf	Hospice Care Provided In Skilled Nursing Facility (Snf)
Q5005	Hospice, Inpatient Hospital	Hospice Care Provided In Inpatient Hospital
Q5006	Hospice In Hospice Facility	Hospice Care Provided In Inpatient Hospice Facility
Q5007	Hospice In Ltch	Hospice Care Provided In Long Term Care Facility
Q5008	Hospice In Inpatient Psych	Hospice Care Provided In Inpatient Psychiatric Facility
Q5009	Hospice/Home Hlth, Place Nos	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (Nos)
Q5010	Hospice Home Care In Hospice	Hospice Home Care Provided In A Hospice Facility
S0255	Hospice Refer Visit Nonmd	Hospice Referral Visit (Advising Patient And Family Of Care Options) Performed By Nurse, Social Work
S0257	End Of Life Counseling	Counseling And Discussion Regarding Advance Directives Or End Of Life Care Planning And Decisions, W
S0271	Home Hospice Case 30 Days	Physician Management Of Patient Home Care, Hospice Monthly Case Rate (Per 30 Days)
S5150	Unskilled Respite Care /15m	Unskilled Respite Care, Not Hospice; Per 15 Minutes
S5151	Unskilled Respitecare /Diem	Unskilled Respite Care, Not Hospice; Per Diem
S9126	Hospice Care, In The Home, P	Hospice Care, In The Home, Per Diem
T2042	Hospice Routine Home Care	Hospice Routine Home Care; Per Diem
T2043	Hospice Continuous Home Care	Hospice Continuous Home Care; Per Hour
T2044	Hospice Respite Care	Hospice Inpatient Respite Care; Per Diem
T2045	Hospice General Care	Hospice General Inpatient Care; Per Diem
T2046	Hospice Long Term Care, R&B	Hospice Long Term Care, Room And Board Only; Per Diem

Statewide PIP, Attachment B: Buprenorphine Products

HICL Sequence Number	Generic Drug Name	Route Administered Code & Description	Included in Opioid PIP?	Review by Nicole O’Kane, PharmD, Clinical Director, HealthInsight Oregon
10731	ACAMPROSATE CALCIUM	PO - ORAL	No	Not opioid
23438	BUPRENORPHINE	TD - TRANSDERM	YES	Exclude from MAT Definition (treats chronic pain)
1762	BUPRENORPHINE HCL	IJ - INJECTION	YES	Exclude from MAT Definition (treats chronic pain)
1762	BUPRENORPHINE HCL	MC - MISCELL	No	Possibly MAT
1762	BUPRENORPHINE HCL	SL - SUBLINGUAL	No	Likely MAT
24846	BUPRENORPHINE HCL/NALOXONE HCL	SL - SUBLINGUAL	No	Likely MAT
529	DISULFIRAM	MC - MISCELL	No	Not opioid
529	DISULFIRAM	PO - ORAL	No	Not opioid
35611	METHYLNALTREXONE BROMIDE	SQ - SUB-Q	No	Not opioid. Exclude from MAT Definition (treats opioid constipation)
36577	MORPHINE SULFATE/NALTREXONE	PO - ORAL	YES	Exclude from MAT Definition (treats chronic pain)
33364	NALTREXONE	MC - MISCELL	No	Not opioid
1875	NALTREXONE HCL	MC - MISCELL	No	Not opioid
1875	NALTREXONE HCL	PO - ORAL	No	Not opioid
33782	NALTREXONE MICROSPHERES	IM - INTRAMUSC	No	Not opioid

Statewide PIP, Attachment C: Study Denominator by Age Group and CCO over Three Time Periods

