HEALTH SYSTEMS DIVISION
Kate Brown, Governor

Oregon Health Authority

500 Summer St NE E35
Salem, OR, 97301
Voice: 503-945-5772 or 800-527-5772
Fax: 503-373-7689
TTY: 711
www.oregon.gov/OHA/HSD

Date: August 14, 2018

To: Coordinated care organizations (CCOs)

From: David Simnitt, Interim State Medicaid Director
Health Systems Division

Subject: Extended timeline for 2017 Delivery System Network (DSN) review

The Oregon Health Authority (OHA) is extending the 2017 DSN review process to allow CCOs to submit additional 2017 DSN documentation to OHA if they choose.

- HealthInsight Assure (HIA) will use this information to conduct an analysis and produce the final 2017 DSN reports for each CCO.
- The posted DSN report required by 42 CFR §438.66(e)(3) will refer only to the final analyses.
- OHA and HIA estimate that, once begun, it will take three months to complete this work.

Over the next two to three weeks, OHA will work with the Office of Contracts and Procurement and HIA to develop a contract for this work.

Why is this happening?

After receiving feedback from CCO's, OHA found that the process for developing the individual 2017 DSN Capacity and Narrative Reports did not offer CCOs an opportunity to adequately review and submit additional data to ensure the report accurately reflected their 2017 provider networks.

OHA and HIA are committed to a collaborative and accurate process. The revised process will accurately reflect the intent and goals of this annual review activity.

What should you do?

If you have concerns about this change to the 2017 DSN review process, please give comment at the next CCO CEO meeting.

Questions?

If you have questions, please contact Allison Tonge, Quality Assurance Coordinator at 503-947-5545 or allison.m.tonge@dhsoha.state.or.us; or Tressa Perlichek, HSD Hearings and Quality Assurance Manager at 503-947-5128 or tressa.i.perlichek@dhsoha.state.or.us.

2017 Delivery Systems Network Capacity Report

Oregon Coordinated Care Organizations

Oregon Health Authority

Finalized January 2019

Presented by
HealthInsight Assure
2020 SW Fourth Avenue, Suite 520
Portland, OR 97201-4960
Phone 503-279-0100
Fax 503-279-0190

HEALTHINSIGHT ASSURE

Experts in Quality Review

2017 Delivery System Network Capacity of Oregon CCOs

Finalized January 2019

Contract #158156

Presented by:

HealthInsight Assure

2020 SW Fourth Avenue, Suite 520

Portland, Oregon 97201-4960

Phone: 503-279-0100

Fax: 503-279-0190

HealthInsight Assure prepared this report under contract with the Oregon Health Authority (Contract No. 158156).

Project Manager–Compliance ..... Linda Fanning, LCSW, CHC

Editor..... Erica Steele Adams

Table of Contents

List of Acronyms Used in This Report

APM	Alternative Payment Methodology
CHW	Community Health Worker
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCO	coordinated care organization
CLAS	culturally and linguistically appropriate services assessments
CMHP	community mental health program
DSN	delivery system network
DPN	dental plan network
ENCC	exceptional needs care coordination
FQHC	federally qualified health center
IHCP	Indian health care providers
MMIS	Medicaid Management Information System
NEMT	non-emergency medical transportation
OHA	Oregon Health Authority
PCP	primary care physician
PCPCH	patient-centered primary care home
SUD	substance use disorder

EXECUTIVE SUMMARY

Federal and state Medicaid regulations require each managed care contractor to maintain a network of health care providers that ensures appropriate, adequate access to all services covered under the Medicaid contract. Each contractor must demonstrate their capacity to serve Medicaid members in their service area according to the state's standards for access to care. They do this by submitting documentation to the state Medicaid authority about their provider network.[1]

In 2017, the Oregon Health Authority (OHA) contracted with 16 regional coordinated care organizations (CCOs) to deliver managed care services for Oregon Health Plan enrollees. Exhibit G of the CCO contract outlines how CCOs must submit documentation about their provider network, also known as the delivery system network (DSN) reports. CCOs must submit a DSN report for state review July 1 of each year.

The 2017 Delivery System Network Capacity of Oregon CCOs report documents HealthInsight Assure's review of each CCO's:

- DSN Provider Narrative Report, and
- DSN Provider Capacity Report (details in Appendix A).

In addition, the report includes recommendations related to the need for technical assistance or clarification regarding OHA expectations.

Overall Results

The majority of CCO submissions generally addressed the topics. More than half of the CCOs provided comprehensive descriptions of their networks and analysis of their adequacy, often including ratios of providers to members. However, several CCOs did not present ratios in a way that would accurately show network adequacy.

The CCOs will need to certify the adequacy of their networks at least annually. Alignment of CCO contract details and requirements with new regulatory provisions for network adequacy will support both OHA and the CCOs in ensuring the adequacy of the networks. In addition, addressing those network areas that are uniquely "Oregon" (i.e., traditional health workers, NEMT,

[1] See 42 CFR §438.206 and §438.207; OAR 410-141-3220.

continuum of care for treatment of behavioral health services and use of alternative therapies) will help describe each CCO's delivery system network.

Below are a few key areas for improvement:

- The CCOs should ensure their networks adequately support inclusion of enrollees with disabilities and special health care needs.
- Coordination of care is not always integrated within the CCOs.
- Less than half of the CCOs reported specific efforts to build network capacity for those metrics where the CCO's performance is below the baseline.
- Most CCOs have the majority of the practitioners and facilities listed in the categories of service. However, many service categories were vague.

INTRODUCTION

Preparation for 2017 Review

In 2016, to fulfill state obligations under 42 CFR §438.207 to review CCO supporting network adequacy documentation, OHA asked HealthInsight Assure, the state's contracted external quality review organization, to review the CCOs' DSN narrative and capacity reports and provide feedback and recommendations through an integrated lens.

In April 2017, OHA collaborated with HealthInsight Assure to provide training for the CCOs regarding the expectations for DSN narrative and capacity reporting. OHA and HealthInsight also provided training and clarification for the CCOs on the information requested within the DSN capacity reports.

2017 CCO DSN Narrative Report Evaluation Criteria

To evaluate CCO DSN narrative reports, HealthInsight Assure developed evaluation criteria in collaboration with the CCOs and OHA in 2015, based on the requirements in Exhibit G of the CCO contracts. These criteria:

- asked for more detailed information related to the Exhibit G contract requirements, specifically regarding delivery network adequacy and access to meet enrollee needs;
- provided a standardized tool for measuring the quality and completeness of CCO narrative reports; and
- included five indicator categories and a pilot score to measure the CCO's response to each question within each indicator.

The CCOs were encouraged to use this document as a tool to evaluate the adequacy of their delivery system networks, in addition to meeting contract requirements. All CCOs received a copy of the evaluation criteria from HealthInsight Assure following the April 2017 CCO training.

2017 DSN Review Process

CCOs were to submit the following reports to OHA CCO Contract Administrator by July 1, 2017:

- A DSN Provider Narrative Report which addressed each topic area listed in Exhibit G of the CCO Contract; and
- A DSN Provider Capacity Report

OHA reviewed these documents and forwarded them to HealthInsight Assure for comparison and analysis. HealthInsight Assure reviewed all CCOs' 2017 DSN narrative reports using the new criteria. The report includes a pilot score for each section based on HealthInsight Assure's final evaluation.

HealthInsight Assure looked at responses that included all services delivered:

- physical health
- mental health
- substance use disorder services
- dental care
- non-emergency medical transportation (NEMT)
- acute care
- specialty care

Five indicator categories were chosen based on contract requirements and areas for further development:

- Description of the Delivery Network and Adequacy
- Description of Enrollees
- Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs
- Coordination of Care
- Performance Metrics

Potential scores for each question within the indicator categories ranged from 0 to 3, as follows:

- 0 = discussion not provided (Not Met)
- 1 = discussion minimally addresses topic (Partially Met)
- 2 = discussion addresses topic adequately (Substantially Met)
- 3 = discussion addresses topic comprehensively (Fully Met)

The CCOs received a total score for each indicator category, which is reflected in each CCO's table and in Table 1.

In addition to the DSN Provider Narrative Report, HealthInsight Assure reviewed the DSN Provider Capacity Report (CCO contract Exhibit G 1.b.) for each CCO. This section of the contract requires all providers (practitioners and facilities) to be listed with required data elements. See Appendix A.

After receiving feedback from CCOs, OHA decided that the 2017 review process approved by OHA did not offer CCOs an opportunity to adequately review draft results or to submit additional data to ensure the final report accurately reflected their 2017 provider networks. To support OHA's commitment to a collaborative and accurate review process, HealthInsight Assure extended the 2017 DSN review process to accurately reflect the intent and goals of this annual review activity.

In the extended 2017 review process, OHA provided the opportunity to all 16 CCOs to:

- address areas in the 2017 report where they received scores that were not comprehensive or fully met;
- submit additional, or supplemental, documentation to describe 2017 provider networks; and
- discuss any questions or concerns with OHA and HealthInsight to guide the final report.

Twelve of the 16 CCOs operating during 2017 took the opportunity to provide updated DSN reports or provider network documentation.

Review Results

The review of CCO DSN narratives below is organized by each topic, with the new evaluation criteria shown in italics, which can be cross-walked to references within Exhibit G of OHA's 2017 CCO contract.

1. Delivery System Network Reports

1(a) DSN Provider Narrative Report

1(a)(1)& (2) Description of the Delivery Network and Adequacy

- *CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting*

documentation, as needed.

- *CCO discusses how the network ensures that the time and distance standards for member access to health care are met.*
- *CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis and triage services 24 hours a day/7 days a week for all members.*
- *CCO analyzes wait times for appointments with providers, including specialists.*
- *CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.*
- *CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers and availability of acute care beds. CCO addresses ratios for pediatric, adult and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.*
- *CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.*
- *CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.*
- *CCO addresses transportation and access for enrollees with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.*
- *CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.*
- *CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.*
- *CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.*

Summary of Description of the Delivery Network and Adequacy

The majority of CCO submissions generally addressed the topics. More than half of the CCOs provided comprehensive descriptions of their networks and analysis of their adequacy. Ratios of providers to members were often provided. However, several CCOs, listed ratios as total number of members divided by total number of providers (PCPs, dental providers or behavioral health providers), which does not necessarily explain an adequate network. Descriptions and analysis of specific network areas (e.g., traditional health workers, NEMT, continuum of care for treatment of behavioral health services, use of alternative therapies) were listed for most CCOs.

Recommendations

In a step toward modernization of network adequacy, new federal regulations for Medicaid managed care require states to develop and implement time and distance standards for network adequacy *(effective January 1, 2019 for Oregon contracts)*. At a minimum, these standards apply to:

- primary care – adult and pediatric
- specialty care – adult and pediatric
- behavioral health (mental health and substance use disorder) – adult and pediatric
- OB/GYN
- hospital
- pharmacy
- pediatric dental

The CCOs will need to certify the adequacy of their networks at least annually. Alignment of the CCO contract details and requirements with new regulatory provisions for network adequacy will support both OHA and the CCOs in ensuring the adequacy of each network. In addition, addressing those network areas that are uniquely "Oregon" (traditional health workers, NEMT, continuum of care for treatment of behavioral health services, use of alternative therapies) will help describe each CCO's delivery system network.

1(a)(1) & (2) Description of Enrollees

- *CCO describes its process for taking into account enrollee characteristics when making provider assignments.*
  - *CCO provides analysis of the language and cultural needs of enrollees.*
  - *CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.*
- *CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.*
- *CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.*

Summary of Description of Enrollees

- Most CCOs do not have a process for considering enrollee characteristics when making provider assignments. However, CCOs do give members the opportunity to choose providers; provide information in alternate languages and formats; and support enrollees with special health care needs in accessing treatment with the support of care coordination.
- All CCOs described the use of specialty providers, and more than half analyzed the prevalence of diseases that require access to specialists among their populations.
- Most CCOs addressed how they assess enrollee needs for continuity of care and transition between levels of care.
- Most CCOs provided analysis of their members' language and cultural needs.

Recommendations

When ensuring that each CCO has an adequate network to meet enrollee needs, the CCOs should be sure to address enrollees with disabilities and special health care needs.

1(a)(2)(a)-(f) Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs

- *CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and the Consumer Assessment of*

Healthcare Providers and Systems (CAHPS). The CCO needs to describe how it uses the input from its community advisory council.

- *CCO describes how it uses technology to deliver team-based care and other innovations.*
- *CCO describes procedures to ensure that enrollees with special health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.*
- *CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.*

Summary of Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs

- All CCOs reported incorporating enrollee feedback through review and analysis of grievances. A few CCOs used member experience surveys, questionnaires or focus groups. Only one CCO reported using mental health survey data from the adult (Mental Health Statistics Improvement Program [MHSIP]), Youth Services Survey for Families (YSS-F) and Youth Services Survey (YSS).
- Many CCOs also described the use of their community advisory councils in providing feedback regarding network adequacy.
- Most CCOs described how they use technology to deliver team-based care and other innovations.
- Most CCOs addressed programs for enrollees with specific health care needs to receive follow-up and training in self-care and other interventions that enrollees may take to promote their own health. However, they did not necessarily have processes in place to ensure members obtained these services and did not fall between the cracks. Individualized patient care planning as well as offering self-management programs were the interventions utilized by most CCOs to address these needs.
- Most CCOs reported a strong commitment to providing culturally and linguistically appropriate services throughout their organization (including their leadership and provider network). These organizations provided examples of this commitment throughout their operations. Two

CCOs reported working with OHA's Office of Equity and Inclusion and the Transformation Center for equity consultation and technical assistance in addressing their delivery of services.

Recommendations

In addition to analysis of grievance data, OHA should encourage the CCOs to incorporate enrollee feedback obtained from the MHSIP, YSS-F and YSS mental health surveys and CAHPS' surveys. OHA gathers the mental health survey data for a variety of reasons. This member satisfaction information is gathered to ensure that Oregon meets its mandates. In addition, the mental health surveys provide a wealth of information regarding member satisfaction with services they have received. A network that takes into account member satisfaction feedback will help the CCO in its assessment of adequacy.

1(a)(2)(a)-(f) Coordination of Care

- *CCO describes relationship (including any memoranda of understanding) with:*
  - *Aging and Persons with Disabilities*
  - *Local public health authority*
  - *Local mental health authority*
  - *Indian Health Service (IHS) and/or Tribal Health Clinics*
- *CCO discusses coordination with above stakeholders.*
- *CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.*
- *CCO describes its process for identifying and assessing all enrollees for special health care needs.*
- *CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.*

Summary of Coordination of Care

Most of the CCOs described their relationships with local Aging and People with Disabilities offices, the local public health authority and the local mental health authority. Half of the CCOs described their relationships with Indian health care providers. Many CCOs responded to this prompt citing there were no Indian

Health Care Providers in their service area or they did not have a contract with the local tribal clinic. See "Recommendations" for additional information.

Most CCOs described how interdisciplinary care teams coordinate services across the continuum. However, coordination with dental care was often lacking. Most did not analyze whether service coordination reduced hospital readmissions or emergency room use. Most CCOs did not describe the process for identifying and assessing all enrollees for special health care needs. Half of the CCOs described how they use electronic health records to coordinate care, including preventive health care, for all enrollees across the continuum of care.

CCOs often described coordinating care between services and levels of care (most often between physical and behavioral health). Dental delegates often provided care coordination, but rarely coordinated with physical or behavioral health providers. If care coordination was delegated to behavioral health agencies, there was often a lack of coordination with physical health or dental health.

As described above, coordination of care is not always integrated within the CCOs.

Recommendations

OHA should continue to support the CCOs in developing effective care coordination efforts to meet the needs of their enrollees and decrease duplication of services and administrative efforts.

OHA should continue to support the CCOs in development of relationships and agreements with IHCPs, including agreements regarding coordination of care. Federal regulations allow Indians enrolled in Medicaid managed care plans to continue to receive services from an IHCP and ensures IHCPs are reimbursed appropriately for services provided. Additionally, these regulations required sufficient network and payment requirements for managed care plans that serve Indians, network provider agreements with IHCPs, state-Tribal consultation requirements, and referrals and prior authorization requirements.[2]

1(a)(2)(d)&(f) Performance on Metrics

- *CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.*

[2] 42 CFR 438.14.

- *CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.*

Summary of Performance on Metrics

Less than half of the CCOs reported specific efforts to build network capacity for those metrics where the CCO's performance is below the baseline.

Many CCOs described efforts to address patterns of underutilization and overutilization when addressing network adequacy.

Recommendations

OHA should consider building the performance metrics into the DSN reporting requirements. In addition, requiring CCOs to address both under- and overutilization when addressing network adequacy will help align these processes.

1(b) DSN Provider Capacity Report

The CCO contract states, "*Contractor shall describe its DSN capacity by submitting a DSN Provider Capacity Report…for the following categories of services or types of service providers [further defined in contract].*

> *(b)(1) Contractor shall include in its DSN Provider Capacity Report the data elements [further defined in contract].*
>
> > *(a) Providers should be grouped by category, such as all Substance Use Disorders treatment Providers should be listed together; all Ambulance and Emergency Medical Transportation Providers should be listed together.*
> >
> > *(b) For patient centered primary care homes, a listing of the Providers who participate in that PCPCH should be listed together; it is not necessary to duplicate those same Providers in the other categories. Information should include the certification Tier and number of Members covered by the Provider.*
> >
> > *(c) For Mental Health Crisis Services, Contractor shall list separately the number of Crisis Hot Lines, Crisis Walk in Centers, Mobile Crisis Teams, Crisis Respite Centers and Short-term Crisis Stabilization Units.*

Summary of Provider Capacity Reports

The OHA's CCO contract identifies specific data elements to include in the Provider Capacity Report (1(b)(2)).

- The majority of CCOs provided the required data elements.
- The contract requires the CCOs to address 29 "categories of service."
  - This list of practitioners and facilities in these categories of service is not comprehensive and not consistent with MMIS provider types or specialty codes.
  - Some of these categories are not in the MMIS (examples: certified or qualified health care interpreters, community prevention services, health education, health promotion, health literacy and palliative care).
  - This list does not help a CCO understand whether its delivery system network is adequate. For example, "Specialty Practitioners," "Dental Services Providers" and "Primary Care Providers" are listed as service categories. All of the CCOs have specialty practitioners, dental providers and primary care providers. However, having these providers does not mean they have an adequate number to address their enrollee needs.
  - This list includes dental services providers and oral health providers separately. It lists mental health providers but does not separate them by LCSW, LPC, psychologist, psychiatric nurse practitioner, psychiatrist, qualified mental health practitioner, etc. Pharmacies and durable medical providers are listed as the same category of service, although they are separate services with separate provider types.
- Most CCOs used the MMIS provider type and specialty codes in the DSN Provider Capacity Report. Some noted categories listed in the OHA-CCO contract.

Recommendations

The following recommendations regarding Provider Capacity Reports are intended to ensure OHA's information requests are clear and enable CCOs to further describe their networks.

OHA may wish to reexamine the purpose of listing the categories of service and the required data elements.

Most CCOs have the majority of the practitioners and facilities listed in the categories of service. However, some categories are vague; for example, "Others not listed but included in the Contractor's integrated and coordinated service delivery network," "health education, health promotion, health literacy" and "community prevention services."

The contract requires the CCO to separately list the number of mental health crisis hotlines, crisis walk-in centers, mobile crisis teams, crisis respite centers and short-term crisis stabilization units.

- Eleven of the 16 CCOs did list these crisis services as outlined in the contract (1(b)(1)(c)). However, only three of the CCOs listed all of the required elements.

OHA should direct the CCOs to report mental health crisis services as required in the contract.

The contract suggests providing narrative information for "other provider categories" such as traditional health workers, including their training, supervision and integration into the care delivery system, if the Excel format is not suitable for describing how the DSN provides these services.

- While half of the CCOs provided this information, the other half did not elaborate on their use of traditional health workers or other provider types, which might have enhanced the description of their integrated delivery systems.
- A few CCOs provided information on "other provider categories" in a narrative format, while others included this information in the Excel spreadsheet or not at all. Many CCOs did not list traditional health workers in either the spreadsheet or a narrative.

OHA should specify which providers need to be reported in the Excel format with the required data elements and which can be listed separately. Traditional health workers have MMIS provider type and specialty codes, so they should be reported in the provider report. However, OHA should encourage the CCOs to describe additional service providers throughout their narratives in order to enhance the description of the CCOs' integrated delivery systems.

See Appendix A for specific information on the CCOs' DSN Provider Capacity Reports.

Summary and Additional Recommendations for OHA

The CCOs are most certainly addressing network adequacy in a variety of ways. Most CCOs were able to provide comprehensive descriptions and analysis when given the second opportunity to address Delivery System Network reporting through a single template format.

To acknowledge exceptional work, HealthInsight would like to recognize Western Oregon Advanced Health's (WOAH) comprehensive DSN reports. This CCO provided in-depth information and analysis of every topic, including how gaps are addressed.

Most CCOs did not describe an integrated approach to their DSN analysis. Often dental health and sometimes behavioral health were not mentioned. OHA should continue to support the CCOs as they fully integrate both dental and behavioral health. Dental care is frequently delegated by the CCOs through subcontracts, with the CCOs ultimately responsible for the dental network and all dental services. Many of the same organizations that hold subcontracts with CCOs for dental services also hold direct contracts with OHA as dental care organizations (DCOs). OHA refers to these entities as dental provider networks (DPNs) to emphasize the delegation arrangement and responsibility for network adequacy lying with the CCOs.

The reports generally did not identify gaps in the DSN. CCOs often failed to address how members with special health care needs are identified and assessed.

Although the Provider Narrative Report criteria require the CCOs to *"ensure to OHA, with supporting documentation, that all Covered Services are available and accessible to Members,"* the CCOs' documentation generally did not establish the availability of all covered services. The Provider Capacity Reports appeared relatively complete, though the CCOs did not address capacity gaps.

The CCO contract stipulates, "*Contractor shall base its DSN upon its community health assessment, community health improvement plan, and Transformation Plan for delivery of integrated and coordinated health, Dental Services, mental health, and Substance Use Disorders treatment services and supports."* To meet the intent of this requirement, HealthInsight recommends that OHA:

- **Encourage the CCOs to use the annual DSN reports as a tool to assess and improve network adequacy, not simply a contract deliverable.**

- **Clarify contractual expectations for the comprehensiveness of the DSN reports.**
- **Ensure that each contract requirement for DSN reporting has a purpose.**
- **Clarifying the intent of new federal regulatory requirements may help to establish objective criteria and scoring for evaluation of the DSN reports. The state performance measures required of OHA by CMS may lend additional data points for assessing access.**

Table 1. Review Section Scores by CCO and Statewide Averages.

	Indicator Categories				
CCO	**Description of Delivery Network and Adequacy** ***(39.0 total possible)***	**Description of Enrollees** ***(12.0 total possible)***	**Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs** ***(12.0 total possible)***	**Coordination of Care** ***(24.0 total possible)***	**Performance on Metrics** ***(6.0 total possible)***
AllCare	26.0	7.0	9.0	21.0	5.0
CHA	20.0	9.0	9.0	17.0	4.0
CPCCO	36.0	12.0	12.0	20.0	5.0
EOCCO	5.0	3.0	0.0	14.0	0.0
FamilyCare	13.0	7.0	7.0	13.0	0.0
Health Share	39.0	12.0	12.0	22.0	6.0
IHN	32.0	12.0	12.0	22.0	4.0
JCC	37.0	12.0	11.0	20.0	6.0
PSCS-CO	38.0	12.0	12.0	24.0	5.0
PSCS-CG	38.0	12.0	12.0	24.0	5.0
PrimaryHealth	32.0	11.0	7.0	16.0	3.0
Trillium	35.0	10.0	12.0	16.0	4.0
UHA	35.0	12.0	12.0	22.0	6.0
WOAH	39.0	12.0	12.0	24.0	6.0
WVCH	39.0	10.0	12.0	24.0	6.0
YCC	23.0	6.0	4.0	15.0	1.0
Statewide Average	**30.4**	**9.9**	**9.7**	**19.9**	**4.1**

HealthInsight Assure reviewed responses and looked for descriptions that included all services delivered (physical health, mental health, substance use disorder services, dental care, NEMT, acute care and specialty care). Potential scores for each question ranged from 0 to 3, as follows:

- 0 = discussion not provided (Not Met)
- 1 = discussion minimally addresses topic (Partially Met)
- 2 = discussion addresses topic adequately (Substantially Met)
- 3 = discussion addresses topic comprehensively (Fully Met)

ALLCARE HEALTH PLAN

AllCare Health Plan contracts with OHA to provide physical, behavioral and dental health services to OHP members in Curry, Jackson, Josephine and Douglas counties. As of October 2017, AllCare had 48,688 enrollees.[3]

Summary

AllCare submitted a comprehensive provider narrative report and a provider capacity report. The CCO continually works to identify gaps and works to contract with necessary providers. Telemedicine is used in parts of the network to ensure access. The CCO described software and systems utilized to deliver team-based care.

