Oregon Health Authority Managed Care: 2017 External Quality Review Annual Report

March 2018

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

HealthInsight

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2017 External Quality Review Annual Report

March 2018

HealthInsight prepared this report under contract with the Oregon Health Authority (Contract No. 142877-04).

External Quality Review Director.....Jody Carson, RN, MSW, CPHQ

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

Project Manager–Quality.....Joyce Caramella, RN, CPHQ, CHC

Information Systems Capabilities Audit Manager .....Colleen Gadbois, MPAHA, PMP

Analytic Services Manager.....Sara Hallvik, MPH

QI Specialist.....Nancy Siegel, PA-C, MPH

Healthcare Information Systems Analyst/Auditor.....Art Bahrs, CISSP

Project Coordinator.....Ellen Gehringer

Project Assistant.....David Sobieralski

Writer/Editor.....Greg Martin, Erica Steele Adams

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Abbreviations and Acronyms Used in This Report

BC/DR	business continuity/disaster recovery
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CCO	coordinated care organization
CHW	community health worker
CMS	Centers for Medicare & Medicaid Services
DPN	dental provider network
DSN	delivery system network
ED	emergency department
EDV	encounter data validation
EHR	electronic health record
EQR	external quality review
ISCA	Information Systems Capabilities Assessment
MAT	medication-assisted treatment
MMIS	Medicaid Management Information System
NEMT	non-emergent medical transportation
OHA	Oregon Health Authority
OHP	Oregon Health Plan
PCPCH	patient-centered primary care home
PIP	performance improvement project
PMV	performance measure validation
QA/PI	quality assessment and performance improvement
QHOC	Quality and Health Outcomes Committee
QI	quality improvement
SBIRT	Screening, Brief Intervention and Referral to Treatment
SHCN	special health care needs

Acronyms for individual CCOs are listed on page 12.

EXECUTIVE SUMMARY

Oregon implemented coordinated care organizations (CCOs) in 2012 to deliver managed care for Medicaid recipients, following approval of the state's 1115 Medicaid Demonstration waiver by the Centers for Medicare & Medicaid Services (CMS). The contracted CCOs manage physical, behavioral and dental health services and non-emergent medical transportation (NEMT) services for Oregon Health Plan (OHP) members across the state.

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

The major review areas for 2017 were:

- *Compliance* with federal and state regulations and contract provisions governing managed care delivery
- *Validation of statewide performance measures*, including a follow-up review of the CCOs' progress in addressing findings from the 2016 Information Systems Capabilities Assessment (ISCA) of CCO information systems, data processing and reporting procedures
- *Validation of performance improvement projects (PIPs)* that the CCOs conducted with the goal of improving care for OHP members, including a Statewide PIP

HealthInsight reviewed the activities of all CCOs (including FamilyCare, which ceased operating as a CCO as of February 2018) and reported the results for each CCO, identifying specific strengths and areas for improvement. This annual report summarizes the CCO reviews, focusing on common strengths and improvement needs. Detailed profiles of the individual CCO reviews appear in Appendix A.

HealthInsight also conducted a review of Greater Oregon Behavioral Health, Inc. (GOBHI), a managed mental health organization. Results of that review appear in a separate section of the report narrative.

Compliance Review

In 2017, HealthInsight evaluated the CCOs' compliance with regulations and contract provisions related to enrollee rights, grievance systems and program integrity. HealthInsight had conducted a compliance review of those same topics in 2014. The 2017 review included following up on compliance findings noted in 2015 but not resolved as of the 2016 annual review.

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

The CCOs continue to increase the number of patient-centered primary care homes (PCPCHs) and the number of enrollees served by them. In 2017, the Transformation Center revised the PCPCH recognition criteria to recognize practices on the forefront of transformation, moving from a three-tier system to a five-tier/five-star system. The CCOs have used transformation funds to initiate innovative projects to transform care, and many of those projects have been incorporated into day-to-day CCO operations.