Among OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever within the measurement year.									
	12–17 years old			18+ years old			Both age groups (Total)		
CCO	CY 2014	CY 2015	12/1/2015 - 11/30/2016	CY 2014	CY 2015	12/1/2015 - 11/30/2016	CY 2014	CY 2015	12/1/2015 - 11/30/2016
AllCare	331	309	280	6240	6428	5510	6571	6737	5790
CHA	95	77	89	1167	2062	1768	1262	2139	1857
CPCCO	209	171	131	3792	3850	3128	4001	4021	3259
EOCCO	431	369	305	5512	6176	5321	5943	6545	5626
FAMILYCARE	621	574	415	11058	13433	10716	11679	14007	11131
FFS	498	463	313	8638	5917	5023	9136	6380	5336
HEALTH SHARE	1538	1330	1027	26214	28850	22948	27752	30180	23975
IHN	480	396	308	7819	8305	6628	8299	8701	6936
JCC	240	195	157	3488	3837	3373	3728	4032	3530
PSCS-Central Oregon	475	399	303	6993	7462	6168	7468	7861	6471
PSCS-Columbia Gorge	82	74	60	1143	1292	1047	1225	1366	1107
PHJC	68	77	47	1391	1451	1170	1459	1528	1217
Trillium	665	614	443	12861	13538	11428	13526	14152	11871
UHA	189	152	140	3711	3676	3231	3900	3828	3371
WOAH	144	126	104	2986	3115	2585	3130	3241	2689
WVCH	643	633	582	9313	10781	9799	9956	11414	10381
YCCO	242	176	154	2627	2748	2435	2869	2924	2589
SUM OF CCOS	6453	5672	4545	106315	117004	97255	112768	122676	101800

For CY 2014 Data extraction date: 12/28/2015

For CY 2015: Data extraction date: 9/28/2016

For 12/1/15-11/30/16 Data extraction date: 3/16/2017

indicates change over period 1/1/16-11/30/16

Statewide PIP, Attachment D: Study Numerators by Age and CCO over Three Time Periods

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥120 mg MED on at least one day.												
CCO	12–17 years			18+ years			Both groups (Total)			Rate for both groups		
	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16
AllCare	6	3	4	396	368	310	402	371	314	6.1%	5.5%	5.4%
CHA	7	2	1	80	96	92	87	98	93	6.9%	4.6%	5.0%
CPCCO	7	2	1	593	558	413	600	560	414	15.0%	13.9%	12.7%
EOCCO	10	6	7	855	916	730	865	922	737	14.6%	14.1%	13.1%
FAMILYCARE	10	9	8	906	1124	941	916	1133	949	7.8%	8.1%	8.5%
FFS	4	10	3	894	549	407	898	559	410	9.8%	8.8%	7.7%
HEALTH SHARE	40	28	22	3300	3504	2604	3340	3532	2626	12.0%	11.7%	11.0%
IHN	10	5	3	911	882	640	921	887	643	11.1%	10.2%	9.3%
JCC	7	1	3	616	575	506	623	576	509	16.7%	14.3%	14.4%
PSCS-CO	8	1	3	545	505	384	553	506	387	7.4%	6.4%	6.0%
PSCS-CG	1	0	0	121	93	79	122	93	79	10.0%	6.8%	7.1%
PHJC	0	0	1	122	124	103	122	124	104	8.4%	8.1%	8.5%
Trillium	14	22	11	1726	1649	1356	1740	1671	1367	12.9%	11.8%	11.5%
UHA	3	5	3	228	220	167	231	225	170	5.9%	5.9%	5.0%
WOAH	3	3	2	198	199	182	201	202	184	6.4%	6.2%	6.8%
WVCH	10	8	3	937	971	708	947	979	711	9.5%	8.6%	6.8%
YCCO	6	6	5	269	275	226	275	281	231	9.6%	9.6%	8.9%
SUM OF CCOS	142	101	77	11803	12059	9441	11945	12160	9518	10.6%	9.9%	9.3%

For denominators and extraction dates, see Attachment C.