A comprehensive description of NEMT was provided, including transportation for those with disabilities.

The CCO tracks data and listens to feedback via Clinical Advisory Panel, Consumer Advisory Council and grievances.

AllCare participates in a regional health equity coalition and internal cultural humility training for staff, including leadership. They described multiple efforts and expectations for their providers and staff related to their commitment to deliver culturally and linguistically appropriate care to their members.

The CCO provided a comprehensive process for identifying and assessing all members for special health care needs, including assessment of continuity of care and transitions between levels of care.

Analysis and actions taken regarding underutilization and overutilization were adequately addressed.

See Table 2 for complete results and recommendations for the next submission.

[3] Oregon Health Plan: Coordinated Care, Managed Care and Fee for Service Enrollment for October 15, 2017. http://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/October%202017%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf.

Table 2. AllCare Results.			
Indicator		**Score**	**Review Comments/Recommendation**
Description of Delivery Network and Adequacy – 26.0 (out of a possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	2	**Comments** ZIP codes of provider and enrollees are gathered and analyzed to target contracting efforts in zip codes with gaps. The CCO uses Medicare distance standards. **Recommendation** For the next submission: • The CCO should include geographic distribution of all providers (dental, mental health, substance use disorder treatment, etc.).
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	2	**Comments** Network adequacy does not currently include time standards; does address distance standards. AllCare is using the Medicare distance standards as they consider them more comprehensive. **Recommendation** For the next submission: • Discuss how time and distance standards are met for required providers (PCP).
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	**Comments** Network adequacy does not currently include time standards; does not address how they ensure provision of appropriate urgent, emergency and crisis. Does address how they work with members post use. **Recommendation** For the next submission: • Address how the CCO ensures provision of appropriate urgent, emergency, crisis and triage services 24 hours a day/7 days a week for all members.
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	**Comments** AllCare surveys membership for participating providers within their APMs for perceived timeliness of services.

Table 2. AllCare Results.			
Indicator		**Score**	**Review Comments/Recommendation**
			Recommendation For the next submission: • Analyze wait times for appointments with providers.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** The CCO identifies gaps and will work to contract with necessary providers. Telemedicine is used in parts of the network that includes urgent care and primary care.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	2	**Comments** Report incorporates ratios. However, no ratios for mental health, substance use disorder treatment providers, dental care providers, and availability of acute care beds are provided. The CCO plans to implement current Network Adequacy policies in oversight of MHOs and DPNs in 2018. **Recommendation** For the next submission: • Describe the ratio of members to providers for mental health, substance use disorder treatment providers, dental care providers, and availability of acute care beds.
6a.	• The CCO addresses ratios for pediatric, adult, and geriatric providers.	1	**Comments** The CCO plans to stratify network adequacy by multiple demographic fields in 2018. **Recommendation** For the next submission: • Address ratios for pediatric, adult, and geriatric providers.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether	2	**Comments** The CCO described roles and how they incorporate the Community Health Workers into their care coordination teams. **Recommendation** For the next submission:

Table 2. AllCare Results.			
Indicator		**Score**	**Review Comments/Recommendation**
	the CCO considers these ratios adequate.		• Analyze ratios of traditional health workers to members and discuss additional types of traditional health workers.
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** A comprehensive description of NEMT was provided. The CCO tracks data and listens to feedback via Clinical Advisory Panel, Consumer Advisory Council and grievances.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** A transportation assessment is conducted by the NEMT when an initial request is made for a ride. This information is utilized for future rides.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	2	**Comments** A description of the continuum of mental health services was provided. The CCO recently made a transition from the CMHP to another organization to provide mental health services. This transition was not mentioned in this delivery system network report as it relates to network adequacy. **Recommendation** For the next submission: • Include analysis and description of changes made to ensure an adequate network.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	2	**Comments** Some substance use disorder treatment was described. **Recommendation** For the next submission: • Describe a comprehensive continuum of SUDs treatment providers.

Table 2. AllCare Results.			
Indicator		**Score**	**Review Comments/Recommendation**
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	2	**Comments** Many specialties were listed, including acupuncture, chiropractic, and physical therapy. **Recommendation** For the next submission: • Describe how the network identifies and contracts with alternative therapies to meet the needs of enrollees.
Description of Enrollees – 7.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	2	**Comments** AllCare's Health Equity and Inclusivity action team generates a quarterly report that is broken down by race, language, age, rural vs. urban, disability, SPMI and substance abuse. Analysis of these needs was not provided. **Recommendation** For the next submission: • Describe how these characteristics are taken into account when making provider assignments.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	1	**Comments** Analysis of the needs of enrollees with disabilities and special health care needs was not provided. **Recommendation** For the next submission: • Provide analysis of the needs of enrollees with disabilities and special health care needs and the process for taking these member characteristics into account when making provider assignments.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	1	**Comments** A description of the process to monitor prevalence of disease was provided. No analysis was provided of the prevalence of diseases that require access to specialists among their population. **Recommendation** For the next submission:

Table 2. AllCare Results.			
Indicator		**Score**	**Review Comments/Recommendation**
			• Provide analysis of the prevalence of diseases that required access to specialists among the CCO population.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** An overview of the assessment process was provided.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 9.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	2	**Comments** A description of efforts outlined by input from all three CACs was described which included information from the Community Health Assessment and the Community Health Improvement Plan. Projects that address social determinants of health were identified to receive funding for projects. **Recommendation** For the next submission: • Include how the CCO incorporates enrollee feedback from the complaint process as well as satisfaction surveys when making decisions about the network.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO described the software and systems utilized to deliver team-based care. **Recommendation** None
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	1	**Comments** The CCO described a performance improvement project addressing access to evidence-based care for special needs populations and a separate project focused on colorectal cancer screening. **Recommendation** For the next submission: • Include a description of procedures utilized with follow up and training in self-care and health promotion for special healthcare needs populations.

Table 2. AllCare Results.			
Indicator		**Score**	**Review Comments/Recommendation**
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** AllCare provided a comprehensive description of their participation in a regional health equity coalition and internal cultural humility training for staff, including leadership. They described expectations for their APM organizations, information provided to members identified as speaking another language, and information about staff members having completed OHA's Developing Equity Leadership through Action (DELTA) program.
Coordination of Care – 21.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** None
20a.	• Local public health authority	3	**Comments** None
20b.	• Local mental health authority	3	**Comments** None
20c.	• IHS and/or Tribal Health Clinics	3	**Comments** Formal agreements with IHS and or Tribal Health Clinics are to be completed in 2018
21.	CCO discusses coordination with above stakeholders.	2	**Comments** None **Recommendation** For the next submission: • Include further discussion of coordination with local mental health authorities and IHS and/or Tribal Health Clinics.

Table 2. AllCare Results.			
Indicator		**Score**	**Review Comments/Recommendation**
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	2	**Comments** A comprehensive description of interdisciplinary care teams was provided. **Recommendation** For the next submission: • Include information on how interdisciplinary care teams coordinate dental care.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	3	**Comments** The CCO provided a comprehensive process for identifying and assessing all members for special health care needs.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	2	**Comments** A statement was provided about coordinating the needs of the member through the EHR. It was not clear if mental health and dental care are included. **Recommendation** For the next submission: • Include information on how the electronic health record is utilized to coordinate all care, including mental health and dental care.
Performance on Metrics – 5.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	2	**Comments** One metric was addressed. In addition, the CCO described multiple efforts to improve individual lives and community health. **Recommendation** For the next submission: • Address efforts to build network capacity for additional metrics where performance is below baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	3	**Comments** Analysis and actions taken regarding underutilization and overutilization were adequately addressed.

CASCADE HEALTH ALLIANCE

Cascade Health Alliance (CHA), based in Klamath Falls, contracts with OHA to provide services to OHP physical, behavioral and dental health services to OHP members in Klamath County. As of October 2017, CHA had 17,316 enrollees.

Summary

CHA submitted a provider narrative report and a provider capacity report. CHA provided little description and analysis of their DSN.

CHA described the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds, as well as, ratios of members to pediatric, adult and geriatric providers. The CCO described the use of traditional health workers. The CCO considers these ratios adequate.

The CCO provided a description of the prevalence of diseases and how they obtain access to specialists.

CHA described comprehensive technology to deliver team-based care and other innovations.

The CCO's quality management (QM) department utilizes software to observe trends among member utilization with regards to quality metrics continuously. They described multiple areas of overutilization and underutilization that have been addressed and plans for the future.

See Table 3 for complete results and recommendations for the next submission.

Table 3. Cascade Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 20.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	0	**Comments** CHA did not describe the distribution of all providers compared to the geographic distribution of enrollees. They did state that, "all enrollees live within the 60-mile time and distance standard." However, it wasn't clear if that time and distance standard was for PCPs or other providers as well. “Geoplanning is on the docket for 2018 and has been budgeted by our IT Department.” **Recommendation** For the next submission: • Describe the geographic distribution of all providers compared with the geographic distribution of enrollees.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0	**Comments** This was not addressed. **Recommendation** For the next submission: • Discuss how the network ensures that the time and distance standards for member access to health care are met.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	2	**Comments** The CCO described a mystery shopper–type call that its customer services department uses to call clinics. They report analyzing the answers to these questions. The CCO provided an analysis of physical health clinics surveyed via phone. All clinics had same-day/urgent need appointments available for patients to schedule. Half of these clinics had after-hours clinic hours at least once per week. None of the clinics surveyed had walk-in availability for appointments. No analysis was provided to demonstrate how the CCO ensures the provision of appropriate urgent, emergency, crisis, and triage services are available 24 hours a day/7 days a week for behavioral health and dental care for all members.

Table 3. Cascade Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			Recommendation For the next submission: • Provide analysis of how the CCO ensures the provision of appropriate urgent, emergency, crisis, and triage services are available 24 hours a day/7 days a week for all members.
4.	CCO analyzes wait times for appointments with providers, including specialists.	0	**Comments** The CCO stated they keep track of same day and next appointment for PCP clinics and specialists. No analysis of wait times for appointments with providers, including specialists was provided. **Recommendation** For the next submission: • Provide an analysis of wait times for appointments with providers, including specialists.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	**Comments** The CCO discussed utilizing specialists in and out of the area to provide services to members. The CCO did not discuss how the network ensures time and distance standards for member access to specialists. The CCO does not currently use telemedicine or video conferencing for specialist consultation. However, they have used this in the past. The CCO does provide transportation and food/lodging if necessary for out-of-area specialists. **Recommendation** For the next submission: • Discuss how the CCO ensures that time and distance standards are met for members' access to specialists.

Table 3. Cascade Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** The CCO described the ratio of members to providers for PCPs, specialists, mental health practitioners, and dental care providers. The CCO stated they have adequate coverage of member to PCP, specialist, behavioral health, and dental provider ratios.
6a.	• The CCO addresses ratios for pediatric, adult, and geriatric providers.	3	**Comments** The CCO described ratios for pediatric, adult and geriatric providers.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** • CHA contracts with Sky Lakes Medical Center (SLMC) to provide Community Health Workers. SLMC currently has six CHWs and "are in the process of hiring one more." SLMC also provides CHA members with nurse case managers to assist in care and navigation. CHA provided an analysis describing what the CCO considers to be adequate ratios.
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	2	**Comments** CHA described how NEMT is provided. They report minimal complaints about transportation and no complaints about access. **Recommendation** For the next submission: • Provide an analysis and describe how the CCO considers the NEMT across the network to be adequate.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	2	**Comments** The CCO provided a comprehensive description of how transportation and access for enrollees with disabilities or special needs is provided. **Recommendation** For the next submission: • Provide analysis of how the CCO determines this is adequate.

Table 3. Cascade Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	1	**Comments** CHA did not describe or demonstrate a continuum of care for treatment of mental health disorders or analyze the adequacy. They did describe meeting regularly with community partners in various committees. The CCO described a consistent case management conference to ensure all parties are on board with member treatment plans. **Recommendation** For the next submission: • Demonstrate a continuum of care for treatment of mental health disorders and analyze the adequacy.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	1	**Comments** The CCO did not describe or demonstrate a continuum of care for treatment of substance use disorders. However, they did describe meeting with SUD providers and case managers. They also PA out of area providers for two weeks at a time so they can receive updates on member progress. They stated they consider this to be adequate. However, no analysis was provided. **Recommendation** For the next submission: • Demonstrate a continuum of care for treatment of substance use disorders and analyze the adequacy.

Table 3. Cascade Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	2	**Comments** The CCO described the use of acupuncture, chiropractic, and physical therapy as alternative therapies that meet the needs of their enrollees. They currently do not provide massage or yoga and did not discuss the adequacy of these services to meet the needs of enrollees. **Recommendation** For the next submission: • Describe how the CCO determines the alternative therapies are adequate to meet the needs of enrollees.
Description of Enrollees – 9.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	2	**Comments** The CCO described a policy on member assignments which takes into account member needs, including special needs and cultural needs. They described a Spanish-speaking "pod" at the local FQHC. The CCO provided numbers and percentages of member ages, languages, ethnicity/race, disabilities and special healthcare needs. **Recommendation** For the next submission: • Analysis of language, cultural needs, disabilities and special health care needs.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	2	**Comments** The CCO provided a good description of transportation and access related to members with disabilities and enrollees with special health care needs. **Recommendation** For the next submission: • Describe the process for taking into account enrollee characteristics (disabilities and special health care needs) when making provider assignments.

Table 3. Cascade Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	3	The CCO provided a description of the prevalence of diseases and how they obtain access to specialists.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	2	**Comments** The CCO described transitions of care as part of the case management program. This includes daily reports from hospitals for admissions, and concurrent review of members while in the hospital. The case management staff meet weekly with local skilled nursing provider to discuss transition planning. **Recommendation** For the next submission: • Describe how continuity of care and transition between levels of care are assessed for other types of care as well (example: psychiatric residential treatment services for youth).
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 9.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	2	**Comments** The CCO described utilizing CAHPS access to care information. They described recruiting community partners (in physical health, behavioral health and starting dental health) and offering incentives to recruitment and retention bonuses. Complaints regarding capacity are less than 1% of their grievances. They discuss adequacy of provider capacity with their Community Advisory Council. **Recommendation** For the next submission: • Describe how the CCO incorporates MHSIP, YSS-F and YSS surveys into network adequacy decisions.

Table 3. Cascade Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** CHA described comprehensive technology to deliver team-based care and other innovations.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	2	**Comments** CHA described how members with special health care needs are assigned a case manager and interdisciplinary team. They described many programs for members to receive follow-up care and training in self-care that enrollees may use to promote their own health. It was not clear what mental health services are provided for members with special health care needs. **Recommendation** For the next submission: • Ensure the description of procedures for members includes all members defined in OHA-CCO contract as having special health care needs.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	2	**Comments** CHA participated in the 2016-2017 Developing Equity Leadership through Training and Action (DELTA) cohort through Oregon's Office of Equity and Inclusion. Through this program, CHA identified many areas lacking in equity focus and described plans to address those areas systematically. CHA has demonstrated a commitment to addressing these needs. **Recommendation** For the next submission: • Implement plans to address the CCO commitment to culturally and linguistically appropriate services. Ensure AT&T Translation line has certified health care interpreters.
Coordination of Care – 17.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with:	3	**Comments** Fully met

Table 3. Cascade Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
	• Aging and Persons with Disabilities		
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	1	**Comments** The CCO has been working to contract with the tribal health clinic for the past few years. The CCO participates in community-wide committees with tribal members and are hopeful the interactions will get a meeting with tribal leadership. The CEO is working on scheduling a meeting with tribal leadership. **Recommendation** For the next submission: • Continue to work toward a formal relationship with the local tribal health clinic.
21.	CCO discusses coordination with above stakeholders.	3	**Comments** Fully met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	**Comments** CHA described daily reports received from the hospital, tracking readmission and ER utilization rates. They described active case management of high utilizers of ER/hospital. The CCO did not describe how interdisciplinary care teams are used to coordinate services across the continuum of care. **Recommendation** For the next submission: • Describe how interdisciplinary care teams are used to coordinate services across the continuum of care.

Table 3. Cascade Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	1	**Comments** CHA described, "Dual members are all considered special health care needs. Also include all aged/blind/disabled and SCF children. Unless OHP identifies using the option code, we don't assign "special needs" label without catastrophic health care needs. No other internal assessment." **Recommendation** For the next submission: • Ensure the process for identifying and assessing all enrollees with special health care needs is consistent with the definition provided in the OHA-CCO contract.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	2	**Comments** CHA described utilizing Sky Lakes Medical center EPIC and Reliance HIE. They described how they use an electronic health record to coordinate physical health care, including preventive health care, for all enrollees across the continuum of care. The CCO described workflows in place for staff to utilize these systems to coordinate health care, including prenatal/maternity and preventative care such as breast cancer screenings, colorectal cancer screenings, and in readmission and ED recall activities. Nurse case managers utilize resources to coordinate with provider offices and members to track progress on shared care plans. **Recommendation** For the next submission: • Describe how the CCO uses an electronic health record to coordinate health care, including preventive health care, behavioral health and dental services, for all enrollees across the continuum of care.

Table 3. Cascade Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Performance on Metrics – 4.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	**Comments** CHA described reasons why metric scores may be below the baseline but did not discuss efforts to address these. **Recommendation** For the next submission: • Describe efforts to meet baseline on CCO performance metrics.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	3	**Comments** The CCO's QM department utilizes software to observe trends among member utilization with regards to quality metrics continuously. They described multiple areas that have been addressed and plans for the future.

COLUMBIA PACIFIC CCO

Columbia Pacific CCO (CPCCO), a fully owned subsidiary of CareOregon, provides physical, behavioral and dental health services to OHP members in Columbia, Clatsop and Tillamook counties. As of October 2017, CPCCO had 24,615 enrollees.

Summary

CPCCO submitted a provider narrative report and a provider capacity report. The CCO provided a comprehensive description of the delivery network and adequacy. The CCO provided a comprehensive description of its members and their needs.

CPCCO provided much information regarding how member feedback is incorporated into network adequacy decisions.

The CCO is committed to providing culturally and linguistically appropriate services. CareOregon has created a position of Health Equity Advisor to ensure the organization has a focus on cultural competence.

CPCCO described efforts to build network capacity for those metrics where the CCO's performance is below the baseline.

The provider capacity report appears to include all of CareOregon's providers. Even though these providers may take CPCCO members, most of them are not local to the CCO; for example, no pharmacies were listed in the CCO's area. School-based health centers listed in the report are not in the CCO's area.

See Table 4 for complete results and recommendations for the next submission.

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 36.0 (out of a possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	3	**Comments** Information regarding geographic distribution of physical health care and psychiatric providers compared to the geographic distribution of enrollees was provided. When establishing and maintaining the behavioral health network, GOBHI looks at geographic location of participating providers to enrollees, including distance, travel time, means of transportation and physical access. GOBHI collects data on an annual basis which includes the number and type of practitioner at each organizational provider within GOBHI's network. GOBHI attempts to contract with all providers in their service area to ensure adequate service provision. The DCO's follow OHA time and distance standards but strive for higher dental industry standards and also employ strategies like mobile dental services to address access issues. The CCO utilized CMS MA network adequacy rules for their physical health providers, rather than Oregon Administrative Rule (OAR) regarding time and distance standards. The CCO described how the dental and behavioral health delegates establish and maintain an adequate network. CPCCO described the geographic distribution of dental providers and analysis of how enrollees can access services.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** CareOregon has a formal Network Adequacy policy that says, “The basic methodology and standards are those incorporated in CMS requirements of Medicare Advantage Plans and include calculations of ratios of providers by specialty type to members, tracking of distances from member residences to provider locations and the time of travel from member residence to provider locations.”

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** CareOregon described how they routinely monitor access for routine, urgent, emergent, crisis, triage and after-hours services for physical health, dental and behavioral health providers. Corrective action plans are implemented for PCPs who do not meet the standards. GOBHI utilizes mobile crisis teams in each CPCCO County to further ensure access for urgent and crisis services for members. They discussed utilizing complaint data. The CCO conducts annual oversight of the dental plan networks to ensure they meet the expectations.
4.	CCO analyzes wait times for appointments with providers, including specialists.	2	**Comments** CareOregon monitors network partners for appointment availability. CareOregon has a Network Adequacy Steering Committee that meets quarterly and works to ensure access across all specialty types and routinely monitors for contracting opportunities. The Quality Assurance department monitors all access complaints and trends are reviewed regularly. Contract language and Provider Manual outline requirements and expectations for primary care providers. An Access Coordinator serves as a point person for assessing and identifying access to specialists for PCPs and is the single point of contact to connect the PCP, specialist and member and ensure efficiency. Access complaints for the CCO were provided for 2016. The CCO conducts annual oversight reviews of its delegated dental plan networks and described how each DPN analyzes wait times. Information was provided regarding GOBHI's tracking of access/wait times for services. However, no analysis or information regarding 2017 behavioral health wait times was provided. **Recommendation** For the next submission: • Analyze wait times for appointments with behavioral health providers.

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** CareOregon has a formal network adequacy policy that includes, "The basic methodology and standards are those incorporated in CMS requirements of Medicare Advantage Plans and include calculations of ratios of providers by specialty type to members, tracking of distances from member residences to provider locations and the time of travel from member residence to provider locations." CareOregon reports that provider contracts have telemedicine services as a payable service providing additional access to specialty providers.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	2	**Comments** The CCO outlined standards for evaluating ratios of behavioral health practitioners to members. They outlined the acceptable ratio for Willamette Dental providers to members as well. The CCO reported the number of PCPs, specialty practitioners OB/GYN and traditional health workers compared to members. However, it is not clear if these providers are available within the service area or where they may be located. (Example: The ratio of 4,309 PCPs to 27,679 members seems quite high for the three-county service area). The CCO provided ratios of providers to members for behavioral health (mental health and substance use disorder treatment) and dental care, which were the total number of members divided by the total number of providers. The CCO did not separate pediatric from adult providers when reporting these ratios. The CCO considers the ratios across physical, mental, and dental health to be adequate when evaluated with Network Adequacy reports and Quality Assurance processes and tools which allow them to monitor and ensure appropriate access and availability to needed services for members. The CCO provided information on acute, critical care and psychiatric inpatient care in the service area and in their statewide network.

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			Recommendation For the next submission: • In order to demonstrate adequate services, describe and analyze ratios of mental health and substance use disorder providers as separate services.
6a.	• The CCO addresses ratios for pediatric, adult, and geriatric providers.	3	**Comments** CPCCO does not separate pediatric from adult primary care providers or specialty care practitioners. However, they described how members are assigned and additional support provided to ensure appropriate care. Assignment is set at a clinic level, not at an individual provider level. Clinics commonly have multiple PCPs that have the proper scope of service to treat pediatrics, adults and geriatric members. Additional specialties common to a PCP office include but are not limited to: • Family medicine • Internal medicine • Physician assistant • Pediatricians • Geriatric medicine • Osteopaths • Naturopaths Because of this multi-specialty availability to treat members under 18, adults, and members over 65 the ratio of providers to members becomes the majority of the CCOs network. CareOregon does monitor access for all members based on a weekly unassigned report for CPCCO. If the auto assignment process cannot assign a member to a PCP clinic, the member information is captured on a report that is reviewed weekly. Every unassigned member is reviewed by a provider relations specialist and assigned to appropriate PCP clinic based on age, distance, etc. This report is refreshed weekly.

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	2	**Comments** CareOregon describe the use of Health Resilience Specialists and doulas. Health resilience specialists are embedded within high volume primary care clinics and based on level of need and as such, some clinics have multiple health resilience specialists. They work with high utilizing members and specifically maintain a low caseload, so they can provide individualized care. Health resilience specialists are trained in motivational interviewing and trauma-informed care. They are highly trained to ensure that members culturally specific needs are met and they are connected to appropriate culturally specific serves. The CCO described the use of doulas and integrating them into the obstetrics community. The CCO is working to create a "Doula Hub" to help increase positive health outcomes for moms and babies. GOBHI utilizes peer-support specialists. The CCO continues to work with community-based organizations to further support efforts in including traditional health workers in appropriate settings to improve cultural responsiveness, quality and value. The CCO's contracted provider network (PCPs and BH) embeds traditional health care workers such as community health workers, personal health navigators, peer wellness specialists, family support specialists, youth support specialists in clinic operations and settings. **Recommendation** For the next submission: • Provide analysis of the traditional health workers and whether the CCO considers these ratios adequate.
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO is directly responsible and manages the NEMT benefit through a local NEMT brokerage contract on behalf of all physical, behavioral, and dental health plans delegated under the CCO's subcontracts. CareOregon provides

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			authorization reviews as requested by the CCO for specific needs.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The NEMT brokerage is responsible for screening for physical and mental health issues that would prevent an individual who would need specific and alternative modes of transportation as part of their disabilities and/or special needs. As part of that screening process member profiles are created to documented in order to provide the right transport type based on any reported physical and/or behavioral health need. CareOregon provides support through the telephonic care coordination access line to refer and provide information to community resources assisting members to access additional transportation options. If there are no community resources members are provided an access point through their medical providers to request CareOregon assistance in transportation solution options. This is administered through the health-related services policy and procedures. CareOregon considers transportation/access adequate to meet the needs of members with disabilities or special needs through the NEMT benefit but not overall transportation access across the service area to fill gaps for other non-medical destinations.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described comprehensive continuum of care for treatment of mental health disorders.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders.	3	**Comments** The CCO described a comprehensive continuum of care for treatment of substance use disorders.