Overall strengths

- The CCOs do a good job of informing members of their rights through the CCOs' member handbooks, websites, provider manuals, contracts and agreements and additional member-facing materials.
- All CCOs make materials available in prevalent non-English languages and alternate formats. All CCOs ensure that language interpreter services are available at no cost for non-English languages. Customer service contact information is readily available to members.
- CCOs have made progress in communicating managed care requirements and information to providers to ensure the delivery of timely, high-quality services to members.
- CCOs use a variety of methods to gather input from members about their satisfaction with services and to identify service gaps.
- Many CCOs have initiated cultural diversity and competency strategies.
- Most CCOs have fully integrated grievance system policies that include expectations for physical, dental and mental health.

- All CCOs have made strides in meeting grievance system requirements, including:
  - monitoring the enrollee notification process and assisting members in addressing grievance and appeal needs
  - overseeing the delegation and monitoring of grievances and appeals
- Most CCOs have comprehensive compliance programs that include training, effective communication and management practices designed to guard against fraud and abuse.

Major areas for improvement and recommendations

HealthInsight offers recommendations in the following areas for OHA to help the CCOs address their improvement needs.

Monitoring enrollee rights. Many CCOs monitor enrollee rights through grievances, but do not gather complaints from every provider. Other than by monitoring through grievances, some CCOs lack processes for monitoring:

- the quality and timeliness of translation or interpretive services and information provided in alternate formats
- the existence of advance directives and declarations for mental health treatment in members' clinical records, or evidence that those directives have been offered
- the use of seclusion and restraint, to ensure the member's right to be free from coercion, discipline, convenience, or retaliation

OHA needs to encourage the CCOs to monitor enrollee rights in a manner that will inform the CCO of areas that need attention.

Member information. Most CCOs have had difficulty providing member-facing materials in easily understood language, including grievance response letters, notices of action and notices of appeals resolution.

OHA needs to provide guidance and support to the CCOs to meet information readability standards.

Many CCOs do not provide required information to their members about all providers, particularly mental health providers. Although most CCOs enable free choice of physical and dental care providers, most CCOs do not offer free choice of mental health providers. Rather, the CCO lists a mental health agency

with which members can make appointments for intake and assessment, and providers are assigned at that time.

> ***OHA needs to clarify which providers should be included in CCOs' provider directories, and continue to require the CCOs to provide all mandated information on all providers to ensure that members have access to the necessary information to make informed choices of providers.***

Advance directives and declarations for mental health treatment. Most CCOs' policies on these directives are not comprehensive, i.e., do not address dental, physical and mental health and do not direct coordination of these directives among dental, physical and mental health providers. Often the CCOs have not monitored clinical records to determine whether members have these directives in place or have been offered these directives. Few CCOs provide community education on these directives outside of the member materials.

> ***OHA needs to clarify expectations for the CCOs regarding integrated policies and coordination of advance directives and declarations for mental health treatment, including monitoring of members' clinical records.***

Content of notices. Most CCOs are challenged to provide all necessary content in notices of action and notices of appeals resolution.

> ***OHA needs to continue to support CCOs in ensuring that notices to members regarding grievances and appeals contain all required content and meet standard disposition timelines.***

Gathering grievances. Although most CCOs monitor enrollee rights via their grievance systems, few CCOs gather grievances from all providers and delegates. Most CCOs review and act only on grievances they receive directly. Very few mental health grievances are gathered. If not all grievances are addressed and analyzed, it is difficult to know whether enrollee rights are being monitored adequately.

> ***OHA needs to continue to work with the CCOs to ensure that grievances are gathered and reported consistently as expected. OHA may need to define what constitutes a grievance, which grievances need to be reported and whether they need to be gathered from all providers.***

Adjudication of final appeals. More than half of the CCOs do not serve as the final adjudicator of appeals, as required by contract, but rely on delegated entities to make the final adjudication. Some CCOs consider the state fair hearing to be the final appeal.

OHA needs to clarify the definition of final adjudication of appeals.

Certifications. Most CCOs face challenges in ensuring that certifications are in place for all appropriate individuals (providers, subcontractors, staff, governing board members, volunteers, etc.), including:

- disclosure of ownership or controlling interests in the business entities and suppliers that deliver services to CCO members
- disclosure of conflicts of interest
- disclosure of vendor relations, gifts and other compensations
- criminal background checks for required individuals
- monthly screening for exclusion from participation in federal health care programs

OHA needs to clarify expectations for CCOs regarding which certifications are required and which individuals need to be included.