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥ 90 mg MED on at least one day.												
CCO	12–17 years			18+ years			Both groups (Total)			Rate for both groups		
	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16
AllCare	7	10	5	739	698	605	746	708	643	11.4%	10.5%	10.4%
CHA	13	5	5	202	228	197	215	233	203	17.0%	10.9%	10.3%
CPCCO	16	5	1	915	910	698	931	915	739	23.3%	22.8%	21.3%
EOCCO	32	21	10	1258	1390	1098	1290	1411	1160	21.7%	21.6%	20.5%
FAMILYCARE	40	35	27	1846	2337	1929	1886	2372	2006	16.1%	16.9%	16.7%
FFS	25	29	16	1574	1000	776	1599	1029	842	17.5%	16.1%	15.7%
HEALTH SHARE	89	82	57	5559	6171	4688	5648	6253	4938	20.4%	20.7%	20.2%
IHN	21	18	10	1372	1400	1019	1393	1418	1049	16.8%	16.3%	14.4%
JCC	12	4	4	824	855	729	836	859	736	22.4%	21.3%	20.5%
PSCS-CO	26	18	15	1063	942	726	1089	960	797	14.6%	12.2%	11.8%
PSCS-CG	2	2	2	200	160	145	202	162	152	16.5%	11.9%	13.6%
PHJC	1	3	2	210	221	175	211	224	184	14.5%	14.7%	14.7%
Trillium	39	53	38	2744	2741	2256	2783	2794	2378	20.6%	19.7%	19.1%
UHA	6	8	9	480	467	366	486	475	390	12.5%	12.4%	11.5%
WOAH	7	8	10	414	435	379	421	443	412	13.5%	13.7%	14.7%
WVCH	27	18	10	1593	1625	1320	1620	1643	1349	16.3%	14.4%	13.0%
YCCO	16	14	10	462	513	424	478	527	450	16.7%	18.0%	16.6%
SUM OF CCOS	354	304	215	19881	21093	16754	20235	21397	17586	17.9%	17.4%	16.7%

For denominators and extraction dates, see Attachment C.

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥ 120 mg MED consecutive 30 days or more.												
CCO	12–17 years			18+ years			Both groups (Total)			Rate for both groups		
	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16
AllCare	0	1	0	83	61	39	83	62	39	1.3%	0.9%	0.7%
CHA	0	0	0	4	6	2	4	6	2	0.3%	0.3%	0.1%
CPCCO	0	0	0	183	148	103	183	148	103	4.6%	3.7%	3.2%
EOCCO	1	0	0	245	244	215	246	244	215	4.1%	3.7%	3.8%
FAMILYCARE	0	0	0	120	109	106	120	109	106	1.0%	0.8%	1.0%
FFS	0	0	0	258	154	91	258	154	91	2.8%	2.4%	1.7%
HEALTH SHARE	0	0	0	766	737	504	766	737	504	2.8%	2.4%	2.1%
IHN	0	0	0	301	271	198	301	271	198	3.6%	3.1%	2.9%
JCC	0	0	0	273	211	158	273	211	158	7.3%	5.2%	4.5%
PSCS-CO	0	0	0	110	109	79	110	109	79	1.5%	1.4%	1.2%
PSCS-CG	0	0	0	36	23	18	36	23	18	2.9%	1.7%	1.6%
PHJC	0	0	0	46	35	26	46	35	26	3.2%	2.3%	2.1%
Trillium	0	0	0	554	470	376	554	470	376	4.1%	3.3%	3.2%
UHA	0	0	0	45	39	30	45	39	30	1.2%	1.0%	0.9%
WOAH	0	0	0	40	36	25	40	36	25	1.3%	1.1%	0.9%
WVCH	0	0	0	259	212	110	259	212	110	2.6%	1.9%	1.1%
YCCO	0	0	0	63	50	30	63	50	30	2.2%	1.7%	1.2%
SUM OF CCOS	1	1	0	3128	2761	2019	3129	2762	2019	2.8%	2.3%	2.0%

For denominators and extraction dates, see Attachment C.