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
	• The CCO should analyze and describe whether the CCO considers this adequate.		
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	3	**Comments** CareOregon has expanded their complimentary alternative medicine provider network in direct response to Guideline Note 56 on the prioritized list (GN56) benefit change in 7/2016. This guideline note is regarding low back pain and conditions of the spine. To address this expanded benefit, the CCO's network was expanded and additional contracts were developed with this specific provider types. In addition, members can utilize non-contracted providers as well. • If members are in need of alternative therapies that are not covered by the health plan, the Population Health Department will work with network and clinical services, our network, and medical directors to identify the appropriate alternative therapy and how to get access for that member.
Description of Enrollees – 12.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** CareOregon makes provider assignments through a complex algorithm that considers a variety of factors including continuity of care, family assignments, clinic capacity and location. Members can request or change their PCP assignment. Clinic rosters of assigned members are produced and available to the network to help them manage their panel of patients. Additionally, if a member chooses to see a provider two or more times that is different from the provider to whom they are assigned, CareOregon automatically reassigns that member to the provider they are seeing, ensuring that our assignment system accurately reflects real member engagement. CCO ensures culturally competent services are delivered by a variety of means. CareOregon provides language line services for all members.

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			If a member were to request a specific provider due to cultural or linguistic preference that is identifiable in the provider directory. Member handbooks are also sent out in the member's primary language as it is identified by the state. Additionally, ongoing monitoring of the member complaint process as well as continuing to engage the provider network to identify the needs they have in being able to deliver the services in a culturally competent manner.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** CareOregon care teams use available tools and data to identify members' special heath needs. This team can also reassign the member's PCP to better address their needs. Exceptional Needs Care Coordination (ENCC) team works closely with providers, Aging and People with Disabilities (APD) caseworkers, members and community agencies in care planning for members receiving care coordination services. Care plans for members with special health care needs may be reviewed by multi-disciplinary teams and updated, as conditions or circumstances change. Multi-disciplinary teams comprised of CCO ENCCs, APD caseworkers, physical health/behavioral health/dental care provider representatives, and members/caregivers are held for long-term care and other members in each CCO. The ENCC team has a central call line to accept referrals, provide information and offer support to providers, members and family members. ENCC staff members are available for referrals from members/caregivers/members' representatives, providers, other health care professionals, DHS/APD caseworkers, DHS Governor's Advocacy Office or Client Advisory Services Unit, community agency staff and CareOregon work units and coordinate care across health plans and community care services, as appropriate. Health resilience specialists coordinate necessary care for high-risk members, working across multiple disciplines and often

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			accompanying members to mental health or dental appointments as needed. The Health Resilience Program employs two staff members who work with CCO members admitted to the Psychiatry Emergency Services at Unity Hospital and an addiction specialist who assists the team with members who need support to connect with inpatient and outpatient treatment programs.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	3	**Comments** CareOregon has an open specialty network. CareOregon's ENCC, Regional Care and other care coordination team monitors volume, trends and they have a specialist dashboard on which they can check access. CareOregon offers specific program options for some chronic disease states, like Hepatitis C. They have provider partners who have Hep C programs that offer services to members throughout the entire course of treatment, including counseling, education and training and other services that support the member but may not be a billable service. CareOregon supports services like MAT, and case management for high-risk children based on the needs of the members served.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** CareOregon uses an algorithm including age, geographic location and historical assignment of the family to ensure continuity of care. CareOregon also utilizes the PreManage platform that provides real time data to care teams and PCPs that support members as their health care needs change. For transitions, CareOregon partners with key hospital providers to ensure safe transitions to next care level, providing support and resources as needed. CareOregon is an advocate of the Emergency Department Information Exchange (EDIE) and PreManage tool that provides real time data to care teams and PCPs that support members through the care moves.

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 12.0 (out of possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	3	**Comments** The CCO described monitoring grievances and identifying trends. If complaint thresholds are exceeded, the complaints are referred to a Peer Review Committee. The committee can recommend corrective action or intervention by provider relations specialists to help resolve issues. The CCO described a Community Advisory Council at every county having discussions about access to supports that mitigate health care issues or social determinates of health. Several themes and related discussion points were listed. CPCCO specifically collected 1,265 narrative stories members in each of the three counties asking about what helps or hinders their health and well-being, for themselves, their families or the communities at large. Those stories and experiences are incorporated into the community needs assessment and improvement plan, and specifically used to improve services in each county. The CCO described how their quality program is operationalized.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO described the use of a wide variety of technology solutions to deliver team-based care and other innovations. PreManage and CareOregon's proprietary Business Intelligence platform provide member level data and identify gaps in care to facilitate team-based care across clinics, hospitals and community partners. CareOregon's provider portal provides 24/7 access to a wide variety of tools for providers to manage patient outreach and work with CareOregon administratively. CareOregon supports telemedicine to give members wider access to quality care and eliminate distance barriers. CareOregon is also piloting an e-consult service that enables PCPs to quickly access clinical experts in over 150 specialties and sub-specialties. CareOregon Mobile App is available

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			for members and promotes health and wellness in a variety of ways. GOBHI utilizes telehealth, electronic refill reminders, e-enrollment in care management and online personal health records.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	3	**Comments** Examples of Intensive Care Coordination services were listed. In addition, the CCO listed multiple programs designed to support members with special healthcare needs to receive follow-up and training in self-care and other interventions that enrollees may take to promote their own health.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** CareOregon provided the following information, "Interpretation services are provided upon request from members or providers. In addition, our provider directory indicates language competency of providers. In addition, member handbooks can come in other languages, audio or Braille. The provider directory is also searchable by language." In addition, CareOregon requires practitioners to have policies and procedures that prohibit discrimination in the delivery of health care services. Clinics must comply with ADA requirements. CareOregon has created a position of Health Equity Advisor to ensure organization wide focus on cultural competence. This advisor works directly with the executive and Board levels as well as staff.
Coordination of Care – 20.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
20c.	• IHS and/or Tribal Health Clinics	1	**Comments** CareOregon described a fee-for-service care coordination program they developed in partnership with OHA. However, they did not describe CPCCO's relationship with Indian Health Care providers.
21.	CCO discusses coordination with above stakeholders.	2	**Comments** The CCO did discuss relationships, coordination and agreements with many community organizations, including the local mental health authorities in the three CCO counties. CareOregon described a fee-for-service care coordination program, created in conjunction with the nine federally recognized tribes and NARA NW, however did not describe the CCO relationship with Indian Health Care Providers. **Recommendation** For the next submission: • Describe the relationship and coordination with Indian Health Care Providers.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	3	**Comments** The CCO described its ENCC "Collaboration and Coordination of Care Between Behavioral Health, Medical, Dental and Other Providers" policy, as well as many tasks coordinated by the ENCC team. CareOregon utilizes PreManage/EDIE to monitor members currently receiving ENCC services and determine when they are experiencing a transition. In addition to the ENCC team, two Health Resilience Specialists are imbedded in two major clinic systems in Columbia County. The Health Resilience Specialists and ENCC team work together to coordinate care for members.

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	2	**Comments** The CCO described various methods to identify members with special healthcare needs. Health risk screenings are conducted beginning at referral for ENCC services, through an Intake and Clinician Assessment documentation process for any Medicare and OHP/CCO member with special health care needs, who is engaged in Care Coordination services. Health Risk Assessments are conducted for Medicare members. The ENCC Intensive Care Coordination Policy language was provided which included various ways in which those with special healthcare needs are identified. An innovative platform is being refined and redesigned to assess member health and stratify the population into healthcare profiles and needs based on a variety of sources which include PERC codes, claims data, diagnosis, PCP referrals, and pharmacy data. **Recommendation** For the next submission: • Describe the CCO's process for assessing all enrollees for special healthcare needs.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	3	**Comments** CareOregon described how they coordinate healthcare for all enrollees across the continuum of care. They recently implemented a process to link PCPs with dental plans.
Performance on Metrics – 5.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	3	**Comments** CareOregon recruited and contracted with primary care clinics to expand PCPCH thresholds and access. They also recruited and contracted with clinics participating in the Vaccine For Children program. CareOregon facilitates community efforts in metrics performance by bringing groups of providers together to share workflows and metrics strategies with each other using an IHI-style collaborative learning

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			process. CareOregon described creating capacity in the network to focus on CCO metrics where performance is low by aligning financial incentives. Their alternative payment models reward clinics for meeting quality measure benchmarks. In addition, clinics must be a recognized PCPCH to be eligible for participation. Metrics the CCO performs poorly on are prioritized for inclusion in the APM program. In addition, a portion of the quality pool metric received by the CCO is repaid to the network based on the organization's contribution to the CCO's success. These financial incentives are used to align network priorities with the CCO priorities. Additional resources, including collaboratives and 1:1 technical assistance, are used as tools to improve clinical workflows and processes. Many network partners are also eligible for an embedded, CareOregon-funded panel coordinator. Panel coordinators conduct outreach and in reach to CCO members to help improve engagement in primary care and close clinical gaps. Panel coordinators focus their attentional on priority measures where the CCO may have lower performance.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	2	**Comments** CareOregon outlined efforts to identify overutilization via payment integrity and efforts. They further described contracting opportunities and payment methodologies to pay for services that may be underutilized. CareOregon has instituted a Payment Integrity Team to analyze utilization patterns that may include, but are not limited to: • Detailed claim analysis of inappropriate patterns of utilization • Updating internal claim processes and procedures • Modifying the claims system to pend or edit billing scenarios identified as inappropriate • Provider education • Corrective action plans for providers

Table 4. CPCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			• Loss of contract and/or a no pay status applied to the provider/clinic • GOBHI's comprehensive policy for over- and underutilization was provided. However, analysis of patterns of underutilization and overutilization and actions the CCO has taken to address these were not present. **Recommendation** For the next submission: • Provide analysis of patterns of underutilization and overutilization and actions the CCO has taken to address these.

EASTERN OREGON CCO

Eastern Oregon CCO (EOCCO) provides physical, behavioral and dental health services for OHP enrollees in 12 Oregon counties: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler. As of October 2017, EOCCO had 45,831 enrollees. The CCO is administered by Moda Health and Greater Oregon Behavioral Health, Inc. (GOBHI).

Summary

EOCCO submitted a provider narrative report and a provider capacity report. Throughout most of their narrative, EOCCO reported information by delegated entity rather than as the CCO. ODS, GOBHI, Advantage and EOCCO may have different processes related to the delivery system network. The CCO provided information related to time and distance standards as well as geo-mapping.

Access to routine, urgent and emergency services was described. The CCO provided an analysis of CCO complaints, as well as a description of monitoring providers and corrective action plans if needed. In addition, the CCO discussed how they monitor the network to ensure adequate capacity. A comprehensive description of how the CCO delivers services in a culturally competent manner to all members was provided.

No analysis was provided of the needs of enrollees with disabilities or special health care needs.

Information regarding coordination with stakeholders was provided.

Table 5. EOCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 5.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	1	**Comments** The CCO described how GOBHI looks at time and distance standards for their providers and also looks at geo-mapping. **Recommendation** For the next submission: • Describe and analyze a comprehensive picture of geographic distribution of all providers compared with the geographic distribution of enrollees.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0	**Comments** This was not addressed. **Recommendation** For the next submission: • Discuss how the network ensures that the time and distance standards for member access to health care are met.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	2	**Comments** The CCO provided information on ODS and GOBHI with respect to access to routine, urgent and emergency services. They provided an analysis of CCO complaints, as well as a description of monitoring providers and corrective action plans if needed. **Recommendation** For the next submission: • Describe and analyze access and how the CCO ensures the provision of all appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.
4.	CCO analyzes wait times for appointments with providers, including specialists.	0	**Comments** Analysis of wait times was not provided. **Recommendation** For the next submission: • Provide an analysis of wait times for appointments with providers, including specialists.

Table 5. EOCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	2	**Comments** The CCO discussed how they monitor the network to ensure adequate capacity. If a member requires a specialist and one is not available, an appropriate provider is located. Further work may be done to contract with this specialist or a single case agreement. Corrective action plans related to access throughout the CCO were outlined. **Recommendation** For the next submission: • Discuss efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	0	No description or analysis was provided.
6a.	• The CCO addresses ratios for pediatric, adult, and geriatric providers.	0	No description or analysis was provided.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	0	No description or analysis was provided.
8.	CCO describes how non-emergency transportation is provided across the delivery network.	0	No description or analysis was provided.

Table 5. EOCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
	• The CCO should analyze and describe whether the CCO considers this adequate.		
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	0	No description or analysis was provided.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	0	No description or analysis was provided.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	0	No description or analysis was provided.
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	0	No description was provided.
Description of Enrollees – 3.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	2	**Comments** A comprehensive description of how the CCO delivers services in a culturally competent manner to all members was provided. GOBHI supports and encourages its providers to recruit practitioners who reflect the diverse cultural and ethnic backgrounds of its members. Quarterly, the CCO verifies

Table 5. EOCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			languages reported on the 834 eligibility files. Spanish-speaking members receive materials in Spanish through this process. GOBHI monitors access to care and services periodically through site reviews that include culturally and linguistically appropriate services assessments (CLAS). **Recommendation** For the next submission: • Describe the process for taking into account enrollee characteristics when making provider assignments. Provide an analysis of the language and cultural needs of enrollees.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.		**Comments** No analysis was provided of the needs of enrollees with disabilities or special health care needs. Monitoring of specialists in the service area was discussed. **Recommendation** For the next submission: • Provide an analysis of the needs of enrollees with disabilities and special health care needs.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	0	**Comments** No analysis was provided. **Recommendation** For the next submission: • Provide analysis of the prevalence of diseases that require access to specialists among the enrollee population.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	0	**Comments** No analysis was provided. **Recommendation** For the next submission: • Describe how enrollee needs for continuity of care and transition between levels of care are assessed.

Table 5. EOCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 0.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	0	No description was provided.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	0	No description was provided.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	0	No description was provided.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	0	No description was provided.
Coordination of Care – 14.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met
20a.	• Local public health authority	3	**Comments** Fully met

Table 5. EOCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	2	**Comments** Yellowhawk Tribal Clinic was listed in the Provider Capacity Report. **Recommendation** For the next submission: • Describe the relationship between EOCCO and Yellowhawk.
21.	CCO discusses coordination with above stakeholders.	3	Information concerning coordination with stakeholders was provided.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	0	**Comments** No description or analysis provided. **Recommendation** For the next submission: • Describe and analyze how interdisciplinary care teams coordinate services across the continuum of care. Analyze whether this is adequate to reduce hospital readmission and emergency room usage.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	0	**Comments** No description was provided. **Recommendation** For the next submission: • Describe the process for identifying and assessing all enrollees for special health care needs.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	0	**Comments** No description was provided. **Recommendation** For the next submission: • Describe how the electronic health record is used to coordinate health care, including preventive health care, for all enrollees across the continuum of care.

Table 5. EOCCO Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Performance on Metrics – 0.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	0	**Comments** No description was provided. **Recommendation** For the next submission: • Describe efforts to build network capacity for those metrics where the CCO's performance is below the baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	0	**Comments** No analysis was provided. **Recommendation** For the next submission: • Analyze patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.

FAMILYCARE CCO

FamilyCare, Inc., a 501(c)(4) public benefit corporation, contracts with OHA as a CCO to provide physical, behavioral and dental health services to OHP members in Multnomah, Clackamas, Washington and Marion counties. As of October 2017, FamilyCare had 116,378 enrollees.

Summary

FamilyCare submitted the provider narrative report and provider capacity report.

FamilyCare described using internal geo-access network adequacy reporting and requiring providers to meet timely access standards. The CCO works with non-participating providers to ensure access and continuity of care for their members. The CCO described their ongoing performance improvement efforts with their NEMT provider. FamilyCare discussed monitoring network adequacy in multiple ways, including: member satisfaction survey results, access audits, monthly network adequacy reports, member grievances and appeals, quarterly reports for the quality management committee, needs identified by participating providers and contracted agents, membership analysis based on utilization, geography, language and ethnicity. The CCO uses specialized software to compare all participating and non-participating providers by office address and member address to ensure appropriate and adequate (including subcontracted dental plans).

The CCO performs a welcome call with each new member. This is a three-way call between the member, their chosen PCP and FamilyCare. Members with special health care needs are referred to the care coordination program.

The CCO described multiple agreements and projects with a diverse group of community-based organizations and others who provide unique culturally specific services.

No information was provided on efforts to build network capacity for metrics where the CCO's performance is below baseline or addressing under and overutilization. The CCO's provider capacity report provided most of the required information.

See Table 6 for complete results and recommendations for the next submission.

Table 6. FamilyCare Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 13.0 (out of a possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	1	**Comments** FamilyCare described using internal geo-access network adequacy reporting. **Recommendation** For the next submission: • Describe and analyze a comprehensive picture of geographic distribution of all providers compared with the geographic distribution of enrollees.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	2	**Comments** FamilyCare requires providers to meet standards for timely access standards through contracting and FamilyCare policies and procedures. The CCO conducts quarterly monitoring phone calls to determine the length of time for next available appointments and after-hours calls. Distance was not discussed. **Recommendation** For the next submission: • Discuss how time and distance standards are met for required providers (PCP).
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	**Comments** FamilyCare did not specifically address how they ensure the provision of urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members. In general, they discussed requiring providers to meet timely access standards through contracting and policies and procedures. **Recommendation** For the next submission: • Address how the CCO ensures provision of appropriate urgent, emergency, crisis and triage services 24 hours a day/7 days a week for all members.

Table 6. FamilyCare Results.			
Indicator		**Score**	**Review Comments/Recommendations**
4.	CCO analyzes wait times for appointments with providers, including specialists.	2	**Comments** FamilyCare conducts quarterly monitoring phone calls to determine the length of time for next appointments and after-hours calls. **Recommendation** For the next submission: • Address how the CCO analyzes wait times for appointments with all services, including physical health, behavioral health, dental and all specialists.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	2	**Comments** FamilyCare requires providers to meet standards for timely access standards through contracting and FamilyCare policies and procedures. The CCO conducts quarterly monitoring phone calls to determine the length of time for next available appointments and after-hours calls. Distance was not discussed. FamilyCare authorizes out-of-network care based on continuity of care, recommendation of division directors, medical directors, or referring provider's assessment that the services required are not available within the network. This care is authorized for as long as the member requires it, or until a contracted source for the services can be secured. **Recommendation** For the next submission: • Discuss how time and distance standards are met for all specialists.

Table 6. FamilyCare Results.			
Indicator		**Score**	**Review Comments/Recommendations**
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	0	**Comments** FamilyCare did not describe the ratio of members to providers. **Recommendation** For the next submission: • Describe the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds.
6a.	• The CCO addresses ratios for pediatric, adult, and geriatric providers.	0	**Comments** FamilyCare did not describe the ratio of members to providers. **Recommendation** For the next submission: • Describe ratios for pediatric, adult, and geriatric providers.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	0	**Comments** The use of traditional health care workers was not described. **Recommendation** For the next submission: • Describe how traditional health care workers (by type) are incorporated into the delivery network.
8.	CCO describes how non-emergency transportation (NEMT) is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** FamilyCare described their ongoing performance improvement efforts with their NEMT provider.

Table 6. FamilyCare Results.			
Indicator		**Score**	**Review Comments/Recommendations**
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	2	**Comments** FamilyCare described multiple ways that they monitor their network for adequacy. In addition, FamilyCare addressed working with non-participating providers, who are not ready to contract, but will service members on a special needs basis. No description of transportation for enrollees with disabilities or special needs was provided. **Recommendation** For the next submission: • Address transportation and access specifically for enrollees with disabilities or special needs.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	0	**Comments** FamilyCare did not discuss a continuum of mental health services or analysis of adequacy. **Recommendation** For the next submission: • Describe the CCO's continuum of mental health treatment.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	0	**Comments** FamilyCare did not discuss a continuum of substance use disorder treatment options. **Recommendation** For the next submission: • Analyze and describe substance use disorder treatment continuum.
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	0	**Comments** The CCO did not describe did not describe the availability, adequacy and use of alternative therapies. **Recommendation** For the next submission: • Describe the availability, adequacy and use of alternative therapies.
Description of Enrollees – 7.0 (out of a possible 12.0)			

Table 6. FamilyCare Results.			
Indicator		**Score**	**Review Comments/Recommendations**
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	2	**Comments** FamilyCare discussed monitoring the network adequacy in multiple ways, including: member satisfaction survey results, access audits, monthly network adequacy reports, member grievances and appeals, Quarterly reports for the Quality Management Committee, needs identified by participating providers and contracted agents, membership analysis based on utilization, geography, language and ethnicity. The CCO uses specialized software to compare all participating and non-participating providers by office address and member address to ensure appropriate and adequate (including subcontracted dental plans). **Recommendation** For the next submission: • Provide analysis of language and cultural needs of enrollees.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	2	**Comments** In addition to the information above, FamilyCare conducts quarterly phone assessments and documents appointment availability and after hours call coverage. Random bi-weekly phone calls to members help then schedule specialist appointments. The CCO monitors and tracks access and availability. The CCO performs a welcome call with each new member; this is a three-way call between the member, their chosen PCP and FamilyCare. Members with special health care needs are referred to the care coordination program. **Recommendation** For the next submission: • Provide analysis of the needs of enrollees with disabilities and enrollees with special health care needs.

Table 6. FamilyCare Results.			
Indicator		**Score**	**Review Comments/Recommendations**
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	0	**Comments** No analysis was provided. **Recommendation** For the next submission: • Provide analysis of the prevalence of diseases that require access to specialists among the enrollee population.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** The CCO described the three-way Welcome Calls, Care Coordination Program for members with special health care needs, and authorization for out-of-network services to ensure continuity of care.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 7.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	2	**Comments** The CCO utilizes member satisfaction survey results and member grievances and appeals when analyzing their network for adequacy. **Recommendation** For the next submission: • Describe how input from the community advisory council and mental health surveys are incorporated.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	2	**Comments** The CCO described the use of software to compare providers' office locations (including dental) compared to member addresses to ensure access. **Recommendation** For the next submission: • Further describe how technology is used to deliver team-based care and other innovations.

Table 6. FamilyCare Results.			
Indicator		**Score**	**Review Comments/Recommendations**
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	1	**Comments** No information (other than referral to the care coordination program) was provided to describe procedures to ensure enrollees receive follow-up and training in self-care and other interventions as appropriate, so enrollees may promote their own health. **Recommendation** For the next submission: • Describe procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	2	**Comments** The CCO described multiple agreements and projects with a diverse group of community-based organizations and others who provide unique culturally specific services. The CCO described monitoring network adequacy through multiple means, including language and ethnicity. The CCO maintains a record of languages spoken by each provider, contracts with several language translation services, and provides internal member navigation services. **Recommendation** For the next submission: • Describe how the CCO addresses its commitment to culturally and linguistically appropriate services at all levels of the organization, including leadership and throughout the provider network.
Coordination of Care – 13.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met

Table 6. FamilyCare Results.			
Indicator		**Score**	**Review Comments/Recommendations**
20a.	• Local public health authority	2	The CCO is working on a draft MOU with the tri-county public health departments.
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	1	**Comments** The CCO works with the Native American Rehabilitation Association of the Northwest. FamilyCare stated they work with pharmacies of Indian tribe, tribal organization and urban Indian organizations to provide convenient access for members. **Recommendation** For the next submission: • Provide additional information about how the CCO has developed relationships with the Indian Health Services and Tribal health clinics where member receive services.
21.	CCO discusses coordination with above stakeholders.	2	**Recommendation** For the next submission: • Further description of relationships and coordination with Indian Health Care Providers.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	**Comments** The CCO discussed the use of their care coordination program and internal member navigation services. **Recommendation** For the next submission: • Describe how interdisciplinary care teams are used to coordinate services across the continuum of care.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	1	**Comments** Members with special health care needs are referred to the care coordination program. A description of how members with special health care needs are identified and assessed was not provided.

Table 6. FamilyCare Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			Recommendation For the next submission: • Describe the process for identifying and assessing all enrollees for special health care needs.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	0	**Comments** No information was provided to describe how the CCO uses its electronic health record to coordinate care across the continuum. **Recommendation** For the next submission: • Describe how the CCO uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.
Performance on Metrics – 0.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	0	**Comments** The CCO did not describe efforts to build network capacity for metrics where the CCO's performance were below the baseline. **Recommendation** For the next submission: • Describe the CCO efforts to build network capacity for those metrics where the CCO's performance is below the baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	0	**Comments** Analysis of underutilization and overutilization patterns was not provided. **Recommendation** For the next submission: • Analyze patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.