Program integrity. Some CCOs do not have mechanisms in place for routine monitoring and auditing of the CCO, providers and subcontractors, or their risk assessment does not assess fraud and abuse.

OHA needs to continue to support CCOs in developing effective compliance programs that include ongoing monitoring and auditing of the CCO, providers and subcontractors to address identified risks.

For more details, see the compliance review section beginning on page 25.
Review results for individual CCOs appear in Appendix A.

Performance Measure Validation (PMV)

Of the state's 18 incentive performance measures for CCOs in 2016, 7 measures were calculated using only encounter data that OHA collects and maintains. As directed by OHA, HealthInsight reviewed those seven measures to determine whether the data used to calculate the measures were complete and accurate and whether the calculation adhered to CMS specifications.

The associated ISCA activities examined state and CCO information systems and data processing and reporting procedures to determine the extent to which they supported the production of valid and reliable performance measures.

PMV results

HealthInsight assigned a "substantially met" score to all seven incentive measures reviewed, consistent with scoring for the measures that HealthInsight validated in 2016. The code review and measure calculation process for these measures is adequate, but the measures were not scored "fully met" because HealthInsight still has concerns about the validity of the data used to calculate the measures.

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

For additional details, see pages 43–47.

ISCA follow-up results

HealthInsight conducted a follow-up review of OHA's data management and reporting systems, and of the individual CCOs' progress in addressing the findings of the full ISCA review performed in 2016. In addition, as directed by OHA, HealthInsight conducted a full ISCA review of four dental provider networks (DPNs) that contract with the majority of CCOs.

The state ISCA review found that OHA had resolved one of four findings from 2016 by developing a Submission Tracker report that displays the status of encounter data submissions. OHA's customer service representative sends this report to each CCO for review and remediation.

OHA is still working to resolve three other findings from 2016, two of which relate to OHA's business continuity/disaster recovery (BC/DR) plan and the contract requirements for CCOs' BC/DR plans. The fourth finding relates to the CCOs' nonperformance of EDV activities that would help ensure the accuracy and reliability of encounter data. OHA is researching how to implement EDV within the agency's Program Integrity Team.

OHA needs to:

- ***Continue progress on its BC/DR plan to fully implement and test the plan. Best practice would include a detailed, documented and fully communicated BC/DR plan, a documented test plan, documented test results and an action plan based on test results.***
- ***Encourage each CCO to finish developing and testing its BC/DR plan. The BC/DR plan should ensure that each business has thought through details of keeping services running during a disaster and ensuring that key personnel are trained and knowledgeable of their responsibilities during a disaster.***
- ***Encourage CCOs to continue to develop strong delegate and provider oversight processes to ensure that information system functions, including hardware destruction processes, adhere to industry norms and CCO expectations.***
- ***Ensure that CCOs are completing their own EDV activities, or OHA needs to fully implement EDV within its Program Integrity Team. OHA needs to communicate its decision and expectations to each CCO and ensure agreement on responsibilities. Best practice would include a written agreement including service-level agreement aspects.***

During 2017, most CCOs showed progress toward resolving their 2016 ISCA findings, and seven organizations succeeded in resolving findings.

Review sections of major concern for the CCOs include Security, Information Systems, Administrative Data and Provider Data. The ISCA reviews identified specific weaknesses in each of those sections. Information system (IS) security concerns outweighed all others. Overall, the CCOs need to improve their IS security and their monitoring of delegated providers' IS security. Significant aspects of security include BC/DR preparedness, system security and access controls such as password management. For more details, see the ISCA section beginning on page 48.

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

CCO Performance Improvement Projects (PIPs)

The managed care contract requires the CCOs to conduct PIPs that are "designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and nonclinical areas that are expected to have favorable effect on health outcomes and OHP Member satisfaction." The CCOs must conduct three PIPs and one focus study targeting improvements in care in designated quality improvement (QI) focus areas. One of the required PIPs is being conducted as a statewide collaborative and addresses the integration of primary care and behavioral health.