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥ 90 mg MED consecutive 30 days or more.												
CCO	12–17 years			18+ years			Both groups (Total)			Rate for both groups		
	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16
AllCare	0	1	0	120	103	79	120	104	79	1.8%	1.5%	0.1%
CHA	0	0	0	9	10	2	9	10	2	0.7%	0.5%	5.1%
CPCCO	0	0	0	252	207	166	252	207	166	6.3%	5.1%	5.8%
EOCCO	1	0	0	350	358	326	351	358	326	5.9%	5.5%	1.8%
FAMILYCARE	0	0	0	200	223	205	200	223	205	1.7%	1.6%	3.1%
FFS	0	0	0	412	245	168	412	245	168	4.5%	3.8%	3.6%
HEALTH SHARE	0	0	0	1114	1135	860	1114	1135	860	4.0%	3.8%	4.2%
IHN	0	0	0	427	402	291	427	402	291	5.1%	4.6%	7.1%
JCC	0	0	0	342	296	249	342	296	249	9.2%	7.3%	1.9%
PSCS-CO	0	0	0	166	161	123	166	161	123	2.2%	2.0%	3.1%
PSCS-CG	0	0	0	51	37	34	51	37	34	4.2%	2.7%	3.3%
PHJC	0	0	0	61	52	40	61	52	40	4.2%	3.4%	4.5%
Trillium	0	0	0	756	674	538	756	674	538	5.6%	4.8%	1.3%
UHA	0	0	0	61	56	43	61	56	43	1.6%	1.5%	1.4%
WOAH	0	0	0	57	61	38	57	61	38	1.8%	1.9%	1.9%
WVCH	0	0	0	384	352	193	384	352	193	3.9%	3.1%	2.0%
YCCO	0	0	0	97	68	52	97	68	52	3.4%	2.3%	3.2%
SUM OF CCOS	1	1	0	4447	4195	79	4448	4196	79	3.9%	3.4%	0.1%

For denominators and extraction dates, see Attachment C.

Statewide PIP, Attachment E: Study Demographics

Number of enrollees age 12 years and older who had least one prescription for an opioid pain reliever filled within the baseline measurement year by race and ethnicity.					
Denominator	Hispanic/ Latino	Non-Hispanic/ Non-Latino	Unknown	Cross Ethnicity	% of denominator
African American	162	4589	46	4797	4.25%
American Indian or Alaskan Native	122	1414	24	1560	1.38%
Asian	120	1566	23	1709	1.52%
Caucasian/White	4943	80,800	1326	87,069	77.21%
Native Hawaiian/Pacific Islander	27	248	0	275	0.24%
Hispanic	25	0	18	43	
Other Race or Ethnicity	874	1826	37	2737	2.43%
Unknown	4611	9827	140	14,578	12.93%
Total	10,884	10,0270	1614	112,768	

Percentage of denominator who are Hispanic = 9.65%.

Data extraction date: 12/28/2015, Office of Health Analytics, OHA.

Number of enrollees in the study baseline denominator with at least 30 consecutive days with ≥ 120 mg MED/day by race and ethnicity.					
Numerator: ≥ 120mg MED/day for 30 days or more	Hispanic/Latino	Non-Hispanic/Non-Latino	Unknown	Cross Ethnicity	% of numerator
African American	2	90	0	92	2.94%
American Indian or Alaskan Native	4	51	0	55	1.76%
Asian	0	10	0	10	0.32%
Caucasian/White	61	2609	18	2688	85.91%
Native Hawaiian/Pacific Islander	0	5	0	5	0.16%
Hispanic	0	0	0	0	0.0%
Other Race or Ethnicity	20	25	1	46	1.47%
Unknown	40	191	2	233	7.45%
Total	127	2981	21	3129	

Percentage of denominator who are Hispanic = 4.10%.

Data extraction date: 12/28/2015, Office of Health Analytics, OHA.

Statewide PIP, Attachment F: Standard 8 Scoring Criteria

8.1 Has the CCO described:

- a. The root cause analysis or quality improvement process used to understand the problem/gap and serve as the basis for adopting interventions.
 - Part 1 should include: presentation of local data that was analyzed to determine root cause(s); listing or discussion of root causes or contributing factors to the problem/gap; and list of stakeholders involved in the decision-making process.
 - *Note: Analyses should be consistent with interventions (e.g., if provider training is an intervention strategy, provider lack of knowledge should be listed in the root cause analysis).*

- b. The intervention strategies as they have been developed or implemented:
 - Part 1 should include information on start dates, staff roles and tools or instruments used.
 - Progress report should include updates on activities on existing interventions, including lack of new activities; new interventions (interventions developed after Part 1 submission) should include information on start dates, staff roles and tool/instruments used.
 - *Note: This information can be reported in the additional information section of the progress report.*