HEALTH SHARE OF OREGON

Health Share of Oregon, comprised of 16 risk-accepting entities, contracts with OHA as a CCO to provide physical, behavioral and dental health services to OHP members in Multnomah, Washington and Clackamas counties. As of October 2017, Health Share had 205,752 enrollees.

Summary

Health Share submitted comprehensive provider narrative report and provider capacity reports. Health Share provided a comprehensive description of their delivery system network and adequacy. The CCO described its investment in and promotion of community health workers to provide support and advocacy for members. A description of how NEMT is provided throughout the service area, as well as analysis of transportation and access needs for members with disabilities or special needs was included. The CCO described some member characteristics and focus areas matched to their needs.

Health Share describe assessment of enrollee needs for special health care needs, continuity of care and transitions between levels of care.

Health Share described system-wide efforts toward equity and inclusion of all of its members.

The CCO provided information on care coordination and interdisciplinary teams.

The CCO described efforts to build network capacity for metrics where performance is below the baseline.

See Table 7 for complete results and recommendations for the next submission.

Table 7. Health Share Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 39.0 (out of a possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	3	**Comments** Health Share described data used to analyze access patterns and gaps in its delivery system network. This information included geographic availability and matching provider types to member demographics.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** Health Share monitors network services to ensure they meet all expectations for timely access. The CCO does take into account geographic distribution and provided information on how the distance standards are met.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** Health Share contractually requires access to adequate and timely services. The CCO monitors the network to ensure timely access. Health Share listed relevant reports and data.
4.	CCO analyzes wait times for appointments with providers, including specialists.	3	**Comments** Health Share monitors timeliness of appointments and wait times for its network.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** The CCO provided details on how they ensure distance standards for member access to specialists. The CCO provided information on tele-mentoring model Project ECHO® to link primary care providers to psychiatrists for a variety of psychotropic medication needs. Additional telehealth information was provided.

Table 7. Health Share Results.			
Indicator		**Score**	**Review Comments/Recommendations**
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** Health Share described ratios of members to providers. In addition, the CCO described a delivery system network they analyzed to consist of all provider types necessary to ensure adequate capacity and access to all covered services.
6a.	• The CCO addresses ratios for pediatric, adult, and geriatric providers.	3	**Comments** Same as above.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** Health Share described its investment in and promotion of community health workers to provide support and advocacy for members. The CCO formally invested in the Oregon Community Health Worker Association to build infrastructure to train, develop, integrate and sustain a CHW workforce and create a hub mechanism for Health Share's partners to access these services.
8.	CCO describes how non-emergency transportation is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** A description and analysis of how non-emergency transportation is provided across the delivery network was provided. The CCO described efforts to improve the NEMT service for its members.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described how transportation and access for enrollees with disabilities or special needs is provided. They further described efforts to coordinate non-covered rides for members, as well as providing care in non-traditional settings to meet the special needs of members.

Table 7. Health Share Results.			
Indicator		**Score**	**Review Comments/Recommendations**
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** Health Share described its continuum of behavioral health services and further described the network as a single regional system of behavioral health care with standardized care management.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** Same as above.
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	3	**Comments** The CCO provides all covered services and specifically described alternative therapies, including provider types, claims and grievance information.
Description of Enrollees – 12.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** Health Share described efforts to match provider types to Member demographics throughout its network. This includes analysis of how well the current network is able to meet the needs of members from a geographic as well as racial, ethnic and linguistic perspective.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** The CCO provided examples of focus areas for their provider network management workgroup that included looking at individuals with SPMI, availability of specialized services, as well as services for individuals with a significant number of ED visits.

Table 7. Health Share Results.			
Indicator		**Score**	**Review Comments/Recommendations**
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	3	**Comments** Health Share described contracting directly with specialty provider networks as necessary to support access and capacity throughout the service area and statewide, when appropriate. The CCO provided analysis of the prevalence of diseases that require specialists, including number of members, encounters and specialists for the top ten prevalent diseases. The CCO further described how one plan partner identifies and serves a sub-population who exhibit higher prevalence of diseases. They conduct an annual analysis to ensure there are sufficient specialists to provide services in their "top five" most utilized programs.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** Health Share described how enrollees needs for continuity of care and transition between levels of care are assessed.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 12.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	3	**Comments** The CCO described utilizing trends in complaints, grievances and appeals as some of the data used to analyze access patterns and gaps across a number of workgroups and initiatives. The CCO described how they incorporate member surveys. The CCO anticipates utilizing the Community Advisory Council to inform network adequacy decisions in the future. However, this is not their current focus.

Table 7. Health Share Results.			
Indicator		**Score**	**Review Comments/Recommendations**
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO described the use of technology to deliver team-based care, including an enterprise data warehouse (Health Share Bridge) to provide member data to all health plan partners and providers on a daily basis. The CCO further described the use of EDIE and PreManage providing real-time updates regarding member emergency department utilization. The CCO's plan partners utilize electronic health records to allow for intra-plan coordination. Health Share developed Referral Manager, a team-based inter-plan platform, to assist with coordination of care for youth in DHS custody. Care coordinators from dental, physical health and behavioral health have access to this tool, along with DHS Child Welfare, to exchange information and expedite access to care.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	3	**Comments** Health Share provided examples regarding how their plan partners coordinate and ensure self-care and other interventions that enrollees may take to promote their own health. The CCO documented the number of service incidents associated with procedure codes for self-care education and home management training. They further described ICCs and ENCCs who assist members with special health care needs. The CCO described work with Area Agency on Aging (AAA/APD) to improve access and utilization of evidence-based self-management education for members. Health Share's physical health plan partners offer in-person and online health and wellness education to support members with specific health care needs. Providers may recommend, or members can register themselves for a variety of classes. Each plan partner has a policy and procedure to support members with exceptional health needs and their caregivers.

Table 7. Health Share Results.			
Indicator		**Score**	**Review Comments/Recommendations**
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** Health Share described system-wide efforts toward equity and inclusion of all of its members. Health Share analyzes member health status and outcomes through the perspective of race, ethnicity and language. The CCO works to determine where there are meaningful differences in access and network capacity sufficient to service culturally specific member populations.
Coordination of Care – 22.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met.
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	2	**Comments** The CCO contracts with NARA NW, an urban Indian program and FQHC. Health Share also contracts with four additional behavioral health organizations that focus on Native American and Alaska Native members and individual behavioral health providers who are tribal members and/or specialize in serving this population. There are no Indian Health Services or Tribal 638 clinics in the Health Share service area. Health Share provided no further discussion of additional relationships or memoranda of understanding with additional Indian Health Care Providers. NARA NW's Executive Director serves on Health Share's Board of Directors. **Recommendation** For the next submission: • Describe the relationship the CCO has with Indian Health Care Providers, ensuring

Table 7. Health Share Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			eligible individuals can receive primary care services, referrals to in-network providers and payment - whether the provider is in the service area or outside of the service area.
21.	CCO discusses coordination with above stakeholders.	2	**Comments** Discuss additional coordination with Indian Health Care Providers as described above.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	3	**Comments** The CCO discussed how health plan partners utilize care management teams. A number of their plan partners deploy navigators and Intensive Care Coordinators (ICC) to coordinate services across the continuum. The CCO convenes a Care Integration Workgroup consisting of ICCs from physical health, behavioral health and dental health to ensure information sharing, case studies of complex members and development of shared care planning. The CCO discussed multiple ways the plan partners are addressing hospital readmission and emergency room usage.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	3	**Comments** The CCO described a comprehensive process for identifying and assessing members with special health care needs.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	3	**Comments** The CCO described the use of Health Share Bridge, an electronic data warehouse, which allows plan partners to access member cohort information. The CCO delegates direct service to its plan partners, who coordinate health and preventative care.
Performance on Metrics – 6.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	3	**Comments** The CCO described efforts and network capacity to address metrics where the CCO's performance is below the baseline.

Table 7. Health Share Results.			
Indicator		**Score**	**Review Comments/Recommendations**
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	3	**Comments** Health Share described focus areas of behavioral health services for individuals who have a significant number of Emergency Department visits. They further discussed underutilization of dental services and efforts to address this.

INTERCOMMUNITY HEALTH NETWORK

Intercommunity Health Network (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. As of October 2017, the CCO had 53,576 enrollees.

Summary

IHN submitted a provider narrative report and a provider capacity report.

The CCO described the geographic distribution of providers compared to members. They further addressed travel time, means of transportation and physical access for members with disabilities when looking at network adequacy. The process for identifying and assessing all enrollees for special health care needs was provided along with analysis of expected utilization of services for enrollees with special health care needs.-In addition, the CCO described ongoing network development efforts to include a range of preventative and specialty services. The continuum of care for treatment of mental health services was described.-However, a description of the continuum of care for treatment of substance use disorders was not included. IHN analyzes out-of-network claims and access to specialty services in isolated areas when reviewing their network for adequacy.

See Table 8 for complete results and recommendations for the next submission.

Table 8. IHN Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 32.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	3	**Comments** IHN described using geocoding. **Recommendation** For the next submission: • Ensure dental providers are included when reviewing geographic distribution.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** Among other characteristics, the CCO looks at geographic location of providers and members and considers distance and travel time, means of transportation, and physical access for members with disabilities when looking at providing an adequate network.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	2	**Comments** IHN monitors the number of members assigned to PCPs. The provider services department investigates network adequacy. Proposals for addressing availability of service needs are reviewed and approved by the provider contracting committee. Availability of medically necessary services as a whole, and on a case-by-case basis is monitored through reviewing MOU activities. The Medical Management Department authorizes medically necessary services through utilization review and reports any concerns of network availability to the Provider Services Department. The Provider Services Department develops a strategy for ensuring the appropriate availability of contracted services. IHN uses a CMS-supported Access to Essential Services process for its plan members as well as special needs plan members to improve access to essential services such as medical, mental health and social health services by maintaining an adequate and appropriate contracted provider network. We measure that goal by making sure the percentage of services received from out of network providers is less than 20 percent. We also

Table 8. IHN Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			mine the data by specialty type to further investigate access to essential services needs in isolated areas. **Recommendation** For the next submission: • Ensure dental and behavioral health providers are included when analyzing access and ensuring provision of services.
4.	CCO analyzes wait times for appointments with providers, including specialists.	2	**Comments** IHN requires compliance with timeliness and access to care standards included in the service agreement and through policy, and state regulation. The CCO only described using grievances to monitor compliance by providers of timely access to care. The CCO states it will develop a plan to address how to analyze wait times for providers, including specialists. They are looking at vendor solutions that help monitor timely access to services. **Recommendation** For the next submission: • Provide proactive monitoring of wait times rather than relying on grievances when analyzing, including specialists.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	2	**Comments** IHN CCO contracts with the majority of providers in its three-county service area, so that its members do not have to travel more than 60 miles or 60 minutes to access health care services in rural areas or 30 miles or 30 minutes in urban areas, which are community standards. The contracted dental plan networks (DPNs) each have processes in place to serve homebound members, either through traveling dentists or partnering with community organizations that treat those members (such as exceptional needs dental services). The DPNs (and Benton County Health Department) are working toward better equipping their teledentistry outreach. IHN is currently developing telehealth services for behavioral health. However, IHN did not describe

Table 8. IHN Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			how they ensure time and distance standards to behavioral health specialists and physical health specialists. The CCO reports having developed a Telemedicine Guideline that has been distributed to appropriate functional areas so gaps in service can be reduced and eliminated. **Recommendation** For the next submission: • Further address efforts to address local service gaps through telemedicine (or other innovative means). Include behavioral health providers including a description of how the CCO ensures time and distance standards for access to specialists, (including behavioral health specialists).
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** A description of the analysis process was provided. IHN provided a description of ratios of member for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds, including analysis that the CCO considers these radios adequate.
6a.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO addresses ratios for pediatric, adult, and geriatric providers.	3	**Comments** The CCO addressed ratios of pediatric, adult and geriatric populations.

Table 8. IHN Results.			
Indicator		**Score**	**Review Comments/Recommendations**
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	2	**Comments** IHN described how traditional health care workers are being utilized. The CCO did not discuss ratios but did state the numbers are adequate due to contracting with any willing provider who meets credentialing requirements. **Recommendation** For the next submission: • Provide analysis on the adequacy of the use of traditional health care workers.
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	2	**Comments** IHN described its contract with the NEMT provider in the service area. IHN described this service as adequate due to contracting with the NEMT provider in their service area. They did not describe grievances or challenges as part of their analysis. **Recommendation** For the next submission: • In addition to having a contract with the NEMT provider in the service area, describe grievances, challenges (if any) and any quality improvement efforts regarding NEMT.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** IHN takes into consideration means of transportation and whether the location provides physical access for members with disabilities when contracting with providers.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The continuum of care for treatment of mental health disorders was discussed and analyzed. The CCO continually works to ensure capacity issues are addressed.

Table 8. IHN Results.			
Indicator		**Score**	**Review Comments/Recommendations**
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	1	**Comments** The continuum of care for treatment of substance use disorders was not discussed. However, the CCO identified a need for additional capacity for SUD residential and detox services and is currently in the process of developing a facility and has recruited medical practitioners to provide medical detox. **Recommendation** For the next submission: • Describe and analyze the continuum of treatment for substance use disorders.
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	3	**Comments** The CCO described contracting with alternative therapies to meet the needs of their members.
Description of Enrollees – 12.0 (out of 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** IHN described training for employees and providers regarding cultural competency, health literacy and interpreter services. The CCO does not take into account enrollee characteristics when making provider assignments. However, they allow members to change PCPs. The CCO looks at a member access report on a monthly basis to verify languages spoken, as well as ensure member materials are available. They offer Spanish-speaking option online through the website with translated forms and documents. The majority of their non-English speaking community is Spanish.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** The CCO described reviewing expected utilization of services for members with special health care needs when reviewing their network. They further describe the use of CMS supported Access to Essential Services when looking at services for those with special health care needs.

Table 8. IHN Results.			
Indicator		**Score**	**Review Comments/Recommendations**
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	3	**Comments** The CCO described continued network development to include a range of preventative and specialty services for their population.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** IHN described how enrollee needs for continuity of care and transition between levels of care are assessed, including an annual assessment of the complex case management program.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 12.0 (out of 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	3	**Comments** The CCO described the use of enrollee grievances, data extracted from the EHR, patient experience surveys in network adequacy decisions.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO described using CMS supported Access to Essential Services process to improve access to essential services. IHN provided extensive information on their creation of the Regional Health Information Exchange solution designed to integrate more complete patient information for the care coordination and delivery to participating partners.

Table 8. IHN Results.			
Indicator		**Score**	**Review Comments/Recommendations**
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	3	**Comments** The CCO described case management activities and mentioned that the interdisciplinary care team promotes self-management of chronic conditions and participation in health promotion and/or prevention activities. Members with special health care needs may receive case management services with the focus on promoting independence, engaging members in prevention, and restoring their highest potential and full level of function. The CCO described the use of individualized care plans to address the special health care needs of members.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** In 2016, a mandatory online training, "Cultural Humility," was completed by all employees. The CCO conducts annual provider trainings on cultural competency, health literacy and interpreter services. Providers agree to provide coverage and services in a culturally competent manner. Interpreters are utilized throughout the network. The CCO partners with the Linn Benton Health Equity Alliance and provides summits and trainings on health equity and cultural competence for medical professionals, clinical staff, social service providers, traditional health workers, administrators, and decision makers serving the needs of IHN-CCO members.
Coordination of Care – 22.0 (out of 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	3	**Comments** The CCO contracts with the Siletz Community Health Clinic.

Table 8. IHN Results.			
Indicator		**Score**	**Review Comments/Recommendations**
21.	CCO discusses coordination with above stakeholders.	3	**Comments** IHN listed services provided through Public Health and Behavioral Health Programs and APD/DHS. The CCO described how they coordinate with the Tribal Health Clinic.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	3	**Comments** IHN described the use of interdisciplinary team approach, Community ICT meetings, CCO health care guides and behavioral health care managers to connect providers with community partners and agencies and coordinate services throughout the community. The CCO states it works with all stake holders to reduce hospital readmissions and emergency room use. IHN described multiple ways that dental services are addressed and included in interdisciplinary care teams and coordinating services across the continuum of care.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	1	**Comments** Information was not provided describing the process to identify and assess all members for special health care needs. As they move forward, the CCO is using its transformation and quality strategy to increase access to services for members with special health care needs. Their medical management staff have created a catalog of data sets available to identify and assess the special health care needs of its members. This catalog along with the dashboard OHA provides to IHN CCO will be used to risk stratify the population. Workflow and processes will be developed to analyze and address members' needs. IHN CCO care coordination staff work closely with OCWCOG Rideline to ensure members have access to providers at the right time, in the right place. **Recommendation** For the next submission: • Describe the CCO process for identifying and assessing all enrollees for special health care needs.

Table 8. IHN Results.			
Indicator		**Score**	**Review Comments/Recommendations**
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	3	**Comments** The CCO described the use of data extracted from electronic health records, along with the Regional Health Information Exchange data to coordinate health care across the provider network, identify gaps and facilitate one health record in real time.
Performance on Metrics – 4.0 (out of 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	3	**Comments** IHN CCO provided information regarding efforts to build network capacity for metrics in 2017 where the CCO's performance was below the baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	**Comments** IHN measures a goal of making sure the percentage of services from out-of-network providers is less than 20 percent. They reported mining data by specialty type to investigate access to essential services in isolated areas. **Recommendation** For the next submission: • Analyze patterns of underutilization and overutilization, and the actions the CCO has taken to address underutilization and overutilization.

JACKSON CARE CONNECT

Jackson Care Connect (JCC), a wholly owned subsidiary of CareOregon, contracts with OHA to provide physical, behavioral and dental health services for OHP members in Jackson County. As of October 2017, the CCO had 30,172 enrollees.

Summary

JCC submitted a comprehensive provider narrative report that met contract requirements and a provider capacity report that met most requirements.

The CCO provided a description and analysis of their delivery system network, as well as a comprehensive description of the CCO members.

JCC described how it uses input from its community advisory council and grievances when making network decisions, yet they did not describe utilizing member experience surveys for input.

The CCO described various methods to identify members with special health care needs. However, no documentation was provided regarding the CCO's process for assessing all enrollees with special health care needs.

The CCO provided information regarding performance on metrics where the CCO's performance is below baseline and described areas of over and underutilization.

The provider capacity report appears to include all of CareOregon's providers. Even though these providers may take JCC members, most of them are not local to the CCO.

See Table 9 for complete results and recommendations for the next submission.

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 37.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	2	**Comments** Information regarding geographic distribution of physical health care providers compared to the geographic distribution of enrollees was provided. The DCO's follow OHA time and distance standards but strive for higher dental industry standards and also employ strategies like mobile dental services to address access issues. The CCO utilized CMS MA network adequacy rules for their physical health providers, rather than OARs regarding time and distance standards. The CCO described how the dental delegates establish and maintain an adequate network, including the use of exceptional needs dental services to provide mobile dental services for those in need. The CCO contracts with the majority of behavioral health providers in the area and continually works to build relationships with community partners to ensure member needs are met. However, they did not describe the geographic distribution of behavioral health and dental providers. **Recommendation** For the next submission: • Describe the geographic distribution of all providers, including behavioral health and dental providers, compared with the geographic distribution of enrollees.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** CareOregon has a formal Network Adequacy policy that states, “The basic methodology and standards are those incorporated in CMS requirements of Medicare Advantage Plans and include calculations of ratios of providers by specialty type to members, tracking of distances from member residences to provider locations and the time of travel from member residence to provider locations.”

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** CareOregon described how they routinely monitor access for routine, urgent, emergent, crisis, triage and after-hours services for physical health, dental and behavioral health providers. Corrective action plans are implemented for PCPs who do not meet the standards. CareOregon monitors access to behavioral health services by collecting monthly provider reports of timeliness to urgent, emergent and routine services. CareOregon also receives a quarterly report of access to crisis services provided by Jackson County Mental Health. The CCO conducts annual oversight of the dental plan networks to ensure they meet the expectations. The CCO provided information regarding how each dental plan network (DPN) ensures the provision of urgent, emergency, crisis and triage services for dental care 24 hours a day/7 days a week. They discussed utilizing complaint data.
4.	CCO analyzes wait times for appointments with providers, including specialists.	3	**Comments** CareOregon monitors network partners for appointment availability. CareOregon has a Network Adequacy Steering Committee that meets quarterly and works to ensure access across all specialty types and routinely monitors for contracting opportunities. The Quality Assurance department monitors all access complaints and trends are reviewed regularly. Contract language and Provider Manual outline requirements and expectations for primary care providers. An Access Coordinator serves as a point person for assessing and identifying access to specialists for PCPs and is the single point of contact to connect the PCP, specialist and member and ensure efficiency. Access complaints for the CCO were provided for 2016. The CCO conducts annual oversight reviews of its delegated dental plan networks and described how each DPN analyzes wait times. Information and analysis regarding behavioral health wait times was provided.

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** CareOregon has a formal Network Adequacy policy that includes, "The basic methodology and standards are those incorporated in CMS requirements of Medicare Advantage Plans and include calculations of ratios of providers by specialty type to members, tracking of distances from member residences to provider locations and the time of travel from member residence to provider locations." CareOregon reports that provider contracts have telemedicine services as a payable service providing additional access to specialty providers.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	2	**Comments** The CCO outlined the acceptable ratio for Willamette Dental providers to members. The CCO reported the number of PCPs, specialty practitioners OB/GYN, behavioral health providers and traditional health workers compared to members. However, it is not clear if these providers are available within the service area or where they may be located. (Example: The ratio of 4,318 PCPs to 32,015 members seems quite high for the service area). The CCO reported ratios of providers to members for dental care, which were the total number of members divided by the total number of providers. The CCO did not separate pediatric from adult providers when reporting these ratios. The CCO considers the ratios across physical, mental, and dental health to be adequate when evaluated with Network Adequacy reports and Quality Assurance processes and tools which allow them to monitor and ensure appropriate access and availability to needed services for members **Recommendation** For the next submission: • Describe ratios of members to providers for mental health and substance use disorder treatment providers.

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
6a.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO addresses ratios for pediatric, adult, and geriatric providers.	3	**Comments** JCC does not separate pediatric from adult primary care providers or specialty care practitioners. However, they described how members are assigned and additional support provided to ensure appropriate care. Assignment is set at a clinic level, not at an individual provider level. Clinics commonly have multiple PCPs that have the proper scope of service to treat pediatrics, adults and geriatric members. Additional specialties common to a PCP office include but are not limited to: • Family medicine • Internal medicine • Physician assistant • Pediatricians • Geriatric medicine • Osteopaths • Naturopaths Because of this multi-specialty availability to treat members under 18, adults, and members over 65 the ratio of providers to members becomes the majority of the CCOs network. CareOregon does monitor access for all members based on a weekly unassigned report for JCC. If the auto assignment process cannot assign a member to a PCP clinic, the member information is captured on a report that is reviewed weekly. Every unassigned member is reviewed by a provider relations specialist and assigned to appropriate PCP clinic based on age, distance, etc. this report is refreshed weekly.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** CareOregon described the use of health resilience specialists and doulas. Health resilience specialists are embedded within high-volume primary care clinics and based on level of need and as such, some clinics have multiple health resilience specialists. They work with high utilizing members and specifically maintain a low case load, so they can provide individualized care. Health resilience specialists are trained in motivational interviewing and trauma informed

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			care. They are highly trained to ensure that members culturally specific needs are met, and they are connected to appropriate culturally specific serves. JCC utilizes peer-support specialists in collaboration with the mental health teams. One of their contractors, Kairos, uses a team-based approach that includes youth peer support specialists and family support specialists. The wraparound program through Jackson County Mental Health has family support specialists as part of the team. The CCO continues to work with community-based organizations to further support efforts in including traditional health workers in appropriate settings to improve cultural responsiveness, quality and value.
8.	CCO describes how non-emergency transportation is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO is directly responsible and manages the NEMT benefit through a local NEMT brokerage contract on behalf of all physical, behavioral, and dental health plans delegated under the CCO's subcontracts. CareOregon provides authorization reviews as requested by the CCO for specific needs.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The NEMT brokerage is responsible for screening for physical and mental health issues that would prevent an individual who would need specific and alternative modes of transportation as part of their disabilities and/or special needs. As part of that screening process member profiles are created to document the right transport type based on any reported physical and/or behavioral health need. CareOregon provides support through the telephonic care coordination access line to refer and provide information to community resources assisting members to access additional transportation options. If there are no community resources members are provided an access point through their medical providers to request CareOregon

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			assistance in transportation solution options. This is administered through the Health-Related Services policy and procedures. CareOregon considers transportation/access adequate to meet the needs of Members with disabilities or special needs through the Non-Emergent Medical Transportation benefit but not overall transportation access across the service area to fill gaps for other non-medical destinations.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a comprehensive continuum of care for treatment of mental health disorders.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a comprehensive continuum of care for treatment of substance use disorders.
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	3	**Comments** CareOregon has expanded their complimentary alternative medicine provider network in direct response to Guideline Note 56 on the prioritized list (GN56) benefit change in 7/2016. This guideline note is regarding low back pain and conditions of the spine. To address this expanded benefit, the CCO's network was expanded and additional contracts were developed with this specific provider types. In addition, members can utilize non- contracted providers as well.