- c. Why the interventions could be expected to improve the study indicator.
 - Part 1 should include a description on how each intervention addresses causes/barriers identified in the root cause analysis and is a system intervention.
 - Part 1 should include a description on how other factors (e.g., evidence-based research, clinical knowledge, previous success, and continuous quality tracking and modification process) increase the likelihood of intervention effectiveness and therefore improvement in the study indicator.
 - Progress report should include descriptions of interventions developed after the Part 1 submission and an explanation of why those new interventions can be expected to improve the study indicator.
 - *Note: This information can be reported in the “additional information” section of the progress report.*

- d. Cultural and linguistic appropriateness (CLA) of the interventions
- Part 1 should include an explanation of how the interventions will address racial, ethnic and/or linguistic differences in the CCO study population.
 - Part 1 should explain how the interventions will address broader cultural considerations relevant to the CCO study population, such as socioeconomic status, geographic location (urban vs. rural living), literacy status, serious and persistent mental illness, etc.
 - Progress report with descriptions of new interventions should include an explanation of their cultural and linguistic appropriateness. This information should be included in the “additional information” section on page 3.
 - *Note: Cultural and linguistic appropriateness considerations should be consistent with the root cause, demographic and barrier analyses (e.g., if analyses indicate that rural environment is a contributing factor/barrier, the CLA discussion should include an explanation as to how that will be taken into account when developing and implementing interventions).*
- e. Tracking and monitoring plans and results/intervention effectiveness
- Part 1 should describe plans to collect study indicator and implementation effectiveness data.
 - Progress report should include study indicator data over time in the outcome table.
 - Progress report should include information on the # or % of study eligible enrollees reached by the interventions (when applicable).
 - Progress report (under the intervention effectiveness column) should include data (quantitative or qualitative) to demonstrate whether or not each intervention was implemented successfully
 - Graphs, run charts and tables can be used to further illustrate tracking and monitoring results.
 - *Note: CCOs should demonstrate that between all of the different interventions, they have covered the entire study population and not just “cherry-picked” sub-populations.*
 - *Note: Graphs and tables should be labelled and consistent with the narrative.*
- f. Barriers:
- Progress report should include information on factors/events/situations that negatively affected the development and implementation of the interventions, where applicable.

- Progress report should include a description of how barriers were addressed (or could not be addressed).
- *Note: The reported barriers should be consistent with next steps/intervention status (e.g., if an intervention is modified or abandoned, there should be a corresponding discussion of barriers in the barriers column).*

g. Next steps:

- Progress report should include information on the status of each intervention (i.e., how the intervention was continued, adapted, abandoned or adopted).
- *Note: Intervention status should be consistent with any tracking and monitoring data and reported barriers.*

Statewide PIP, Attachment G: Results of First Remeasurement Standard 8 Rating by CCO

M = Met P = Partially met N = not met

CCO	Root cause			Description interventions			How improves the indicator			Cultural/linguistic appropriateness			Tracking and monitoring			Barriers			Next steps			
	M	P	N	M	P	N	M	P	N	M	P	N	M	P	N	M	P	N	M	P	N	
AllCare	1				1			1			1			1			1			1		
CHA	1			1			1			1				1			1			1		
CPCCO	1			1			1			1				1			1			1		
EOCCO	1			1			1			1				1			1			1		
FamilyCare	1			1			1				1		1			1			1			
Health Share	1			1			1				1			1			1			1		
IHN	1			1			1			1			1			1			1			
JCC	1			1			1				1		1			1			1			
PSCS-CO	1				1		1				1			1			1			1		
PSCS-CG	1				1		1				1			1			1			1		
PHJC	1			1			1				1		1			1			1			
TCHP	1				1		1				1				1		1				1	
UHA	1			1			1			1				1			1			1		
WOAH	1			1			1			1			1			1			1			
WVCH	1			1			1			1			1			1			1			
YCCO	1			1			1			1			1			1			1			
Sum	16	0	0	12	4	0	15	1	0	9	7	0	7	8	1	15	1	0	15	1	0	

Appendix C: Results of State-Level ISCA Review

In 2016, HealthInsight Oregon conducted a full ISCA review of OHA's data management and reporting systems through interviews with key staff and review of system documentation.

The ISCA review found that OHA continues efforts to strengthen its infrastructure and IT processes and procedures by performing daily backups of Medicaid data and replicating the backups to an offsite location. OHA reported continuing efforts to expand server, database and storage capability to handle workload increases due to Medicaid expansion. CCOs reported that OHA continues to improve the integrity of member eligibility data sent to the CCOs. OHA also continues working to address issues related to:

- maintenance and ongoing support for Medicaid Management Information System (MMIS) hardware and software
- expanding the teams responsible for processing, reviewing and auditing the CCOs' claims and encounter data
- inconsistencies in data submission by the CCOs
- regular review and updating of policies, procedures and business continuity/disaster recovery (BC/DR) plans

Table C-1 reports OHA's scores for each major category of the ISCA review, along with recommendations for improvement.

Oregon's MMIS receives encounter data from the CCOs, their dental provider networks (DPNs) and their third-party administrators (TPAs). MMIS houses data for all encounters, including pharmacy, dental and vision services. Electronic Data Interchange processes run a series of edits to accept, pend or reject claims before data are imported into MMIS. Rejected claims are not imported and are not tracked by OHA. OHA sends a "999" acknowledgement file to the submitter of claims. CCOs do not necessarily receive copies of the 999 files for claims and encounters submitted on their behalf by DPNs and/or TPAs.

DSSURS is the data warehouse for the main reporting database for MMIS. Medicaid data are loaded into DSSURS by an Extract, Transform and Load process on a weekly basis. Hewlett-Packard (HP) creates PDF-formatted reports for OHA based on MMIS data, using the COLD tool.

HP manages and supports multiple key systems for OHA but is not authorized to make financial decisions on behalf of OHA. HP manages the software and hardware for MMIS, DSSURS and the provider portal. The servers supporting these systems are located in the state data center. OHA has completed the technology refresh project started in 2014. As part of this project, hardware was replaced, virtualized or upgraded to support the increase in MMIS activity due to Medicaid expansion.

OHA staff use SQL and SAS software to calculate the incentive performance measures, based on data from DSSURS. OHA contracts with Providence's Center for Outcomes Research and Education (CORE) to validate the code used to calculate the performance measures that use encounter data. OHA's Health Analytics team sends a subset of data to CORE, depending on the measure year. As of the ISCA review, CORE also managed performance data reporting on behalf of Health Share of Oregon CCO.

OHA continues to work with CORE to enhance reporting related to performance measure calculation and data detail for each CCO.

OHA continues to formalize its system development practices (processes for planning, creating, testing and deploying information systems, software and/or reports) for the incentive performance measures. Data accuracy is delegated to the CCOs and their TPAs. OHA continues to refine and enhance its version control and peer review processes for internally developed reports such as performance measures.