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			If members are in need of alternative therapies that are not covered by the health plan, the Population Health Department will work with Network and Clinical Services, our network, and medical directors to identify the appropriate alternative therapy and how to get access for that member.
Description of Enrollees – 12.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** CareOregon makes provider assignments through a complex algorithm that considers a variety of factors including continuity of care, family assignments, clinic capacity and location. Members can request or change their PCP assignment. Clinic rosters of assigned members are produced and available to the network to help them manage their panel of patients. Additionally, if a member chooses to see a provider two or more times that is different from the provider to whom they are assigned, CareOregon automatically reassigns that member to the provider they are seeing, ensuring that our assignment system accurately reflects real member engagement. CCO ensures culturally competent services are delivered by a variety of means. CareOregon provides language line services for all members. If a member were to request a specific provider due to cultural or linguistic preference that is identifiable in the provider directory. Member handbooks are also sent out in the member's primary language as it is identified by the state. Additionally, ongoing monitoring of the member complaint process as well as continuing to engage the provider network to identify the needs they have in being able to deliver the services in a culturally competent manner.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** CareOregon care teams use available tools and data to identify members' special heath needs. This team can also reassign the member's PCP to better address their needs.

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			The ENCC team works closely with providers, APD caseworkers, members and community agencies in care planning for members receiving care coordination services. Care plans for members with special health care needs may be reviewed by multi-disciplinary teams and updated, as conditions or circumstances change. Multi-disciplinary teams comprised of CCO ENCC, APD caseworkers, physical health/behavioral health/dental care provider representatives, and members/caregivers are held for long-term care and other members in each CCO. The ENCC Team has a central call line to accept referrals, provide information and offer support to providers, members and family members. ENCC staff members are available for referrals from members/caregivers/members' representatives, providers, other health care professionals, DHS/APD caseworkers, DHS Governor's Advocacy Office or Client Advisory Services Unit, community agency staff and CareOregon work units and coordinate care across health plans and community care services, as appropriate. Health Resilience Specialists coordinate necessary care for high-risk members, working across multiple disciplines and often accompanying members to mental health or dental appointments as needed. The Health Resilience Program employs two staff members who work with CCO members admitted to the Psychiatry Emergency Services at Unity Hospital and an addiction specialist who assists the team with members who need support to connect with inpatient and outpatient treatment programs.

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	3	**Comments** CareOregon has an open specialty network. CareOregon's Exceptional Needs Care Coordination, Regional Care and other care coordination team monitors volume, trends and they have a specialist dashboard on which they can check access. CareOregon offers specific program options for some chronic disease states, like Hepatitis C. They have provider partners who have Hep C programs that offer services to members throughout the entire course of treatment, including counseling, education and training and other services that support the member but may not be a billable service. CareOregon supports services like MAT, and case management for high-risk children based on the needs of the members served.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** CareOregon uses an algorithm including age, geographic location and historical assignment of the family to ensure continuity of care. CareOregon also utilizes the PreManage platform that provides real time data to care teams and PCPs that support members as their health care needs change. For transitions, CareOregon partners with key hospital providers to ensure safe transitions to next care level, providing support and resources as needed. CareOregon is an advocate of the EDIE and PreManage tool that provides real time data to care teams and PCPs that support members through the care moves.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 11.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS.	2	**Comments** The CCO described monitoring grievances and identifying trends. If complaints thresholds are exceeded, the complaints are referred to a Peer Review Committee. The committee can recommend corrective action or intervention by provider relations specialists to help resolve issues. The CCO described a Community Advisory Council where there is opportunity for open

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
	• The CCO needs to describe how it uses the input from its community advisory council.		comments, feedback, needs, ideas, etc. The use of patient experience of care surveys was not described. **Recommendation** For the next submission: • Describe how the CCO incorporates patient experience of care surveys into network adequacy decisions.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO described the use of a wide variety of technology solutions to deliver team-based care and other innovations. PreManage and CareOregon's proprietary Business Intelligence platform provide member level data and identify gaps in care to facilitate team-based care across clinics, hospitals and community partners. CareOregon's provider portal provides 24/7 access to a wide variety of tools for providers to manage patient outreach and work with CareOregon administratively. CareOregon supports telemedicine to give members wider access to quality care and eliminate distance barriers. CareOregon is also piloting an e-consult service that enables PCPs to quickly access clinical experts in over 150 specialties and sub-specialties. CareOregon Mobile App is available for members and promotes health and wellness in a variety of ways.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	3	**Comments** Examples of Intensive Care Coordination services were listed. In addition, the CCO listed multiple programs designed to support members with special healthcare needs to receive follow-up and training in self-care and other interventions that enrollees may take to promote their own health.

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** CareOregon provided the following information, "Interpretation services are provided upon request from members or providers. In addition, our provider directory indicates language competency of providers. In addition, member handbooks can come in other languages, audio or Braille. The provider directory is also searchable by language." In addition, CareOregon requires practitioners to have policies and procedures that prohibit discrimination in the delivery of health care services. Clinics must comply with ADA requirements. CareOregon has created a position of health equity advisor to ensure organization wide focus on cultural competence. This advisor works directly with the executive and board levels as well as staff.
Coordination of Care – 20.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met.
20a.	• Local public health authority	3	**Comments** Fully met.
20b.	• Local mental health authority	3	**Comments** Fully met.
20c.	• IHS and/or Tribal Health Clinics	1	**Comments** The CCO states "there are no Indian Health Service Health Centers in the JCC Service area." CareOregon described a fee-for-service care coordination program they developed in partnership with OHA. However, they did not describe JCC's relationship with Indian Health Care providers.
21.	CCO discusses coordination with above stakeholders.	2	**Comments** The CCO discussed relationships, coordination and agreements with many community organizations. CareOregon described a fee-for-service care coordination program, created in conjunction with the nine federally recognized

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			tribes and NARA NW, however did not describe the CCO relationship with Indian Health Care Providers. **Recommendation** For the next submission: • Describe the relationship and coordination with Indian Health Care Providers.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	3	**Comments** The CCO described its Exceptional Needs Care Coordination (ENCC) "Collaboration and Coordination of Care Between Behavioral Health, Medical, Dental and Other Providers" policy, as well as many tasks coordinated by the ENCC team. CareOregon utilizes PreManage/ EDIE to monitor members currently receiving ENCC services and determine when they are experiencing a transition. In addition to the ENCC team, two health resilience specialists are embedded in two major clinic systems in Columbia County. The health resilience specialist and ENCC team work together to coordinate care for members.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	2	**Comments** The CCO described various methods to identify members with special healthcare needs. Health Risk Screenings are conducted beginning at referral for ENCC services, through an Intake and Clinician Assessment documentation process for any Medicare and OHP/CCO member with special health care needs, who is engaged in Care Coordination services. Health Risk Assessments are conducted for Medicare members. The ENCC Intensive Care Coordination Policy language was provided which included various ways in which those with special healthcare needs are identified. However, no documentation was provided regarding the CCO's process for assessing all enrollees for special healthcare needs. **Recommendation** For the next submission: • Describe the CCO's process for assessing all enrollees for special healthcare needs.

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	3	**Comments** CareOregon described how they coordinate healthcare for all enrollees across the continuum of care. They recently implemented a process to link PCPs with dental plans.
Performance on Metrics – 6.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	3	**Comments** CareOregon recruited and contracted with primary care clinics to expand PCPCH thresholds and access. The also recruited and contracted with clinics participating in the Vaccine For Children program. CareOregon facilitates community efforts n metrics performance by bringing groups of providers together to share workflows and metrics strategies with each other using an IHI-style collaborative learning process. CareOregon described creating capacity in the network to focus on CCO metrics where performance is low by aligning financial incentives. Their alternative payment models reward clinics for meeting quality measure benchmarks. In addition, clinics must be a recognized PCPCH to be eligible for participation. Metrics the CCO performs poorly on are prioritized for inclusion in the APM program. In addition, a portion of the quality pool metric received by the CCO is repaid to the network based on the organization's contribution to the CCO's success. These financial incentives are used to align network priorities with the CCO priorities. Additional resources including collaboratives and 1:1 technical assistance is used as a tool to improve clinical workflows and processes. Many network partners are also eligible for an embedded, CareOregon funded, panel coordinator. Panel Coordinators conduct outreach and in reach to CCO members to help improve engagement in primary care and close clinical gaps. Panel coordinators focus their attentional on priority measures where the CCO may have lower performance.

Table 9. Jackson Care Connect Results.			
Indicator		**Score**	**Review Comments/Recommendations**
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	3	**Comments** CareOregon outlined efforts to identify overutilization via payment integrity and efforts. They further described contracting opportunities and payment methodologies to pay for services that may be underutilized. JCC described conducting four provider post payment reviews each month for behavioral health providers based on utilization trends. They look for above average utilization, issue corrective action plans and recoupment of payments made for any services that were not medically necessary or documented as such. The CCO has hired a national consultant to provide network training on establishing medical necessity and clinically appropriate treatment plans to address patterns or trends of concern.

PACIFICSOURCE CENTRAL OREGON

PacificSource Community Solutions administers two CCOs: Central Oregon (PSCS-CO) and Columbia Gorge (PSCS-CG). PSCS-CO contracts with OHA to provide physical, behavioral and dental health services to OHP enrollees in Crook, Deschutes, Jefferson and Klamath counties. As of October 2017, PSCS-CO served 46,832 enrollees.

Summary

PSCS-CO submitted comprehensive provider narrative and comprehensive provider capacity reports. The CCO described how it maintains and monitors its network to provide all covered services, taking into account time and distance, need for specialists and high-volume behavioral health specialists. The CCO analyzed and reported expected provider-to-member ratios for multiple provider types. The CCO described the needs of their enrollees and coordination of care for members with special health care needs.

PSCS-CO described its commitment to culturally and linguistically appropriate services through a variety of efforts. The CCO has promoted increased engagement in Spanish-language and American Indian/Alaska Native diabetes self-management programs and is working to have provider clinics report clinical quality data by race/ethnicity.

The CCO described how traditional health workers are incorporated into the delivery network.

See Table 10 for complete results and recommendations for the next submission.

Table 10. PacificSource Central Oregon.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 38.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	2	**Comments** The CCO submitted a comprehensive policy that described their time and distance standards for primary care, high impact specialists, high volume specialists (OBGYN, oncology, etc.), and high volume behavioral health specialists. Dental geographic distribution was not addressed. **Recommendation** For the next submission: • Address dental geographic distribution.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** The CCO utilizes policies, provider surveys, reporting, tracking, analysis, and evaluation of geographic distribution of PCPs and high-volume specialists and behavioral health providers using Quest Analytics Suite.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** Contract standards and language in provider manual require subcontractors to comply with OHA access standards. Provider workshops are held multiple times each year to offer training opportunities for all types of providers to stay up to date on policies and requirements. Provider newsletters are sent out multiple times per year. The dental plans oversee compliance with access standards through reporting, tracking, corrective action plans, and utilization of grievance and appeals information. PacificSource's contracts with CMHPs contain performance measures related to access and member engagement. The CCO sends out quarterly access surveys to participating providers to determine compliance with contract requirements. The CCO analyzes changes in utilization, performance, access to out-of-network providers, and grievances related to access to determine network adequacy.

Table 10. PacificSource Central Oregon.			
Indicator		**Score**	**Review Comments/Recommendations**
4.	CCO analyzes wait times for appointments with providers, including specialists.	3	**Comments** Wait times for primary care providers, behavioral health providers and availability of timely access is monitored at the clinic level. Quarterly access surveys are sent to physical, behavioral and oral health providers to determine if contract access requirements are being met. The dental plan networks are required to send monthly appointment availability reports.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** The CCO addressed and analyzed specialty care accessibility and included opportunities for improvement.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** Expected ratios are explained in policy and results were analyzed and reported.
6a.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO addresses ratios for pediatric, adult, and geriatric providers.	3	**Comments** Expected ratios are explained in policy and results were analyzed and reported.

Table 10. PacificSource Central Oregon.			
Indicator		**Score**	**Review Comments/Recommendations**
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** The CCO provided a comprehensive description of the traditional health workers, how they are incorporated into their CCO and their analysis of the adequacy of these providers.
8.	CCO describes how non-emergency transportation (NEMT) is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO monitors the NEMT benefit and how it pertains to access to services through frequent interaction with their service provider. Evaluation of capacity denials, grievances and ad-hoc inquiries. An annual audit of the NEMT provider occurs, which reviews the contract for compliance.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO contracts with the Central Oregon Intergovernmental Council (COIC) to provide NEMT services. During an intake screening process, conducted by COIC, the needs of the member are discussed and the appropriate mode of transportation is scheduled. This is also confirmed with every ride scheduled for recurring riders. The PacificSource Care Management team also assesses members using a Care Management assessment form to determine if there are special transportation needs for the members. PacificSource also has a unique role in coordinating challenging out-of-area transportation needs, by coordinating with the providers, nurse case managers, COIC, out-of-area providers, and the OHA. This team partners with COIC to ensure these needs are met. The CCO reviews network adequacy information monthly to ensure the transportation network is adequate. The CCO requires, through contracts, that providers' offices meet ADA accessibility requirements. ADA accessibility is assessed during site visits by PacificSource provider service

Table 10. PacificSource Central Oregon.			
Indicator		**Score**	**Review Comments/Recommendations**
			representatives. Quarterly provider demographics survey, which includes ADA and accessibility questions are sent out. Providers offices that are found to have deficient access are referred to the credentialing team for follow up. Follow up includes, but is not limited to, reviewing exceptions and addressing questions or concerns received from the provider offices/clinics. In addition to tracking provider responses, grievances are continually monitored to determine if there are any member complaints related to access. If there are access issues related to the quality of access to the offices/clinics, those will be addressed with the PacificSource Quality department. PacificSource considers this adequate for ensuring that members have access to the appropriate services and locations.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a comprehensive continuum of mental health services, including monitoring efforts to ensure an adequate provider panel. The CCO described how they have identified and recruited for specific behavioral health specialty providers to meet the needs of their members.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a comprehensive continuum of substance use disorder services, including monitoring efforts to ensure an adequate provider panel. Medication assisted treatment and adult residential SUD treatment with programming in Spanish are among the services provided.

Table 10. PacificSource Central Oregon.			
Indicator		**Score**	**Review Comments/Recommendations**
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	3	**Comments** The CCO contracts directly with providers of alternative and complementary medicine, including providers of acupuncture, chiropractic, massage, PT/OT. They monitor these services through grievances and appeals, as well as provider requests via members.
Description of Enrollees – 12.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** The CCO described an auto-assignment formula that generates member assignments, which includes language preference among other factors. The CCO is developing a suite of reports that will be regularly delivered to providers that include information on member language, race/ethnicity, special healthcare needs, risk factors or ICCS status. The CCO works with providers to ensure they are developing capacities to provide culturally and linguistically appropriate care and meeting the special healthcare needs of their members. The CCO ensures members are assigned to PCPs who are well suited to meet their needs - and members can quickly and easily change their assignment.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** The case management department works directly with members with special health care needs to facilitate access and availability of services.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	3	**Comments** The CCO described high impact and high-volume specialists to treat specific enrollee needs.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** The case management department works directly with members facilitate access and availability of services.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 12.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network	3	**Comments**

Table 10. PacificSource Central Oregon.			
Indicator		**Score**	**Review Comments/Recommendations**
	adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.		CAHPS scores and complaints are key indicators for the OHA Access to Care work group that is working to identify opportunities to improve members ability to access care without barriers. PacificSource is represented on this workgroup. Member complaint trends are collected and reported quarterly. Trends related to network adequacy are reviewed and additional providers are added when possible. The CCO reviews MHSIP, YSS and YSS-F survey results internally and with community partners. CAHPS information is shared annually with the CAC and their personal experiences help inform CCO action plans.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO described its use of a variety of technology solutions to assist with UM decision-making, assignment to teams, entering service requests, on-line messaging for communications, as well as extensive use of EDIE and PreManage throughout the continuum of providers in their network. Several of the CCO providers have also adopted routine sharing of patient information through use of the Reliance Health Information Exchange, improving communication and transparency between providers. Additionally, the CCO worked closely with the local hospital system as it on boarded a new EHR system, Epic, to ensure other key non-Epic community providers, such as Community Mental Health Providers (CMHPs) were granted access to Epic CareLink, to ensure continuity of care and cross-organizational team-based collaboration is done electronically.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	3	**Comments** The CCO is promoting increased engagement in Spanish-language and American Indian/Alaska Native diabetes self-management programs and working to have provider clinics report clinical quality data by race/ethnicity.

Table 10. PacificSource Central Oregon.			
Indicator		**Score**	**Review Comments/Recommendations**
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** Bilingual customer service representatives handle incoming calls from members with Spanish as their primary language. Immediate access to telephonic translation and technology services is available. The Community Advisory Councils review and improve member-facing materials. The CCO is working to identify health and health care disparities with a focus on Latino and Native American/Alaska Indian populations. They are developing culturally and linguistically appropriate Grievance and Appeals process. The CCO actively engages providers to train them on how to bill for interpreter services and the CCO monitors the rates of services provided. Workforce development efforts with increased diversity is an objective of the CCO. A provider survey to monitor capacity and promote progress toward CLAS has been implemented.
Coordination of Care – 24.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	3	**Comments** PacificSource has reached out to the Warm Springs Health and Wellness Center. A service agreement has not yet been signed. The CCO coordinates services for American Indian/Alaska Native members without preauthorization and are permitted to directly

Table 10. PacificSource Central Oregon.			
Indicator		**Score**	**Review Comments/Recommendations**
			refer their patients to specialists in the CCO network.
21.	CCO discusses coordination with above stakeholders.	3	**Comments** The CCO described the relationship with the above stakeholders.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	3	**Comments** The CCO described how its case management department works with members with special health care needs to facilitate access to services. There are integrated care management meetings for this population, and integrated physical health and behavioral health services in several settings. The dental plans work with the PacificSource case management team around care coordination needs. The CCO utilizes PreManage/EDIE to help its continuum of care (including dental) identify trends that could signal opportunities to improve access.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	3	**Comments** The CCO described processes for identifying and assessing enrollees for special health care needs, including developing a comprehensive stratification of its membership with the intention of delivering information to providers in order to facilitate the efficient delivery of care to enrollees.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	3	**Comments** PacificSource staff support providers to develop workflows to use EDIE, obtained through the PreManage platform, to coordinate care for members with concerning utilization of ED and hospital inpatient services. Internally, electronic systems are utilized to integrate data from multiple sources including claims, chart reviews, pharmacy benefits manager, and proprietary vendor databases. This information is used for reporting and to

Table 10. PacificSource Central Oregon.			
Indicator		**Score**	**Review Comments/Recommendations**
			inform care coordination, communication with members about needed preventive care services, outreach to providers about members with care management or preventive service needs, oversight of ED utilization, and tracking of clinical quality measures. It is also used for prior authorization and inpatient utilization reviews and interacts with the claims system for correct claims payment. Utilization management staff access health care providers' electronic records systems remotely as well.
Performance on Metrics – 5.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	2	**Comments** The Central Oregon Independent Provider Association (which includes many practices in the Gorge CCO service area, too) has developed a matrix in order to encourage metric performance and growth. This matrix applies to specialty and primary care. PacificSource evaluates providers that are below baseline performance metrics to understand if their performance is related to capacity and/or lack of access. PacificSource has established the Access to Care Team as a formalized cross-functional group that reviews and support the execution of initiatives that support providers working to improve access to care and performance on metrics. The CCO reports strong performance on the Quality Incentive Measures but did not describe specific performance metrics. The CCO described evaluating the Provider Accessibility Report to analyze provider data against performance metrics. In addition, they use a variety of internal quality improvement processes and strategies to support achievement of goals and metrics. **Recommendation** For the next submission:

Table 10. PacificSource Central Oregon.			
Indicator		**Score**	**Review Comments/Recommendations**
			• Describe the CCO efforts to build network capacity for specific metrics where the CCO's performance is below the baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	3	**Comments** The CCO described a comprehensive process of analyzing underutilization and overutilization and provided examples of actions taken to address areas of concern.

PACIFICSOURCE COLUMBIA GORGE

PacificSource Community Solutions administers two CCOs: Central Oregon (PSCS-CO) and Columbia Gorge (PSCS-CG). PSCS-CG contracts with OHA to provide physical, behavioral and dental health services to OHP enrollees in Hood River and Wasco counties. As of October 2017, PSCS-CG served 11,736 enrollees.

Summary

PSCS-CG submitted comprehensive provider narrative and provider capacity reports. The CCO described how it maintains and monitors its network to provide all covered services, taking into account time and distance, need for specialists and high-volume behavioral health specialists. The CCO analyzed and reported expected provider to member ratios for multiple provider types. The CCO described the needs of their enrollees and coordination of care for members with special health care needs.

PSCS-CG described its commitment to culturally and linguistically appropriate services through a variety of efforts. The CCO has promoted increased engagement in Spanish-language and American Indian/Alaska Native diabetes self-management programs and is working to have provider clinics report clinical quality data by race/ethnicity.

The CCO described how traditional health workers are incorporated into the delivery network.

See Table 11 for complete results and recommendations for the next submission.

Table 11. PacificSource – Columbia Gorge Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy 38.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	2	**Comments** The CCO submitted a comprehensive policy that described their time and distance standards for primary care, high impact specialists, high volume specialists (OBGYN, oncology, etc.), and high-volume behavioral health specialists. Dental geographic distribution was not addressed. **Recommendation** For the next submission: • Address dental geographic distribution.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** The CCO utilizes policies, provider surveys, reporting, tracking, analysis, and evaluation of geographic distribution of PCPs and high-volume specialists and behavioral health providers using Quest Analytics Suite.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** Contract standards and language in the CCO's provider manual require subcontractors to comply with OHA access standards. Provider workshops are held multiple time each year to offer training opportunities for all types of providers to stay up to date on policies and requirements. Provider newsletters are sent out multiple times per year. The dental plans oversee compliance with access standards through reporting, tracking, corrective action plans and utilization of grievance and appeals information. PacificSource's contracts with CMHPs contain performance measures related to access and member engagement. The CCO sends out quarterly access surveys to participating providers to determine compliance with contract requirements. The CCO analyzes changes in utilization, performance, access to out-of-network providers, and grievances related to access to determine network adequacy.

Table 11. PacificSource – Columbia Gorge Results.			
Indicator		**Score**	**Review Comments/Recommendations**
4.	CCO analyzes wait times for appointments with providers, including specialists.	3	**Comments** Wait times for primary care providers, behavioral health providers and availability of timely access is monitored at the clinic level. Quarterly access surveys are sent to physical, behavioral and oral health providers to determine if contract access requirements are being met. The dental plan networks are required to send monthly appointment availability reports.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** The CCO addressed and analyzed specialty care accessibility and included opportunities for improvement.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** Expected ratios are explained in policy and results were analyzed and reported.
6a.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO addresses ratios for pediatric, adult, and geriatric providers.	3	**Comments** Expected ratios are explained in policy and results were analyzed and reported.