Table C-1. State-Level ISCA Review: Strengths and Recommendations

Information Systems (data flow) – Partially met (2.5)
<i>Recommendations</i>
<p>Version control</p> <p>OHA does not use version control software or processes. Instead, staff renames previous versions of files or programs, and edits new copies as needed. OHA uses informal version control for DSSURS and Health Analytics group reports and output. Version control software can improve the ability to identify changes and return to previous versions of files if needed, and automates revision history.</p> <ul style="list-style-type: none"> • OHA should develop and implement a formal version control process for Medicaid data reporting. • OHA should explore options and implement enterprise version-control management software for its Medicaid reporting.
<p>Finding #1: 999 files not being sent to the CCOs</p> <p>OHA sends a 999 file to the submitter of claims/encounter data confirming receipt of the data file and the transaction status of claims/encounters in the data file. It was unclear whether the CCOs receive copies of the 999 files when claims and/or encounters are submitted on their behalf by other organizations. A CCO will not know the status of claims and/or encounters submitted if the CCO does not receive either the 999 file or the information contained within the file.</p> <ul style="list-style-type: none"> • OHA should evaluate providing 999 files to the CCOs for any encounters submitted to OHA for members assigned to a CCO. • OHA needs to add language to the CCO contract requiring CCOs to require copies of all 999 files related to encounter data submitted to OHA, regardless of who submits the encounter data.
<p>Data flow for reporting</p> <p>OHA submitted limited documentation explaining how different types of data are received from the CCOs, processed, integrated and submitted to CMS. Such documentation could help OHA monitor various data sources.</p> <ul style="list-style-type: none"> • OHA needs to develop an integrated data flow diagram that describes the data process for all encounters received from CCOs. The diagram should include receipt of encounter data, reporting solutions and submission to CMS. This documentation should be stored and/or communicated in a manner that is easily accessible to staff members who need it.
Staffing (claims and encounters, authorization) – Fully met (3.0)
<i>Recommendations</i>
None
Configuration Management (hardware systems) – Fully met (3.0)
<i>Recommendations</i>
None

Security (incident management, risk management) – Partially met (2.4)
Recommendations
<p>Need process for monitoring subcontractor’s BC/DR plan</p> <p>OHA outsources MMIS support, maintenance and design to HP. The ISCA interview revealed that OHA lacked processes for monitoring HP’s BC/DR plan for OHA’s MMIS system.</p> <ul style="list-style-type: none"> OHA should work with HP to develop formal documentation of the configuration, maintenance processes, support procedures and BC/DR plan for OHA’s MMIS.
<p>Finding #2: BC/DR plan in progress</p> <p>OHA continues to expand and enhance its BC/DR plan, which is still in draft form. OHA is working on an internal Continuity of Operations Plan and a stop-gap recovery plan with HP. OHA scheduled a test of the current plan in January 2017, with a pre-test in late 2016.</p> <ul style="list-style-type: none"> OHA needs to implement a strategy to recover data in the event of a disaster. OHA needs to determine the level of detail necessary to include in the plan to enable a skilled IT person to recover or assist with resuming operations in a timely manner. OHA should monitor and verify that the plan is tested at least every other year, reviewed at least every two years and updated when significant changes occur.
<p>Mobile device policies</p> <p>OHA lacks policies and procedures for mobile device management. OHA needs to control the configuration, encryption and data being accessed by mobile devices.</p> <ul style="list-style-type: none"> OHA should establish mobile device management policies and procedures to ensure that mobile devices are configured, maintained and controlled to safeguard sensitive data.
Administrative Data (claims and encounter data) – Partially met (2.1)
Recommendations
<p>Race/ethnicity data not required</p> <p>OHA reported that CCOs are not required to supply members’ race/ethnicity data. If the race/ethnicity field is blank on a claim/encounter, OHA assigns a value of “unknown” to this field. 42 CFR §438.10(c)(3) requires CCOs to provide written materials that are critical to obtaining services, including provider directories, enrollee handbooks, appeal and grievance notices and denial and termination notices, in the prevalent non-English languages in the CCO’s service area. It is unclear how either OHA or the CCOs would be aware of prevalent non-English languages in the CCOs’ service areas without members’ racial/ethnicity data.</p> <ul style="list-style-type: none"> OHA needs to determine and specify the prevalent non-English languages for all CCO service areas. OHA should include language in the CCO contract requiring that the CCOs determine and report, as part of the encounter data, a member’s racial/ethnicity data.
<p>Finding #3: CCO contract requirements for BC/DR plans</p> <p>OHA does not require the CCOs to maintain BC/DR plans or plans for testing BC/DR plans. Without sufficient and effective BC/DR plans, CCOs risk being unable to fulfill their contractual obligations. OHA noted that CMS has made a recent rule change requiring Medicare/Medicaid cost centers to conduct more effective BC/DR planning. OHA reported that its Health Systems Division is evaluating the</p>

implications of this rule change and has assembled a team to work with partner organizations and CCOs to determine how to monitor for compliance, when monitoring will begin and how assistance will be provided to the CCOs.

- OHA needs to add language to the CCO contract requiring the CCOs and their subcontractors to maintain working BC/DR plans.
- OHA needs to develop a process to evaluate the CCOs' BC/DR plans and BC/DR plan testing on a regular basis.

Monitoring process for data completeness

OHA reported that it is unaware whether the CCOs require subcontractors to submit all claims and/or encounters, including zero-dollar claims, to OHA and/or the CCOs. OHA is evaluating whether it needs to establish policies and procedures to ensure that all CCO subcontractors are aware of and complying with OHA's expectations to submit complete claims and/or encounters. PH Tech has been working to clarify requirements to match the state expectations.

- OHA should inform all CCOs and their subcontractors that zero- or low-dollar claims must be submitted to OHA.
- OHA should develop a process to monitor Medicaid claims being submitted to OHA.

Finding #4: CCOs not performing encounter data validation (EDV)

OHA does not require CCOs to perform EDV to validate their encounter data against clinical records, nor does OHA conduct EDV on data submitted by the CCOs. OHA continues to evaluate who should perform this activity.

- OHA should develop and implement an EDV process or require the CCOs to regularly conduct EDV to compare a sample of the state's encounter data with clinical records. This process could be conducted by OHA, the CCOs or a third party.

Trust in NEMT payment vs. encounter data

OHA has developed procedures to evaluate non-emergent transportation (NEMT) potential encounters versus actual NEMT encounters submitted by the CCOs. OHA reported being concerned that it is not receiving all NEMT encounter data. OHA said it was unclear if the payments being made for NEMT services are correct and supported by the NEMT encounter data submitted by the CCOs to OHA.

- OHA should communicate its expectations and requirements concerning the submission and validation of complete, timely and accurate NEMT data.

Enrollment Systems (Medicaid eligibility downloads) – Fully met (2.9)

Recommendations

Need method for members to update their enrollment information in a timely manner

Multiple CCOs reported issues arising from member-supplied enrollment data not matching MMIS-supplied enrollment data. OHA's process for updating member enrollment information requires that the member submit a completed MSC 2094 form. OHA then has 60 days to respond after receiving the member's request. OHA may extend the time to respond by an additional 30 days, but must inform the member of the extension and reason for the delay.

This method of updating member enrollment data requires the CCOs to maintain multiple copies of member data. The CCOs must keep a copy of the enrollment information that the member provides the CCO and a copy of the 834 enrollment data. Multiple CCOs reported issues when mailing important

information to members for whom the 834 enrollment data were not current, causing mail to be returned or delivered to someone other than the member. OHA reported that it is working on a process to make it easier for members to update their enrollment data via electronic or other means.

- OHA needs to move forward with efforts to streamline the process for updating member enrollment data so that the data can be processed in a timely manner.

Vendor Data Integration and Ancillary Systems – Fully met (3.0)

Recommendations

None

Report Production and Integration and Control of Data for Performance Measure Reporting – Partially met (2.4)

Recommendations

Documentation of MMIS data extraction

OHA did not submit documentation detailing how data used for reporting are extracted from the data repositories and archived.

- OHA needs to fully document the processes used to create, store, access and restore from encounter data archives.
- OHA needs to develop an integrated data flow diagram that describes the archiving process for encounter data used for reporting.

Peer review practices

Performance measure report writing and program development processes and practices appear not to require peer reviews. Peer review is conducted informally and inconsistently when reports and/or programs are created or modified. OHA lacks a formal peer review and approval process for programming data report production to validate data accuracy and completeness before production.

- OHA needs to develop a formal process for peer review of report and data extract production.

Need formal process for sign-off on calculations used in performance metric dashboard

OHA described the current process for verification and acceptance of the performance measure data as being based on a verbal consensus arrived at during OHA management meetings by comparing OHA's performance measures with CORE's performance metric calculations.

- OHA needs to document and formalize its process to verify the accuracy of the performance metric dashboard data.

Provider Data (compensation and profiles) – Fully met (3.0)

Recommendations

None

Meaningful Use of Electronic Health Records – Fully met (3.0)

Recommendations

None