Table 11. PacificSource – Columbia Gorge Results.			
Indicator		**Score**	**Review Comments/Recommendations**
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** The CCO provided a comprehensive description of the traditional health workers, how they are incorporated into their CCO and their analysis of the adequacy of these providers.
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO monitors the NEMT benefit and how it pertains to access to services through frequent interaction with their service provider. Evaluation of capacity denials, grievances and ad-hoc inquiries. An annual audit of the NEMT provider occurs, which reviews the contract for compliance.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO contracts with Mid-Columbia Council of Governments (MCCOG) for NEMT services. During an intake screening process, MCCOG ensures the needs of the member are discussed and the appropriate mode of transportation is scheduled. With every ride scheduled, MCCOG confirms the members needs to ensure the mode of transportation is adequate. The CCO reviews network adequacy information monthly to ensure the transportation network is adequate. PacificSource requires, through contracts, that providers' offices meet ADA accessibility requirements. ADA accessibility is assessed during site visits by PacificSource Provider Service Representatives. PacificSource also sends out a quarterly provider demographics survey, which includes ADA and accessibility questions. Providers offices that are found to have deficient access are referred to the Credentialing team for follow up. Follow up includes, but is not limited to, reviewing exceptions and addressing questions or concerns received from the provider offices/clinics. In addition to tracking provider responses, grievances are continually monitored to determine if there are any member complaints related to access. If there are access issues related to the quality of access to the offices/clinics, those will be

Table 11. PacificSource – Columbia Gorge Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			addressed with the PacificSource quality department. PacificSource considers this adequate for ensuring that members have access to the appropriate services and locations.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a comprehensive continuum of mental health services, including monitoring efforts to ensure an adequate provider panel. The CCO described how they have identified and recruited for specific behavioral health specialty providers to meet the needs of their members.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a comprehensive continuum of substance use disorder services, including monitoring efforts to ensure an adequate provider panel. The medication-assisted treatment is among the services provided.
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	3	**Comments** The CCO contracts directly with providers of alternative and complementary medicine, including providers of acupuncture, chiropractic, massage, PT/OT. They monitor these services through grievances and appeals, as well as provider requests via members. Pre-service requests for these services have steadily increased during this review period.
Description of Enrollees – 12.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** The CCO described an auto-assignment formula that generates member assignments, which includes language preference among other factors. The CCO is developing a suite of reports that will be regularly delivered to providers that include information on member language, race/ethnicity, special healthcare needs, risk factors or ICCS

Table 11. PacificSource – Columbia Gorge Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			status. The CCO works with providers to ensure they are developing capacities to provide culturally and linguistically appropriate care and meeting the special healthcare needs of their members. The CCO ensures members are assigned to PCPs who are well suited to meet their needs - and members can quickly and easily change their assignment.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** The case management department works directly with members with special health care needs to facilitate access and availability of services.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	3	**Comments** The CCO described high impact and high-volume specialists to treat specific enrollee needs.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** The case management department works directly with members facilitate access and availability of services.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 12.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	3	**Comments** CAHPS scores and complaints are key indicators for the OHA Access to Care work group that is working to identify opportunities to improve members ability to access care without barriers PacificSource is represented on this workgroup. Member complaint trends are collected and reported quarterly. Trends related to network adequacy are reviewed and additional providers are added when possible. The CCO reviews MHSIP, YSS and YSS-F survey results internally and with community partners. CAHPS information is shared annually with the CAC and their personal experiences help inform CCO action plans.

Table 11. PacificSource – Columbia Gorge Results.			
Indicator		**Score**	**Review Comments/Recommendations**
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO described its use of a variety of technology solutions to assist with UM decision-making, assignment to teams, entering service requests, online messaging for communications, as well as extensive use of EDIE and PreManage throughout the continuum of providers in their network. Several of the CCO providers have also adopted routine sharing of patient information through use of the Reliance Health Information Exchange, improving communication and transparency between providers. Member Insight reports are sent electronically to providers, identifying priority populations and complex members.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	3	**Comments** The CCO is promoting increased engagement in Spanish-language and American Indian/Alaska Native diabetes self-management programs and working to have provider clinics report clinical quality data by race/ethnicity.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** Bilingual customer service representatives handle incoming calls from members with Spanish as their primary language. Immediate access to telephonic translation and technology services is available. The Community Advisory Councils review and improve member-facing materials. The CCO is working to identify health and health care disparities with a focus on Latino and Native American/Alaska Indian populations. They are developing culturally and linguistically appropriate grievance and appeals process. The CCO actively engages providers to train them on how to bill for interpreter services and the CCO monitors the rates of services provided. Workforce development efforts with increased diversity is an objective of the CCO. A provider survey to monitor capacity and promote progress toward CLAS has been implemented.

Table 11. PacificSource – Columbia Gorge Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Coordination of Care – 24.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	3	**Comments** Fully met
21.	CCO discusses coordination with above stakeholders.	3	**Comments** The CCO described the relationship with the above stakeholders.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	3	**Comments** The CCO described how its case management department works with members with special health care needs to facilitate access to services. There are integrated care management meetings for this population, and integrated physical health and behavioral health services in several settings. The dental plans work with PacificSource's case management team around care coordination needs. The CCO utilizes PreManage/EDIE to help its continuum of care (including dental) identify trends that could signal opportunities to improve access.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	3	**Comments** The CCO described processes for identifying and assessing enrollees for special health care needs, including developing a comprehensive stratification of its membership with the intention of delivering information to providers in order to facilitate the efficient delivery of care to enrollees.

Table 11. PacificSource – Columbia Gorge Results.			
Indicator		**Score**	**Review Comments/Recommendations**
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	3	**Comments** PacificSource has fully funded implementation of Reliance Health Information Exchange to allow data sharing and identification of care needs for community members across health care and social service providers. The CCO has supported health care providers to develop workflows to use EDIE, obtained through the PreManage platform, to coordinate care for members with concerning utilization of Emergency Department and hospital inpatient services. PacificSource's electronic systems are utilized to integrate data from multiple sources including claims, chart reviews, our pharmacy benefits manager, and proprietary vendor databases. This information is used for reporting and to inform care coordination, communication with members about needed preventive care services, outreach to providers about members with care management or preventive services needs, oversight of ED utilization, and tracking of clinical quality measures. It is also used for prior authorization and inpatient utilization reviews and interacts with the claims system for correct claims payment. For concurrent review of inpatient stays and information collection for pre-service requests, utilization management staff also access health care providers' electronic records systems remotely. Electronic systems are utilized for reporting and to inform internal care management referral, ED utilization oversight processes and quality incentive measure and clinical measure tracking. PacificSource staff retrieves data directly from provider electronic records systems.

Table 11. PacificSource – Columbia Gorge Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Performance on Metrics – 5.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	2	**Comments** The Central Oregon Independent Provider Association (which also includes many practices in the Gorge CCO service area) has developed a matrix in order to encourage metric performance and growth. This matrix applies to specialty and primary care. PacificSource evaluates providers that are below baseline performance metrics to understand if their performance is related to capacity and/or lack of access. PacificSource has established the Access to Care Team as a formalized cross-functional group that reviews and support the execution of initiatives that support providers working to improve access to care and performance on metrics. The CCO reports strong performance on the quality incentive measures but did not describe specific performance metrics. They use a variety of internal quality improvement processes and strategies to support achievement of goals and metrics. **Recommendation** For the next submission: • Describe the CCO efforts to build network capacity for specific metrics where the CCO's performance is below the baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	3	**Comments** The CCO described a comprehensive process of analyzing underutilization and overutilization and provided examples of actions taken to address areas of concern.

PRIMARYHEALTH

PrimaryHealth, owned by Oregon Health Management Services (OHMS), contracts with OHA as a CCO to provide physical, behavioral and dental health services for OHP members in Josephine County. As of October 2017, PrimaryHealth had 9,997 enrollees.

Summary

PrimaryHealth submitted the provider narrative report and provider capacity report. The CCO provided a comprehensive analysis of access and described how they ensure the provision of appropriate urgent, emergency, crisis, and triage services for all members. The CCO described utilizing community health workers and peer wellness specialists to provide community-based case management to high risk and "super-utilizer" members with high patterns of potentially avoidable health plan utilization.

Information was not provided describing procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.

Little information was provided describing the use of technology and electronic health records to support team-based care and coordination. The CCO did describe reviewing emergency room claims to identify areas where poor access to routine care may be identified and improved.

See Table 12 for complete results and recommendations for the next submission.

Table 12. PrimaryHealth Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 32.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	3	**Comments** Ninety percent of PrimaryHealth providers are located in Josephine and Jackson Counties, providing Member access to primary care at a variety of locations within a routine travel time that is within the community standard of care. The CCO described geographic distribution of all participating providers. Their network includes providers in Jackson County as well.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** The CCO described where providers and members are located and the time/distance between.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** Providers are informed of access requirements through contracts, provider handbooks and ongoing educational provider outreach activities. Periodically a formal survey of PCP access is conducted. Any outliers are reported to the QCC. Reports and information related to access are monitored through the grievance system and CAHPS surveys.
4.	CCO analyzes wait times for appointments with providers, including specialists.	2	**Comments** The CCO informs providers of requirements in a multitude of ways mentioned above. No specific examples were given of analyzed wait times. **Recommendation** For the next submission: • Analyze wait times for appointments with providers, including specialist.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** The CCO described the service area as relatively small and able to ensure time and distance standards for PCPs. The CCO contracts for out-of-network services such as organ transplants, that are not available in the local service area. PrimaryHealth described time/distance to specialists for its members who live in more

Table 12. PrimaryHealth Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			remote areas of the CCO. The CCO discussed the use of telemedicine for mental health assessments and psychiatry services.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	**Comments** The CCO does not establish specific patient to provider ratios. However, the CCO monitors the number of outpatient visits per 1,000 member months which may demonstrate the need for additional practitioners. PrimaryHealth monitors provider access based on CAHPS survey results, member feedback, wait times and grievances. **Recommendation** For the next submission: • Describe expected ratios of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds and whether these are adequate. Include ratios for pediatric, adult, and geriatric providers.
6a.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO addresses ratios for pediatric, adult, and geriatric providers.	1	**Comments** Specific ratios were not described. **Recommendation** For the next submission: • See above.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	The CCO utilizes Community Health Workers and Peer Wellness Specialists to provide community-based case management to high-risk and "super-utilizer" members with high patterns of potentially avoidable health plan utilization. Options employs several peer specialists to participate in the delivery of mental health care.

Table 12. PrimaryHealth Results.			
Indicator		**Score**	**Review Comments/Recommendations**
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** TransLink and provides transportation services throughout Josephine County. PrimaryHealth helps coordinate rides for Members who need medical services in Jackson County. Bus transport is also available within Josephine county. PrimaryHealth considers their transportation system adequate to meet member needs.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	2	**Comments** PrimaryHealth stated that many types of transportation are available to meet the special needs of disabled members, including wheelchair and gurney transportation. Access to provider offices for enrollees with disabilities or special needs was not specifically addressed. **Recommendation** For the next submission: • Analyze and describe transportation and access for enrollees with disabilities or special needs and whether the CCO considers this adequate.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	2	**Comments** PrimaryHealth described a continuum of mental health services. However, residential services were not described. The CCO considers the continuum of mental health services to be adequate. **Recommendation** For the next submission: • Include a description of child, adolescent and adult residential services as part of the continuum of mental health services.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a continuum of care for treatment of substance use disorders which they assess as adequate.

Table 12. PrimaryHealth Results.			
Indicator		**Score**	**Review Comments/Recommendations**
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	3	**Comments** PrimaryHealth described a network of alternative therapies available to their members. They continue to recruit providers to meet the needs.
Description of Enrollees – 11.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** The CCO provides many PCP options for Spanish-speaking members. PCPs are chosen by members whenever possible. If a member cannot be reached, assignment is based on location, age, and language accessibility.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** The CCO provided a description of members with challenges and special health care needs, including how these members are identified, assessed and the spectrum of case management services available.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	3	**Comments** PrimaryHealth described how they identify areas of disease burden among members and the community.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	2	**Comments** The CCO described the use of community health workers in serving as a bridge between the community and the system of health and social services. They described coordination with multiple community organizations and exceptional needs care coordination and Intensive care coordination services to support, coordination, and case management for members with complex needs. **Recommendation** For the next submission: • Describe how enrollee needs for transition between levels of care is assessed.

Table 12. PrimaryHealth Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 7.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	2	**Comments** Members provide input into network adequacy decisions through access surveys (such as CAHPS) and grievance reports. The CCO's Quality and Compliance Committee and Clinical Advisory Panel review access surveys and grievances information. Case Management Department and Community Health Workers provide additional information to the QCC on areas of concern related to access and grievances. **Recommendation** For the next submission: • Describe how input from the community advisory council is incorporated when addressing network adequacy.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** PrimaryHealth described how they use technology to coordinate care, prevention efforts, referrals, eligibility, assignment, and monitor special needs populations. Review of emergency room records occurs in order to identify possible access concerns.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Describe procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.

Table 12. PrimaryHealth Results.			
Indicator		**Score**	**Review Comments/Recommendations**
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	2	**Comments** The CCO's PCP panel provides several options for Spanish-speaking members. Telephonic services and, if possible, in-person translators are available. The CCO provides staff with annual training on cultural competency and sensitivity. The CCO is working to address areas of opportunity noted in their 2013–2015 Cultural Competency Assessment. The CCO promotes the provision of trauma-informed care and several clinics offer trauma-informed care models. **Recommendation** For the next submission: • Describe how leadership demonstrates, and the provider network is oriented to, the CCO's commitment to culturally and linguistically appropriate services. Describe the areas of opportunity noted in the 2013–3015 Cultural Competency Assessment.
Coordination of Care – 20.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** OPTIONS for Southern Oregon is the mental health provider for PrimaryHealth and serves as the local mental health authority in Josephine County. Fully met.

Table 12. PrimaryHealth Results.			
Indicator		**Score**	**Review Comments/Recommendations**
20c.	• IHS and/or Tribal Health Clinics	1	**Comments** The CCO states there are no Indian Health/Tribal Health clinics in their service area and so they have no contracts for these services. If members wish to receive services in these settings, they may do so without prior authorization. **Recommendation** For the next submission: • Describe relationships with Indian Health Care Providers.
21.	CCO discusses coordination with above stakeholders.	3	**Comments** The CCO discussed coordination with the above providers and the support for members receiving services at Indian Health Services or Tribal Health clinics through no need for prior authorization.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	3	**Comments** The CCO described the use of community health workers in serving as a bridge between the community and the system of health and social services. The CCO described the use of community health workers in serving as a bridge between the community and the system of health and social services. In addition, the CCO described the use of exceptional needs care coordination and intensive care coordination services to provide support, coordination and case management for members with complex needs.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	2	**Comments** PrimaryHealth identifies members with special healthcare needs via rate group. These member populations receive a Health Risk Assessment survey. **Recommendation** For the next submission: • In addition to identifying members with special health care needs using rate groups, describe how these members, as defined in the contract with OHA, are identified when there is no rate group.

Table 12. PrimaryHealth Results.			
Indicator		**Score**	**Review Comments/Recommendations**
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	2	**Comments** PrimaryHealth described how providers are connected, care is coordinated, referrals are made, eligibility is monitored, and assignments are made, using technology. **Recommendation** For the next submission: • Elaborate on how the CCO uses electronic health records to coordinate health care, including preventive health care, for all enrollees across the continuum of care - including behavioral health and dental services.
Performance on Metrics – 3.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Describe the CCO's efforts to build network capacity for those metrics where the CCO's performance is below the baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	3	**Comments** PrimaryHealth staff review emergency room claims for any indication that the ER visit is related to poor access to routine care. Follow up occurs if this is the case. ER utilization rates are monitored for each clinic. The CCO is currently working to improve utilization of preventive services in the Cave Junction area. The QCC reviews data for each clinic based on the number of outpatient visits/1000 mm and the % of patients assigned that have been seen in the last year. The Clinical Advisory Panel and QCC review quality measures related to both under and overutilization of services and acts on any concerns or gaps.

TRILLIUM COMMUNITY HEALTH PLAN

Trillium Community Health Plan (TCHP) contracts with OHA to provide physical, behavioral and dental health services for OHP members in Lane County and portions of other counties. As of October 2017, the CCO had a total of 89,370 enrollees.

Summary

TCHP submitted a provider narrative report and a provider capacity report that described the CCO's efforts to maintain adequate network capacity. TCHP provided analysis of access to care and how they ensure appropriate urgent, emergency, crisis and triage services for their members. The CCO described a comprehensive continuum of treatment for behavioral health disorders. The CCO works closely with the NEMT provider to review trends in utilization and ensure appropriate transportation based on individual need.

The CCO provided a comprehensive description of how they incorporate member feedback into network adequacy decisions.

TCHP described procedures to ensure that members with special health care needs receive follow-up and training on self-care and other interventions that members may take to promote their own health. However, they provided little information regarding how they identify and assess all enrollees for special health care needs.

The CCO discussed the analysis of oral health data by their clinical advisory panel.

The CCO addressed most categories of service and required data elements in the provider capacity report, including mental health crisis services.

See Table 13 for complete results and recommendations for the next submission.

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 35.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	3	**Comments** The CCO described the geographic distribution of providers compared to the geographic distribution of enrollees and provided geo-mapping as well as an analysis of how enrollees can access services. The CCO discussed contracting with essentially all available specialists within the service area and obtaining specialty services out of the area as well. Trillium reviews the distribution of providers in Lane County and assures that services are available in Eugene and Springfield as well as in rural communities.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** The CCO runs quarterly network adequacy reports and more often as needed if there is a threat to member access to care. Trillium will contract with providers accepting new members to ensure time and distance standards are met. Time and distance criteria are also discussed at quarterly Quality Improvement Committee meetings where geo-network adequacy reports are shared. The CCO offers behavioral health providers a semi-rural rate enhancement of 10% and a rural rate enhancement of 20%. Members are assigned to dental plans based on the member's proximity to office locations.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** The CCO contractually requires providers to meet OAR-defined timelines for services. Behavioral health providers are monitored at least annually to ensure these timelines are met. Care coordinators often make emergent and urgent referrals, and they are able to refer to an alternate provider if the current one is unable to meet the timeline. The CCO monitors access through a secret shopper program. Inadequate results from the secret shopper program may result in a site

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			visit with additional inquiry and subsequent training. Investigation of a provider occurs when more than three complaints around access.
4.	CCO analyzes wait times for appointments with providers, including specialists.	3	**Comments** Annually, the CCO monitors primary care, specialty care and behavioral health providers' wait times against its standards and initiates actions as needed to improve. Trillium's analytics department runs reports for behavioral health, including "time period between assessment and first follow-up appointment." Dental Plan Networks are required to meet OAR defined timelines for routine oral health services. Member access issues with providers are routinely monitored through grievances by the DPNs. The CCO described how the four contracted dental plan networks (DPNs) monitor wait times.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** The CCO described how they identify and address service gaps as they work to ensure time and distance standards for member access to specialists. Telepsychiatry is utilized by the CCO to ensure access. The CCO covers telemedicine services as a covered benefit. Trillium contracts with over 30 different organizational providers and more than 80 licensed clinicians for behavioral health services. If the CCO identifies an access issue, they survey their behavioral health providers and develop a list of those that offer specialty services. Trillium works with a provider to manage an Access database of behavioral health contractors. This ensures provider capacity to meet demand. Agencies that have openings can let other providers know so appropriate referrals can be made. The CCO also uses, “surge planning” for times when demand exceeds capacity for a specific service. During these periods, each provider increases the number of new members they serve to meet demand. Trillium contracts with

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			essentially all available specialists within the service are and has arrangements with out-of-area specialists when required.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** Trillium outlined acceptable ratios of members to providers and reported results for primary care, specialists, dental care providers, mental health practitioners, substance use disorder treatment providers, and availability of acute care beds. Of providers reported, the CCO finds these ratios to be adequate.
6a.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO addresses ratios for pediatric, adult, and geriatric providers.	3	**Comments** The CCO addressed ratios for members to pediatricians. The CCO also described the number of adult/geriatric PCPs per member. Pediatric and adult provider to member ratios were also listed for mental health, substance use disorder treatment and dental care.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** Trillium employs community health workers that are trained by Trillium's medical management department and they are assigned to members. The community health workers are supervised by the care coordination supervisor in the medical management department. The CCO described the use of traditional health care workers or "Member Connection Representatives" in a variety of ways to help increase member engagement. They further discussed ratios of these providers to members.

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO states that adequate access exists in all modes of NEMT, including out-of-area transportation. The CCO and NEMT provider have convened a workgroup to look at trends in utilization and appropriate transportation based on individual need.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	2	**Comments** Trillium contractually requires their NEMT provider to comply with applicable OARs and to provide all equipment and staff necessary for adequate operation of the transportation program, including assisting those with disabilities or special needs. The CCO monitors grievances and service denials and actively works to address any gaps. The CCO described gathering information on barriers to access through the annual CAHPS survey. The CCO did not address contract or site visit requirements of providers to ensure access to clinics or facilities for members with disabilities or special needs. **Recommendation** For the next submission: • Address access to clinics and facilities for enrollees with disabilities or special needs and whether the CCO considers this adequate.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a comprehensive continuum of treatment for mental health disorders. They discussed successful quality efforts to improve access related to mental health treatment over the past few years.

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a comprehensive continuum of treatment for substance use disorders.
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Describe network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.
Description of Enrollees – 10.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** The CCO requires providers to meet minimal cultural competency standards such as accessing translator services. The CCO identifies providers with specific cultural expertise and language proficiency. Care coordinators refer members to these identified clinicians. The CCO provides an incentive to providers to employ bicultural and bilingual staff by offering a rate enhancement for clinical services offered by these identified providers to CCO members with these diverse backgrounds. The CCO contracts with a culturally appropriate behavioral health provider to provide wraparound services for their children and families.
13a.	• CCO provides analysis of the needs of enrollees with	2	**Comments** The CCO described efforts to meet the needs of members with behavioral health needs as

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
	disabilities and enrollees with special health care needs.		described above. When making provider assignments, the CCO did not describe the process for taking into account disabilities and special health care needs. However, they did describe early identification of members in need of care coordination and care management services and development of care plans. **Recommendation** For the next submission: • Describe the process for taking into account enrollee characteristics when making provider assignments. Include disabilities and special health care needs of enrollees.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	2	**Comments** The CCO provides access to specialists as needed, both in and out of the network. In general, the CCO described identifying member disease profiles and stratifying data to maximize access to specialists for specific diseases. They further described defining and analyzing high risk members with chronic physical health conditions as well as severe and persistent mental illness. **Recommendation** For the next submission: • Provide analysis of the prevalence of diseases that require access to specialists among the enrollee population.

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** The CCO discussed utilizing care coordinators in behavioral health to ensure members have their needs met. Community health workers connect members with their primary care medical home and help identify gaps in care for members. Care coordinators often make emergent and urgent referrals when necessary to best meet the needs of the members. Information about continuity of care and transitions in dental care was provided.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 12.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	3	**Comments** Trillium monitors performance through a variety of methods including satisfaction surveys (CAHPS). The CCO also uses grievance data when making network adequacy decisions. Trillium described examples of using enrollee feedback through their member engagement committee (a sub-committee of the Community Advisory Committee).
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO has an automated prior authorization and claims payment process where providers enter information directly via their portal. This minimizes administrative oversight and allows CCO staff to actively engage in helping Members access care and treatment. Trillium utilizes TruCare EMR, allowing all departments to access clinical and non-clinical records. Tele-psychiatry is used especially for access to child psychiatrists.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	3	**Comments** Trillium's care managers provided individualized care plans based on needs identified in a variety of ways. The CCO described their diabetes prevention program as an example of self-care training that enrollees may take to promote their own health.

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** Providers are required to meet minimal cultural competency standards such as accessing translator services. Trillium surveys contractors and identifies providers with specific cultural expertise and language proficiency. Care coordinators refer members to these identified clinicians. Trillium's Equity Officer leads the transformation objectives that are set to assist providers in providing services in a culturally competent manner. Trillium contractually requires services be delivered in a linguistically and culturally appropriate fashion.
Coordination of Care – 16.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	0	**Comments** The CCO did not contract with any Indian Health Care Providers in 2017. **Recommendation** For the next submission: • Describe any relationships with Indian Health Care Providers.

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
21.	CCO discusses coordination with above stakeholders.	2	**Comments** Discussed coordination with the above stakeholders except Indian Health Care Providers. **Recommendation** For the next submission: • See above.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	2	**Comments** Trillium described "well-rounded interdisciplinary plans" incorporating a variety of experts as needed. Trillium Case Management participates in weekly Interdisciplinary Care Team (ICT) meetings where physical and behavioral health challenges are identified, and appropriate coordination of supports are determined. Members identified on hospital readmission and ED are contacted by Trillium Case Management. ICT's are completed for members with high ED and hospital readmission visits. Trillium Behavioral Health and Community Partners collaborate through the ED Utilization Workgroup which is a workgroup of the Clinical Advisory Panel (CAP). Sub-work groups that have been formed to concentrate on specifics identified as barriers and/or system needs are as follows: PreManage Workgroup; Alternative to ED use; Health Navigators in the ED; Community-Wide Algorithms; Same Day Transportation; Urgent Care Access; Chronic Pain Programs. The CCO is working to decrease utilization of inpatient and EDs. Dental services were not included when describing interdisciplinary care teams. They did not analyze whether these efforts are adequate to reduce hospital readmission and emergency room usage. **Recommendation** For the next submission:

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			• Further discuss how interdisciplinary care teams are used to coordinate services throughout the continuum of care, including dental services. Analyze whether this is adequate to reduce hospital readmission and emergency room usage.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	1	**Comments** In general, Trillium described utilizing a variety of sources to identify special needs proactively. All members have outreach and review of a health risk assessment which includes a review of specific health needs and development of a care plan in collaboration with the member to address special health care needs. **Recommendation** For the next submission: • Describe the process for identifying and assessing all enrollees for special health care needs, as defined in the CCO contract with OHA, to ensure all members with special health care needs are identified and assessed.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	2	**Comments** Trillium described the use of electronic health record to coordinate health care between physical and behavioral health. There was no discussion of coordination of dental care. **Recommendation** For the next submission: • Describe how the electronic health record is used to coordinate health care, including preventive health care, for all enrollees across the continuum of care, including dental care.

Table 13. Trillium Community Health Plan Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Performance on Metrics – 4.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	2	**Comments** The CCO discussed the analysis of oral health data by their Clinical Advisory Panel. They are paying specific attention to the CCO metric related to dental sealants. Trillium developed a strategy to increase and support the number of PCPCH recognized clinics (tier 3 and above) by the end of 2018. The CCO discussed analyzing and utilizing performance data throughout their CCO in order to make decisions on network adequacy. **Recommendation** For the next submission: • Further discuss efforts to build capacity for those metrics where the CCO's performance is below the baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	2	**Comments** The CCO described a process to review over/underutilization. High utilization of inpatient admissions and ED use were two areas of overutilization where the CCO has taken action to address. The CCO described monitoring of underutilization of PCP use, medication adherence, and medical supplies, but did not describe actions taken to address these. **Recommendation** For the next submission: • Analyze patterns of underutilization and the actions the CCO has taken to address.

UMPQUA HEALTH ALLIANCE

Umpqua Health Alliance (UHA), based in Roseburg, provides physical, behavioral and dental health services for OHP members in Douglas County. As of October 2017, UHA had 25,382 enrollees.

Summary

UHA submitted a provider narrative report and a provider capacity report. The CCO analyzed and described how it ensures appropriate services throughout its network. The CCO is in the process of implementing proactive monitoring of the geographic distribution of providers and enrollees and analysis of time and distance standards. Description of their network and ratios of members to providers was included. However, the CCO did not provide ratios of members to pediatric, adult and geriatric providers. The CCO described the process to identify members with special health care needs upon enrollment. The CCO described coordination and relationships with community organizations and agencies to meet the needs of their members.

The CCO described the delivery of services in a culturally competent manner. The CCO contracts with Cow Creek Band of the Umpqua Tribe of Indians.

The CCO describe a comprehensive process for identifying and assessing all enrollees for special health care needs that will be effective in 2018.

Efforts to build network capacity for metrics where the CCO's performance is below baseline was provided, as well as analysis and actions taken by the CCO to address underutilization and overutilization

The provider capacity report included most categories of service outlined in the CCO contract and included all required data elements for those providers and listed mental health crisis services.

See Table 14 for complete results and recommendations for the next submission.

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 35.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	3	**Comments** UHA described the rural nature of their CCO along with the distribution of providers compared with the geographic distribution of enrollees and ratios of providers to members. The CCO described how members can access services.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** The CCO described the use of Quest Analytics to do geo mapping and ensure all providers meet the time and distance standards. This process is completed on a monthly basis.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** Through contracts, the CCO requires providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services. The contract also requires services to be available 24 hours a day/7 days a week when medically necessary. The CCO provider agreement requires call coverage for medically appropriate services 24 hours a day/7 days a week, 365 days per year. UHA uses advanced information systems to coordinate across all provider types and care settings, regardless of geographic location. UHA also analyzes utilization of services as necessary, at least monthly, and anticipates Medicaid enrollment based on available information. The CCO is in the final stages of implementing several policies that proactively monitor the network. These include reporting to monitor timeframes for emergent, urgent, routine PCP, specialist and dental care appointments. They will review the timeframe for non-urgent behavioral health appointments.

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
4.	CCO analyzes wait times for appointments with providers, including specialists.	3	**Comments** UHA circulates Access to Care surveys on a monthly basis to PCP, specialists, DCO and behavioral care network providers to determine appropriate appointment times. Overall, the network is performing at standards in accordance with the acceptable access and availability requirements defined by Umpqua Health. UHA tracks grievances due to extensive appointment wait times for seeing any type of provider. If there is an excessive amount of grievances for a provider regarding timely access, UHA would engage that provider and implement a corrective action plan to address the behavior. UHA has not had to do issue a correction action plan for this reason during the reporting period.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** UHA runs monthly geo-mapping reports to verify appropriate time and distance standards for all provider types. In the event, UHA was below the 90% threshold, it would engage in contracting with providers. However, because UHA resides in a rural community, it contracts with most of the provider available. UHA will allow members to go out-of-network and/or out of the services area, in the event a provider is unable to see a member in a timely manner. UHA currently does not offer telemedicine or video conferencing within their network as currently there is not a gap for services. UHA is open to this in the future and had previously experimented with telepsychiatry which was not utilized frequency by its members.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds.	3	**Comments** UHA described and routinely monitors and evaluates the number of members assigned to a PCP. UHA considers the current ratios to be adequate. In terms of other provider types, because UHA is located in a rural community it essentially contracts with any provider that is

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
	• The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.		available within the community. Therefore, member-to-provider ratio is considered ineffective for measuring adequacy with many other provider types (e.g., specialist, facilities, behavioral health, etc.) due to the limited pool of providers available.
6a.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO addresses ratios for pediatric, adult, and geriatric providers.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Address ratios for pediatric, adult, and geriatric providers.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	2	**Comments** The CCO does not directly contract with traditional health workers. Many of the contracted FQHCs, Rural Health Clinics, SUD/behavioral health facilities have these individuals on staff. **Recommendation** For the next submission: • Describe how traditional health care workers (by type) are provided within the delivery network, including contracted clinics and facilities.
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO describe their NEMT provider and monitoring to ensure quality service. The CCO considers this to be adequate.

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** Bay Cities is UHA's NEMT provider and has a full network of transportation modes; wheelchair vans, gurney transports, secure transport and a well-managed provider network of medical sedan transports. UHA receives monthly report that includes whether or not they had any rides that were not met due to shortages of transportation modes available. The on-time performance for specialty vehicles has been exceptional. UHA considers this adequate. Providers provide all necessary ADA accommodations. This process is monitored via UHA Member Services Group. Additionally, Member Services is available to entertain any grievance requests. UHA considers this adequate.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a continuum of care for treatment of mental health disorders. The CCO monitors provider capacity for mental health and adds additional independent mental health providers when their delegate, Adapt, has limited capacity.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** UHA contracts with Adapt/Compass to provide treatment for substance abuse disorders. The CCO authorizes out-of-network and out-of-area services as necessary to ensure adequate level of services are being provided to meet members' needs based on ASAM guidelines. The CCO ensures members who are not able to receive services in a timely manner by contracted provider, the CCO will review for out-of-network (OON) and or out-of-area (OOA) services through the prior authorization process. UHA believes this to be adequate.

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	3	**Comments** The CCO uses prior authorization for chiropractic, acupuncture and physical therapy w/ massage. The CCO provides flexible spending with the purpose of covering other "Non-Medical" services. These services are for health/wellness related service not covered under the Oregon Health Plan, and that do not have billing encounter codes. Members are referred by their PCPs with a treatment plan and supporting documentation that consists of individual care coordination and case management services. Services requested should demonstrate goals to improve health outcomes for individuals, prevent or delay health deterioration.
Description of Enrollees – 12.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** UHA is dedicated in ensuring its members are assigned to a PCP in a timely and appropriate manner. UHA assigns members based on member choice, geographic location, and provider “Open” status (accepting patients). If the member has or requests a specific PCP, the member is assigned per that request. Per UHA’s MS1- Member Assignment and Reassignment policy, UHA also considers members language and cultural needs, as well as special health care needs when assigning to a PCP. When UHA engages a member for PCP assignment it inquires what kind of PCP a member is seeking if there are certain needed. UHA monitors the number of members that are identified by OHA with a non-English language via weekly report. Also, the ethnicity and language information are also displayed in the Community Integration Manager (CIM) database. UHA’s member services receives requests from members for special accommodations such as alternate format materials, translation, and interpretation services. These requests are

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			accommodated and tracked by type of request to ensure that UHA has an adequate network and processes in place to handle these requests.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** UHA's Member Services receives requests from members for special accommodations such as alternate format materials, translation, and interpretation services. These requests are accommodated and tracked by type of request to ensure that UHA has an adequate network and processes in place to handle these requests.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	3	**Comments** The CCO has a case management department that focuses on chronic disease management such as COPD, HF, and diabetes. Members are managed through Pre-Manage, a web-based program that notifies UHA CM if a member is in the ED. TOC (Transitional of Care team) programs assists members with Chronic Disease with medication management and education specific to member's disease. Case managers will make follow up phone calls or home visits whichever is appropriate to sustain active involvement in member healthcare needs through care plans, and treatment plans, collaborate with Primary care physician and or specialist. UHA also has a Utilization Review Committee, which reports to its Quality Advisory Committee, that periodically trends diagnoses to determine whether there are any new prevalence of diseases in which UHA would need to take a more proactive approach with its providers in terms of engagement and care.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** UHA has case managers that assist with discharge planning at each level of transitions, i.e. hospital, skilled nursing facility to home health, including inpatient psychiatric hospital, residential care, detox to outpatient services. The CCO provides and assists with transportation, access to specialty services, and

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			provides resources to community services. UHA also has its Transitions of Care (TOC) Team that assist any members discharging form the hospital in which follow-up care to their PCP is a barrier. The TOC Team essentially acts as conduit for care until the member can see the PCP. The TOC Team consist of a nurse and a nurse practitioner that can provide care to the members post discharge - designed to act as a safety net between the transitions in order to prevent readmission. The CCO described using advanced information systems to coordinate across all provider types and care settings, regardless of geographic location. Upon enrollment, the CCO identifies members with special health care needs and the intensive care manager helps coordinate their health care needs. UHA participates on the Wraparound Committee with Adapt and Community Health Alliance to promote mental health among high risk youth. The CCO's clinical staff, including behaviorists and clinical case managers assist community providers in coordinating services within and outside the community. **Recommendation** For the next submission: • Further describe how enrollee needs for continuity of care and transition between levels of care are assessed.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 12.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	3	**Comments** UHA's Community Advisory Council (CAC) oversees the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). The UHA Board receives a monthly report on CAC business, ensuring another avenue for input from CAC members to UHA. UHA CAC members also oversee funds for projects that aim to improve the overall health of residents in our service area, with a focus on projects that impact provider access, addictions, mental

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			health, parents and children and healthy lifestyle. UHA utilizes responses from Health Risk Assessments and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to evaluate feedback from the population. Grievances are also reviewed as a way to evaluate the adequacy of the provider network. Feedback and complaints related to access, interactions with providers, and types of services may be shared with the Provider Relations department and Network Performance Committee. In the event any of these entry points identify gaps in access, UHA would make attempts to either contract with additional providers, or issue corrective action plans for applicable providers to ensure timely access. UHA has not had to take such actions during this report period.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO described using advanced information systems to coordinate across all provider types and care settings, regardless of geographic location. CCO utilizes Pre-Manage, to track member utilization of Emergency Department visits and admissions to local hospitals. The early identification of member being seen in the ED provides the opportunity to consult with ED case managers or social workers to assist member with appropriate discharge needs or placement, therefore reducing readmissions/ hospitalizations. The CCO Case Management Coordinators are able to assist members in real time with follow up appointments, referrals, placement in a timely manner. Additionally, the CCO subsidizes an EMR to facilitate care coordination across the care continuum. About 75% of UHA's contracted PCPs are on this EMR, as well as specialty groups. The EMR has interfaces with many of the other EMRs (including the hospital) in the community in

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			order to freely share information for care and coordination. The EMR also participates in a HIE. UA has both hired a staff member who is a member of the HIMSS National Innovation Committee and also instituted an internal IT innovation committee, so it can constantly investigate potential ways to utilize new technologies to better deliver on the quadruple aim.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	3	**Comments** The CCO provides culturally sensitive health education, including self-care, prevention, and disease management. UHA's Transitions of Care (TOC) Team provides education and medication management using the Coleman's model of care to assist members in promoting their own healthcare needs. The TOC Team identifies members at risk by diagnoses, ED utilization and LACE score. The TOC Team provides assistance with making follow-up appointments, transportation, and medication management. CCO also has Case Managers that provide Diabetes education and education on chronic disease management, such as COPD. Case managers continue to follow the patient through each level of care.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** The CCO described the delivery of services in a culturally competent manner. The CCO contracts with the Cow Creek Band of the Umpqua Tribe of Indians.
Coordination of Care – 22.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with:	3	**Comments** Fully met

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
	• Aging and Persons with Disabilities		
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	3	**Comments** Fully met
21.	CCO discusses coordination with above stakeholders.	3	**Comments** The CCO discussed its relationships and coordination with the above stakeholders.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	3	**Comments** The CCO described coordinating mental health services. UHA's case management coordination is constructed from data found in a self-reported health risk assessment survey, health plan utilization and pharmacy administrative data. The data is collected from PCP's involved in the care, number of prescribers involved in the care and changes of 1 or more chronic disease medications and multiple ED visits. Additionally, dental providers are engaged in this process, including representation on the monthly Interdisciplinary Team meetings.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	2	**Comments** The CCO reports, "Members with Special Health Care Needs are identified at the Tier level (A-B-C-F-M-O). Upon enrollment, UHA identifies all members on Tiers A-B-C-F-M-O and the Intensive Care Manager helps coordinate their health care needs." *Effective in 2018*, CCO's case management coordination is constructed from data found in a self-reported health risk assessment survey, health plan utilization and pharmacy administrative data. The data is collected from PCP's involved in the care, number of prescribers involved in the care and changes of 1 or more chronic disease medications and multiple ED visits. Special health needs are identified through the Health

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			Risk Survey. Member services does 3 attempts to follow up per member. Twice by mail and at least once by phone. The data collected from this survey in conjunction with date gleaned from EDIE is used by UHA to identify special health care needs. **Recommendation** For the next submission: • Further describe the process for identifying and assessing all enrollees for special health care needs.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	2	**Comments** The CCO described using advanced information systems to coordinate across all provider types and care settings, regardless of geographic location. UHA feels very strongly that an electronic health record is a key tool for allowing providers to successfully deliver direct care and also for identifying care gaps, supporting health information exchange, and coordinating care across the care continuum. UHA has subsidized an electronic health record for providers for many years. About 75% of all UHA contracted PCPs are on this EMR, along with many specialists. Additionally, the EMR has interfaces with many other EMRs in the community and is also connected to an HIE. This approach has created a "Community EMR," in which records can be easily distribute between providers and hospitals throughout Douglas County. UHA has access to this EMR which helps reduce administrative workload for providers with regards to care coordination and prior authorization. UHA staff can readily access patient information in the EMR to provide more timely assistance and care to these members. The CCO did not discuss coordination with dental care providers through an EMR or other technology. **Recommendation** For the next submission:

Table 14. Umpqua Health Alliance Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			• Further describe how the CCO uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care, including dental care providers.
Performance on Metrics – 6.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	3	**Comments** Generally speaking UHA performs quite well with respect to CCO performance metrics. UHA described a past performance metric where they fell below the baseline and mitigated the risk. UHA routinely provides technical assistance, dashboards, and at times administrative assistance to help providers with meeting performance metrics. However, UHA has not had to expand access due to inadequate metrics performance.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	3	**Comments** UHA monitors and identifies utilization trends in a routine manner in an effort to make timely informed decisions as necessary. Data is analyzed to determine trends, both at the specialty-level and health-plan level. Based on information such as the referral requests for out-of-network providers, UHA will engage its current network providers to identify barriers to access. UHA identifies areas for potential remediation of over/under or inappropriate utilization and recommends improvement strategies. Resulting actions may include additional care coordination, recommendations for the providers, and/or establishing additional contracting with providers. This information is routinely provided through UHA's Utilization Management Committee, which reports to its Quality Advisory Committee. Both committees are tasked with taking in this information and identify opportunities for interventions. The CCO described specific actions to address identified areas of under- and over-utilization.

WESTERN OREGON ADVANCED HEALTH

Western Oregon Advanced Health (WOAH), based in Coos Bay, contracts with OHA as a CCO to provide physical, behavioral and dental health services to OHP members in Coos and Curry counties. As of October 2017, WOAH had 19,591 enrollees.

Summary

WOAH submitted both a comprehensive provider narrative report and a comprehensive provider capacity report. The CCO reported the history, analysis, monitoring and processes for maintaining and improving its delivery system network.

See Table 15 for complete review results. There are no recommendations for improvement in the reports for the next submission.

Table 15. Western Oregon Advanced Health.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 39.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	3	**Comments** WOAH provided a comprehensive description of their process to locate enrollees and providers using Tableau analytic software. They review this information quarterly and senior management reviews this data at the same intervals.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** WOAH provided a comprehensive description of how they meet time and distance standards for member access to health care.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** The CCO provided analysis and described how they ensure provision of appropriate urgent, emergency, crisis and triage services for physical health, dental health and behavioral health services. Part of their analysis includes review of grievance data related to access.
4.	CCO analyzes wait times for appointments with providers, including specialists.	3	**Comments** WOAH provided analysis of wait times for appointments. Monitoring grievance data, analyzing survey data and engaging in secret-shopper–style telephone calls are some of their methods to monitor wait times. Comprehensive proactive panel management is described in detail for physical health providers, including specialists. Analysis of dental, mental health and substance use disorder wait times, along with solutions, were also provided.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** Comprehensive information related to time and distance standards and use of telemedicine was provided.

Table 15. Western Oregon Advanced Health.			
Indicator		**Score**	**Review Comments/Recommendations**
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** The CCO provided the requested information related to all providers and services listed. They further described whether these ratios are adequate. The CCO also mentioned it was critical to examine not only the ratio of providers who are available to service their enrollee population, but the general population, as well.
6a.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO addresses ratios for pediatric, adult, and geriatric providers.	3	**Comments** See above.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** WOAH provided a comprehensive description of traditional health workers in their service area, including the history.
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** A comprehensive description and analysis of NEMT services across the service area was provided.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** Analysis and description of transportation and access for enrollees with disabilities or special needs was provided.

Table 15. Western Oregon Advanced Health.			
Indicator		**Score**	**Review Comments/Recommendations**
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a continuum of care for treatment of mental health disorders.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a continuum of care for treatment substance use disorders.
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	3	**Comments** The CCO described its network availability/access and use of alternative therapies to meet the needs of enrollees. They further discussed initiatives addressing back pain using alternative approaches.
Description of Enrollees – 12.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** WOAH describe its process for taking into account enrollee characteristics when making provider assignments, including analysis of language and cultural needs of enrollees and the needs of those with disabilities and enrollees with special health care needs. The CCO described receiving consultation and technical assistance through the Transformation Center and OHA's Office of Equity and Inclusion in 2016 to assist them with addressing the needs of their enrollees.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** See above.

Table 15. Western Oregon Advanced Health.			
Indicator		**Score**	**Review Comments/Recommendations**
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	3	**Comments** The CCO outlined and ranked in order the most common reasons for youth and adults consulting with a health care professional. They further described how these are addressed for their members.
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** WOAH described care coordination, case management and discharge planning to meet the needs of its members.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 12.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	3	**Comments** WOAH provided a comprehensive description of how they incorporate member feedback into network adequacy decisions including grievance data, mental health surveys, CAHPS and Community Advisory Council's input. They also described how they are mid-stream in obtaining information from the South Coast Oral Health Coalition needs assessment study which includes input from patients, oral health providers and focus groups. The CCO has also been eliciting consumer input for their performance improvement projects. Consumer voices are also heard through their housing and homelessness coalitions.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO described efforts to address the "rapid-fire change" in health care delivery through inter-professional teams, coordination across settings and utilizing evidence-based practices to improve quality, safety and promote great efficiency in care delivery. WOAH described using its predictive risk stratification solution at every practice location. They further described how team members are using this software. WOAH described its Innovation Incubator Grant Program where the CCO provides financial support for innovative projects to support various health and social projects throughout their service area.

Table 15. Western Oregon Advanced Health.			
Indicator		**Score**	**Review Comments/Recommendations**
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	3	**Comments** WOAH described its self-management educational offerings.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** WOAH outlined the organization's commitment to diversity from the leadership downward. As previously described, the CCO requested and received consultation and technical assistance from the Transformation Center and OHA's Office of Equity and Inclusion to gather data and address any disparities in care. The CCO described access to language interpretation as well.
Coordination of Care – 24.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	3	**Comments** Fully met
21.	CCO discusses coordination with above stakeholders.	3	**Comments** The CCO discussed involvement with the above organizations and their participation with their Community Advisory Council and Quality Assurance Committee as well as services provided by these organizations for their members.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care.	3	**Comments** Interdisciplinary care teams used to coordinate services across the continuum of care were described by WOAH. The CCO further described

Table 15. Western Oregon Advanced Health.			
Indicator		**Score**	**Review Comments/Recommendations**
	• The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.		analysis of hospital re-admission and emergency department utilization.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	3	**Comments** WOAH described using its Milliman tool to identify enrollees with special health care needs as well as requiring delegates to have mechanisms in place to assess each member for special health care needs.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	3	**Comments** The CCO described how they are working toward interoperability of electronic health records and other solutions among all of the medical, dental, and behavioral health providers.
Performance on Metrics – 6.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	3	**Comments** WOAH provided a comprehensive description of its efforts to address performance on CCO metrics that were below baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	3	**Comments** The CCO addressed patterns of both under- and overutilization and actions the CCO is taking to address these in physical, dental and behavioral health services.

WILLAMETTE VALLEY COMMUNITY HEALTH

Willamette Valley Community Health (WVCH) contracts with OHA to provide physical, behavioral and dental health services for OHP members in Marion and Polk counties. As of October 2017, the CCO had 96,319 enrollees.

Summary

WVCH submitted both a comprehensive provider narrative report and a comprehensive provider capacity report.

The CCO's narrative addressing the adequacy of the network included input from its delegates.

The CCO described providing support to families with children with complex medical needs, including support between CCO services and social services. They further discussed the Emergency Department Intervention Team, which includes traditional health workers, nurse care managers and a psychiatrist, and the work of interdisciplinary care teams.

The CCO provided a comprehensive description of its commitment to providing culturally and linguistically appropriate services.

The CCO described how interdisciplinary care teams are used to coordinate services across the continuum of care, including the use of Emergency Room Intervention Teams.

The CCO described its process for identifying and assessing all enrollees for special health care needs.

WVCH described its efforts to build network capacity for those metrics where performance is below baseline and analysis of under- and overutilization.

The CCO provided a comprehensive provider capacity report addressing most categories of services and required data elements. However, details related to their mental health crisis services were not included in the report.

See Table 16 for complete results and recommendations for the next submission.

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 39.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	3	**Comments** WVCH described distribution of physical health, behavioral health and dental services throughout its service area. Data analysis of provider location in the most rural areas show that an enrollee at the farthest edge of either Marion or Polk County can access the closest Primary Care Provider within the acceptable standard. Access to physical health providers takes into account the location of the enrollee, the proximity of the closest provider and the appropriateness of the provider for the enrollee's needs. Enrollee access to mental health/SUD providers is adequate to cover the geographical region to serve the membership. To ensure enrollees living in rural areas near county lines have proper access to mental health services, Mid-Valley Behavioral Care Network has contracted with mental health and SUD providers in Linn and Benton counties, which may be closer in proximity than services located in the WVCH service area. WVCH DCO partners (Capitol Dental, Advantage Dental, Willamette Dental Group and ODS Community Dental) ensure adequate dental provider capacity with geo-mapping software to visualize geographical distribution of membership, proximity to dental care providers and utilization of services. Access to dental providers is coordinated with each DCO to locate the most appropriate primary care dentist in closest proximity to an enrollee's reported address. Physical, behavioral, and oral health provider distribution is located throughout the greater Salem-Keizer area with satellite clinics/campuses in Woodburn, Silverton, Dallas, Stayton and Grand Ronde.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** The CCO described how the network ensures that the time and distance standards for member access are met for physical, behavioral and dental care providers. Alternative outreach for members

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			in rural areas includes a dental van or coordination with non-contracted providers to lessen the 60-minute/60-mile community standard to the members' home location.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** WVCH described hot it ensure the provision of appropriate urgent, emergency, crisis and triage services 24 hours a day/7 days a week for all members for physical health, behavioral health and dental services. The CCO reviews access grievances for trending of potential access issues within a specific practice or provider type and performance of the annual access and availability survey. Two of the four dental delegates provided responses that included utilizing grievances, review of quarterly utilization reports including emergency/urgency as well as routine and preventative services. One dental delegate has the QI Committee review utilization data by provider and general service area.
4.	CCO analyzes wait times for appointments with providers, including specialists.	3	**Comments** WVCH performs access and availability surveys on 10% of the participating physical health provider offices to analyze wait times for routine care appointments, follow-up care appointments, and urgent care access. Offices with appointment times beyond the average of the surveyed offices are contacted to discuss options to improve appointment timeliness to fall within the 7-day average. Primary care offices may be suspended from accepting new WVCH members until they are within the 7-day timeliness standard. Mental health providers timeliness standard is 14 days. During the monthly mental health access coordinator meeting, data specific to wait times is reviewed, and providers identified as not meeting the requirement are offered education and data reports for the area of concern. Mental health providers outside of the expected guidelines are monitored for compliance by the Provider Relations Manager and the Quality Improvement Coordinator. DCO partners query practices for

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			appointment wait times for emergency care, urgent care, and routine care appointments. Wait times are analyzed by staff and providers are educated when timeliness concerns are present. The timeliness standards WVCH holds each DCO accountable for is dependent on the appointment type - emergency dental care: seen or treated within 24 hours; urgent dental care: within one to two weeks or as indicated in the initial screening; routine dental care: within an average of eight weeks. WVCH analyzes physical, mental health, and DCO member complaints for trends related to appointment wait times and engages plan staff and providers to address concerning trends.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** The CCO has specialty clinics in Marion and Polk counties that allow timely access to specialty services. Potential gaps are analyzed through grievances to ensure access is adequate. Out-of-network services are authorized when providers are unavailable within the network.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** The CCO described ratios of members to providers of primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care. WVCH considers the patient to provider/facility/clinic ratios above to be adequate.
6a.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds.	3	**Comments** The CCO described ratios of members to providers for pediatric, adult and geriatric providers.

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
	• The CCO addresses ratios for pediatric, adult, and geriatric providers.		
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** The CCO provided a comprehensive description of traditional health care workers and their role within the network.
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** WVCH delivers NEMT benefits across the delivery network through a contract with a transportation brokerage company. The transportation brokerage maintains a panel of transportation providers to deliver a range of transportation services for OHP members to participate in receiving health care benefits and services. The transportation brokerage and transportation providers are able to meet the 30-minute/30-mile or 60-minute/60-mile community standard for access to benefits and services. Transportation services use a variety of specialized vehicles including secured transportation. WVCH members also are provided transit passes to access the Salem-Keizer mass transit system. Member mileage expense reimbursement is provided for private vehicle transportation to covered services and benefits. The CCO actively works to address any issues that arise with their NEMT.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** WVCH's transportation contract for NEMT benefits requires the transportation broker to accommodate enrollees with special health care needs, by using vehicles designed to transport various wheelchair configurations and other non-traditional mobility conveyances, including stretcher transportation. Additionally, transportation provider drivers are trained in trauma-based care to allow for appropriate travel

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			with enrollees experiencing behavioral health issues, including secured transportation when required or requested. WVCH's transportation brokerage coordinates closely with provider offices to ensure that enrollees' physical or behavioral health needs are appropriately accommodated. WVCH considers the transportation brokerage and transportation provider services to be adequate for the delivery of the OHP non-emergent medical transportation benefit.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** A continuum of mental health services that the CCO considers adequate was described.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	3	**Comments** The CCO described a continuum of care for treatment of substance use disorders. Additionally, WVCH coordinates with residential providers across the state to ensure access and coordinate care for members in higher level facilities and ensure smooth discharge transitions between levels of care. WVCH considers this network adequate for servicing OHP members.
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	3	**Comments** WVCH describe network availability and use of alternative therapies. The CCO monitors wait time to ensure timely access to these services. WVCH is actively seeking to engage Licensed Massage Therapists in currently contracted physical therapy offices to allow access to that alternative therapy. WVCH currently considers the above alternative therapies adequate. Additional alternative therapies are considered for member needs as they become available.

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Enrollees – 10.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	3	**Comments** Initial PCP assignment for new enrollees is based on member age, provider specialty, and zip code. Member Service Representatives work with enrollees to help facilitate provider selection for both physical and mental health for enrollees with disabilities or special health care needs, cultural, or linguistic requirements. Providing the enrollee with selection assistance is designed to ensure that the clinic and provider are capable of meeting the unique needs of the enrollee, assuring successful outcomes. WVCH surveys clinics to determine the linguistic capabilities of staff. Dental partners offer enrollee choice as a key factor to facilitate building a successful health care patient/provider relationship, considering the needs of enrollees with disabilities or special health care needs and cultural and linguistic requirements. Dental staff are well versed in the provider network to help enrollees focus on a provider most able to meet their cultural, linguistic, physical, behavioral, and oral health needs.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** See above.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	1	**Comments** WVCH, in conjunction with Marion and Polk Counties, developed a community health profile to identify health indicators and prevalence of diseases among the OHP and community-wide populations that require access to specialists. They did not an analysis of the prevalence of diseases that require access to specialists. **Recommendation** For the next submission: • Provide analysis of the prevalence of diseases that require access to specialists among the enrollee population.

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	3	**Comments** WVCH's Transition of Care policy directs WVCH ICM services coordinate with providers and enrollees to facilitate smooth transition of care including appropriate discharge planning for short and long-term hospital and psychiatric stays to reduce duplication of assessment and care planning activities for OHP members, including those with special health care needs. Hospital and psychiatric facilities discharge planners coordinate with outpatient case managers or care coordinators for the smooth transition to other care facilities or other residential or living situations. WVCH also coordinates care for new enrollees coming onto the plan who are currently in treatment with a non-network provider to ensure continuation of services until in-network physical health, mental health and oral health providers can be established. The CCO described providing support to families with children with complex medical needs, including support between CCO services and social services. They further discussed the Emergency Department Intervention Team which includes traditional health workers, nurse care managers and a psychiatrist and the work of interdisciplinary care teams.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 12.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	3	**Comments** WVCH analyzes enrollee feedback, survey results, and enrollee grievance trends to evaluate the adequacy of the provider network. In addition to CAHPS surveys, WVCH, in partnership with Mid-Valley Behavioral Care Network, conducted a consumer satisfaction survey for mental health services for adults/families and children. Gaps in the network and timeliness standards are tracked. If network adequacy issues are identified through grievance analyses or surveys, WVCH's Contracting department is engaged to locate and contract with additional providers both within the WVCH service area and out-of-area to eliminate identified service gaps.

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			The Community Advisory Council (CAC) assists WVCH in identifying trends in the community, providing critical feedback to the development of the network. As community members, CAC's feedback is an assessment of the community's overall needs. Meeting minutes from the WVCH CAC are reviewed by the WVCH Chief Medical Officer and submitted to the WVCH Board for review. Recommendations may be adopted by the WVCH Board, Transformation and Quality Committee, and relevant WVCH workgroups to be applied to the CCO's TQS, CHIP, and CHA, as well as in the formation of policies and workflow. CAC provides feedback on the acceptability of enrollee materials and potential success of WVCH-funded transformation projects in the lives of enrollees.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	3	**Comments** The CCO described several team-based initiatives. In addition, WVCH utilizes fax, encrypted email, and the Clinical Integration Manager (CIM) for communication with physical health, behavioral health and dental health providers and community partners to ensure collaboration between providers and partners for a team-based, holistic health care approach to OHP members. WVCH staff, physical health, mental health, and dental health providers and their respective case managers use several software programs like PreManage, EPIC, and CIM, to identify high risk and special health care needs members; coordinate OHP member service and benefit delivery; and facilitate care coordination through multi-disciplinary case management.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	3	**Comments** The CCO described how programs in self-care and other interventions are provided, as appropriate for enrollees to promote their own health.

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** The CCO provided a comprehensive description of its commitment to providing culturally and linguistically appropriate services.
Coordination of Care – 24.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met.
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	3	**Comments** Fully met
21.	CCO discusses coordination with above stakeholders.	3	**Comments** The CCO described comprehensive coordination with the stakeholders listed above.

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	3	**Comments** The CCO described how interdisciplinary care teams are used to coordinate services across the continuum of care, including the use of Emergency Room Intervention Teams. WVCH coordinates frequent Interdisciplinary Care Team (ICT) meetings with case managers across the continuum of multi-disciplinary care to discuss and collaborate on enrollees who are high ED utilizers; who present with multiple complex medical and mental health conditions; have little or no understanding of how to navigate health care benefits and services or the delivery system; have been under-represented in the delivery of preventive services; and typically display low health literacy. The teams evaluate enrollee condition, improvements, regressions, creates an individualized care plan, to increase health care outcomes. WVCH has behavioral health care coordinators who collaborate on complex cases with medical and substance use disorder services for adults and children. Dental case managers help coordinate care for enrollees suffering from a chronic illness such as diabetes or have other special health care needs. Dental case managers also reach out to enrollee's physical or behavioral health providers if a clinic noticed utilization patterns, such as no-show appointments or drug seeking behaviors. All case managers monitor the PreManage program to oversee emergency room utilization and are able to assist the enrollee in obtaining appropriate dental care. Data analysis on hospital readmissions and emergency room usage are showing improvements in both categories, underscoring the adequacy of service coordination efforts.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	3	**Comments** The CCO described providing members with a health risk survey questionnaire upon enrollment to provide a self-assessment of their health. The CCO follows up if these surveys are not returned. WVCH shares the results of its screening identification and treatment plans appropriate for ICM services with participating providers.

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			Further identification of special health care needs enrollees is accomplished by using and analyzing the following data collection programs: a. Internal report extrapolation (over utilization, underutilization, stop-loss claims); b. PERC code identification; c. PreManage reports; d. CIM referral history; e. Prior Authorization history; f. Claims history
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	3	**Comments** WVCH does not host an electronic health record system for its health care network, however the CCO does promote the use of PreManage across the network, which is an online platform that alerts the CCO and providers to enrollees' ED visits, closing communication gaps and helping facilitate collaboration to make better care decisions while reducing medically unnecessary hospital admissions. All four regional hospitals utilize this program to help monitor enrollees' ED utilization, as well as many other non-regional hospitals in Oregon and Washington. Currently, PreManage alerts both providers and the CCO to ED utilization when physical, behavioral, and oral health-related visits take place. When a high-utilizer is identified in the system, case managers work with the enrollee to help direct them to their PCP, behavioral health provider, or dental provider, as well as to educate them on what should constitute medical necessity for a visit to the emergency room. PreManage is also used for inpatient visits in some of WVCH's contracted clinics and is used as a mechanism to coordinate care and communication amongst physical, behavioral, and dental health providers.
Performance on Metrics – 6.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	3	**Comments** WVCH described multiple efforts to improve metrics, including: offering Medication Assisted Treatment (MAT) trainings to increase the

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			number of providers offering substance use disorder treatment; initiatives to increase utilization and access to reproductive health services, including early prenatal care services, with a special focus on youth and the housing-insecure population; and evaluation and review of high ambulatory emergency room utilization. WVCH is currently evaluating population health tools and building provider consensus around the use of these tools to be more effective in the oversight and monitoring of performance in real time. This effectively helps the CCO identify and provide outreach to those enrollees who have existing care gaps, especially those related to those metrics below the baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	3	**Comments** WVCH works with primary care providers to monitor and enhance the provision of preventative services across a broad range of indicators. Every primary care provider in the WVCH network receives a monthly preventative service performance report that details member-level adherence to best practice guidelines for prominent OHA incentive measures. These reports include, but are not limited to, tracking adolescent well care visits, childhood immunizations, colorectal cancer screening, developmental screening and effective contraceptive use. This information enables WVCH to assess each primary care practice's ability to provide CCO members with critical preventative services. These reports have been used to develop payment arrangements, implement improvement activities, and identify individuals and cohorts that would benefit from supplemental programs and resources at both the CCO and clinic level. The CCO also uses performance metrics to monitor broad utilization patterns at both the enrollee and organizational level. WVCH tracks high-level indicators such as overall expense, pharmacy expense, inpatient admissions, ED visits and outpatient utilization.

Table 16. Willamette Valley Community Health Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			This information is shared with care teams and case management staff across the network and is frequently used to guide patient interventions. The CCO also stratifies utilization information by variety of indicators to better identify existing and emerging disparities amongst vulnerable populations.

YAMHILL COMMUNITY CARE ORGANIZATION

Yamhill Community Care Organization (YCCO), located in McMinnville, is a private not-for-profit organization. The CCO provides physical, dental and behavioral health services to OHP members in Yamhill County and parts of Polk, Marion and Washington counties. As of October 2017, the CCO had 24,457 enrollees.

Summary

YCCO submitted a provider narrative report and a provider capacity report. YCCO provided a comprehensive picture of their delivery system network and efforts to ensure adequate access. The CCO described its use of traditional health workers throughout the network and included information on training, supervision and coordination. The CCO did not provide information on NEMT or information on transportation and access needs of members with disabilities or special needs. Grievances from members are reviewed, however, no other member input into network adequacy decisions was noted.

The CCO demonstrates a commitment at all levels to culturally and linguistically appropriate services.

Little information was provided regarding how care is coordinated and how members with special health care needs are identified and assessed. Performance on metrics to build network capacity in the areas where the CCO is below baseline was not described.

The CCO provided a comprehensive provider capacity report addressing most categories of services and required data elements. However, details related to their mental health crisis services were not included in the report.

See Table 17 for complete results and recommendations for the next submission.

Table 17. Yamhill Community Care Organization Results.			
Indicator		**Score**	**Review Comments/Recommendations**
Description of Delivery Network and Adequacy – 23.0 (out of possible 39.0)			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. • The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.	3	**Comments** The CCO and its delegates have mechanisms to determine provider compared to geographic distribution of members.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	3	**Comments** The CCO and delegates calculate the ratio of providers by specialty type to the member population related to specific locations and the distance from member residence to provider location.
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	3	**Comments** Timely access standards are incorporated into delegated provider agreements and monitored at the CCO level by service-level reporting related to access and authorization metrics. The CCO and its delegates utilize a variety of reports to monitor the network. All networks attempt to recruit and contract with necessary providers within the service area. Grievances and appeals are reviewed with follow up as needed. Case management staff also assist in coordinating services that may fall into urgent, complex or unique service requests.
4.	CCO analyzes wait times for appointments with providers, including specialists.	3	**Comments** The CCO monitors monthly service-level reporting to ensure timely access and service authorization standards are met. Grievance systems data and customer service access is monitored. Delegated utilization management teams monitor service requests and authorization of services.

Table 17. Yamhill Community Care Organization Results.			
Indicator		**Score**	**Review Comments/Recommendations**
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. • CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	3	**Comments** The CCO and delegates calculate the ratio of providers by specialty type to the member population related to specific locations and the distance from member residence to provider location.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	**Comments** The CCO discussed ratios in general terms, rather than specific ratios. They continually work to monitor service areas for new primary care and specialists to augment the network as needed. **Recommendation** For the next submission: • Describe the ratio of members to the listed providers and provide analysis of whether these are considered adequate.
6a.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. • The CCO addresses ratios for pediatric, adult, and geriatric providers.	1	See above.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. • The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	3	**Comments** The CCO described its use of traditional health workers, including training and supervision. In addition, they provided information on an agreement with other agencies to provide peer supports through the use of certified recovery mentors and peer supports through the community health hub.

Table 17. Yamhill Community Care Organization Results.			
Indicator		**Score**	**Review Comments/Recommendations**
8.	CCO describes how NEMT is provided across the delivery network. • The CCO should analyze and describe whether the CCO considers this adequate.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Describe how NEMT is provided across the delivery network and whether the CCO considers this adequate.
9.	CCO addresses transportation and access for enrollees with disabilities or special needs. • The CCO should analyze and describe whether the CCO considers this adequate.	1	**Comments** The CCO does monitor office limitations when monitoring provider offices. **Recommendation** For the next submission: • Describe transportation and access for enrollees with disabilities or special needs and whether the CCO considers this adequate.
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) for treatment of mental health disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	1	**Comments** The CCO monitors the network on a regular basis. A continuum of care for treatment of mental health disorders was not described. **Recommendation** For the next submission: • Describe a continuum of care for treatment of mental health disorders.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. • The CCO should analyze and describe whether the CCO considers this adequate.	1	**Comments** The CCO monitors the network on a regular basis. A continuum of care for treatment of substance use disorders was not described. **Recommendation** For the next submission: • Describe a continuum of care for treatment of substance use disorders.

Table 17. Yamhill Community Care Organization Results.			
Indicator		**Score**	**Review Comments/Recommendations**
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Describe the network availability/adequacy and use of alternative therapies to meet the needs of enrollees.
Description of Enrollees – 6.0 (out of a possible 12.0)			
13.	CCO describes its process for taking into account enrollee characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of enrollees.	1	**Comments** The CCO works with providers of culturally specific services to meet the needs of the members. Information was not provided taking into account member characteristics when making provider assignments. **Recommendation** For the next submission: • Describe the process for taking into account enrollee characteristics when making provider assignments, including analysis of language and cultural needs of enrollees.
13a.	• CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.	3	**Comments** Delegates monitor assignment, provider capacity, and office limitations on an ongoing basis.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.	1	**Comments** The CCO provided general information regarding specialty needs. The CCO did not provided analysis of the prevalence of diseases that require access to specialists among the enrollee population. **Recommendation** For the next submission: • Provide analysis of the prevalence of diseases that require access to specialists among the enrollee population.

Table 17. Yamhill Community Care Organization Results.			
Indicator		**Score**	**Review Comments/Recommendations**
15.	CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.	1	**Comments** Case management and authorization staff are available to coordinate services. Community health workers assist where appropriate. **Recommendation** For the next submission: • Further describe how enrollee needs for continuity of care and transition between levels of care are assessed.
Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs – 4.0 (out of a possible 12.0)			
16.	CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. • The CCO needs to describe how it uses the input from its community advisory council.	1	**Comments** Grievance and appeals information is reviewed by the CCO. **Recommendation** For the next submission: • Provide additional information regarding how the CCO incorporates member survey data and Community Advisory Council input when making network adequacy decisions.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Describe how the CCO uses technology to deliver team-based care and other innovations.
18.	CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Describe procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions to promote their own health.

Table 17. Yamhill Community Care Organization Results.			
Indicator		**Score**	**Review Comments/Recommendations**
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). • The CCO should address all levels within the organization, including leadership and provider network.	3	**Comments** The CCO demonstrates a commitment at all levels to culturally and linguistically appropriate services.
Coordination of Care – 15.0 (out of a possible 24.0)			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities	3	**Comments** Fully met
20a.	• Local public health authority	3	**Comments** Fully met
20b.	• Local mental health authority	3	**Comments** Fully met
20c.	• IHS and/or Tribal Health Clinics	3	**Comments** Fully met
21.	CCO discusses coordination with above stakeholders.	3	**Comments** The CCO described its relationships with the entities listed.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. • The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Discuss how interdisciplinary care teams are used to coordinate services across the continuum of care, and whether this is adequate to reduce hospital readmission and emergency room use.
23.	CCO describes its process for identifying and assessing all enrollees for special health care needs.	0	**Comments** This information was not provided. **Recommendation** For the next submission:

Table 17. Yamhill Community Care Organization Results.			
Indicator		**Score**	**Review Comments/Recommendations**
			• Describe the process for identifying and assessing all enrollees for special health care needs.
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Describe how the CCO uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.
Performance on Metrics – 1.0 (out of a possible 6.0)			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	0	**Comments** This information was not provided. **Recommendation** For the next submission: • Describe CCO's efforts to build network capacity for those metrics where the CCO's performance is below the baseline.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	**Comments** Claims data is reviewed to address capacity. **Recommendation** For the next submission: • Provide an analysis of patterns of underutilization and overutilization, and the actions the CCO has taken to address these.

APPENDIX A: Provider Capacity Report Review Results

Table A-1. Category of Service.																
Category of Service	All Care	CHA	CPCCO	EOCCO	Family Care	Health Share	IHN	JCC	PSCS-CO	PSCS-CG	Primary Health	Trillium	UHA	WOAH	WVCH	YCCO
Acute inpatient hospital psychiatric care	x	x	o	o	x	x	x	x	x	x	o	x	o	x	x	x
Ambulance and emergency medical transportation	o	x	o	x	o	x	x	x	x	x	o	x	x	x	x	x
Certified or qualified health care interpreters	o	o	o	o	x	x	o	o	x	x	o	x	x	x	o	o
Certified traditional health workers	x	x	o	o	o	x	o	o	x	o	o	x	x	x	x	x
Community prevention services	o	o	o	o	o	x	o	o	o	x	o	x	x	x	o	o
Dental services providers	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
FQHCs	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x
Health education, health promotion, health literacy	o	o	o	o	o	x	o	o	x	x	o	x	o	x	o	o
Home health	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x
Hospice	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x
Hospital	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Imaging	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x
Indian Health Service and Tribal health services	o	o	x	x	x	x	o	x	x	x	o	o	x	x	x	x
Mental health providers	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Table A-1. Category of Service.																
Category of Service	All Care	CHA	CPCCO	EOCCO	Family Care	Health Share	IHN	JCC	PSCS-CO	PSCS-CG	Primary Health	Trillium	UHA	WOAH	WVCH	YCCO
Mental health crisis services	x	o	o	o	x	x	x	o	x	x	x	x	x	x	x	x
Non-emergent medical transportation	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	o
Oral health providers	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Palliative care	o	o	x	o	x	x	x	x	x	x	o	o	x	x	x	x
Patient-centered primary care homes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Pharmacies and durable medical providers	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x
Post-hospital skilled nursing facility	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Primary care providers	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Rural health centers	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x
School-based health centers	x	o	x	x	x	x	o	x	x	x	x	o	x	x	o	x
Specialty practitioners	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Substance use disorders providers	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Traditional health workers	x	x	o	o	o	x	o	o	x	x	o	x	x	x	x	x
Urgent care center	o	o	x	o	x	x	x	x	x	x	x	x	x	x	x	x

Table A-1. Category of Service.															
Category of Service	All Care	CHA	CPCCO	EOCCO	Family Care	Health Share	IHN	JCC	PSCS-CO	PSCS-CG	Primary Health	Trillium	UHA	WOAH	WVCH	YCCO
Others not listed but included in the contractor's integrated and coordinated service delivery network	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

x = Present
o = Not present

Table A-2. Providers.																
	AllCare	CHA	CPCCO	EOCCO	Family Care	Health Share	IHN	JCC	PSCS-CO	PSCS-CG	Primary Health	Trillium	UHA	WOAH	WVCH	YCCO
Last name of physician or mid-level practitioner	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
First name of physician or mid-level practitioner	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Individual provider type code	x	x	x	x	o	x	x	x	o	x	o	x	x	x	x	x
Individual provider specialty type code	x	x/o	x	x	o	x	x	x	o	o	o	o	x	x	x	x
Provider NPI #	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
DMAP # (Medicaid ID)	x	o	x	x	o	x	x	x	x	x	x	o	x	x	o	x
Credentialing date	x	o	o	o	o	o	x	o	o	o	o	o	x	x	o	o
Non-English language spoken	x	x/o	x	o	x	x	x	x	x	x	x	o	x	x	x	x
Business practice address	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Business practice city	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Business practice ZIP code	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Table A-2. Providers.																
	AllCare	CHA	CPCCO	EOCCO	Family Care	Health Share	IHN	JCC	PSCS-CO	PSCS-CG	Primary Health	Trillium	UHA	WOAH	WVCH	YCCO
County	x	o	x	x	o	x	x	x	x	x	x	o	x	x	x	x
Phone	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Business provider type code	x	o	x	x	o	x	x	x	x	x	o	x	o	x	x	x
Business provider specialty code	x	o	x	x	o	x	x	x	o	o	o	o	o	x	x	x
Facility/business NPI #	x	o	x	x	o	x	x	x	x	x	x	x	x	x	x	x
PCPCH identifier	x	x/o	o	o	o	o	x	o	o	o	o	o	x	x	o	o
PCPCH tier	x	x/o	x	x	o	x	x	x	x	x	o	x	x	x	x	x
Number of members assigned to PCP	x	O	x	x	o	x	x	x	x	x	x	x	x	x	x	x
Open to new enrollees	x	O	x	x	o	x	x	x	o	o	o	x	x	x	o	x
In-network, Out-of-area	x	x/o	o	x	o	x	x	x	o	o	o	x	x	x	o	x

x/o = Not present for dental and behavioral health
x = Present
o = Not present

Table A-3. Crisis Services.

Mental Health Crisis Services	AllCare	CHA	CPCCO	EOCCO	Family Care	Health Share	IHN	JCC	PSCS-CO	PSCS-CG	Primary Health	Trillium	UHA	WOAH	WVCH	YCCO
Crisis service type	x	x	o	o	o	x	x	o	x	x	x	x	x	x	x	x
Business name	x	x	o	o	x	x	x	o	x	x	x	x	x	x	x	x
Business provider type code	x	o	o	o	o	x	o	o	o	o	o	o	x	x	o	o
Business provider specialty type code	x	o	o	o	o	x	o	o	o	o	o	o	x	x	o	o
Business practice address	x	o	o	o	x	x	x	o	x	x	x	x	x	x	o	o
Business practice city	x	o	o	o	x	x	x	o	x	x	x	x	x	x	o	o
Business practice ZIP code	x	o	o	o	x	x	x	o	x	x	x	x	x	x	o	o
County	x	o	o	o	o	x	x	o	x	x	x	x	x	x	o	o
Phone	x	o	o	o	x	x	x	o	x	x	x	x	x	x	o	o
Facility/ business NPI #	x	o	o	o	x	x	x	o	x	x	x	x	x	x	o	o
Non-English language spoken	x	x	o	o	x	x	x	o	x	x	x	x	x	x	o	o

x = Present

o = Not present