Statewide PIP

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

HealthInsight is responsible for facilitating and documenting the overall PIP in accordance with CMS guidelines. CCOs are responsible for developing their own interventions and for documenting their progress in quarterly reports submitted to OHA. At the end of the second remeasurement period (January 1–December 31, 2017), CCOs were asked to summarize their progress on this PIP, including achievement of study targets. At the time of this annual report, HealthInsight is reviewing the CCO reports. Each CCO will receive an evaluation (met, partially met or not met) for the degree of completeness, clarity and consistency in addressing each of the evaluation criteria. Updated results of the Statewide PIP appear on pages 64–70.

The CCO profiles in Appendix A report each CCO's interventions, barriers and next steps for the Statewide PIP, as well as the topics of additional PIPs and focus projects the CCO conducted in 2017. Appendix B reports the interim results of the Statewide PIP.

Delivery System Network Reporting

Federal and state regulations governing Medicaid services require each managed care contractor to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. Each contractor must submit evidence to the state Medicaid authority demonstrating the contractor's capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care.

OHA requires the CCOs to submit their individual Delivery System Network (DSN) reports for state review by July 1 every year. As part of the 2017 EQR, OHA asked HealthInsight to evaluate and score the CCOs' 2017 DSN reports. HealthInsight reviewed the reports and delivered summary analysis and recommendations to OHA in the DSN report for each indicator, as well as a review of each CCO's submission.

> ***CCOs need to continue to work toward ensuring access to services for all enrollees.***
>
> ***CCOs need to analyze and monitor the capacity of their entire service delivery networks to ensure an appropriate distribution of services and to identify service gaps or disparities.***

For more details, see pages 73–74.

OHP Member Satisfaction Surveys

As in previous years, HealthInsight surveyed OHP members who had received mental health services to determine their satisfaction with those services. The survey of adults who received outpatient services achieved a response rate of 22%, up from 18% in 2016. The Youth Services Survey for Families also had a 22% response rate from children's caregivers, similar to previous years, and the Youth Services Survey of young people age 14 to 18 years had a 23% response rate, up from 22% in 2016. HealthInsight delivered the results of these surveys to OHA in separate reports.

INTRODUCTION

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

Review activities

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

- a review every three years of health plan compliance with federal and state regulations and contract provisions regarding access to care, managed care structure and operation, quality measurement and improvement and program integrity
- annual validation of PIPs, a required element of health plans' QI programs
- annual validation of performance measures reported by plans or calculated by the state, including an ISCA

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

In 2017, HealthInsight conducted its second full review of the CCOs' compliance with Enrollee Rights, Grievance Systems and Certifications and Program Integrity standards; conducted PMV-related activities, including ISCA follow-up reviews; facilitated and documented the Statewide PIP, evaluated CCO-specific PIPs and provided feedback to OHA. These review activities addressed the following questions:

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

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

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

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

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

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

Oregon's Coordinated Care Organizations

More than 9 out of 10 OHP members receive managed care through a CCO. After extending Medicaid coverage to additional Oregonians as authorized by the federal Affordable Care Act, OHP now covers more adults (60%) than children (40%). Table 1 displays the CCOs and their enrollment totals as of November 2017 (before the closure of FamilyCare).

Table 1. OHP Enrollment by CCO, November 2017.

CCO	Total enrollees
AllCare Health Plan	49,279
Cascade Health Alliance (CHA)	17,694
Columbia Pacific CCO (CPCCO)	24,987
Eastern Oregon CCO (EOCCO)	46,520
FamilyCare CCO	117,693
Health Share of Oregon (HSO)	207,742
Intercommunity Health Network (IHN)	54,318
Jackson Care Connect (JCC)	30,406
PacificSource Community Solutions–Central Oregon (PSCS-CO)	47,454
PacificSource Community Solutions–Columbia Gorge (PSCS-CG)	11,907
PrimaryHealth of Josephine County (PHJC)	10,039
Trillium Community Health Plan (TCHP)	90,339
Umpqua Health Alliance (UHA)	25,785
Western Oregon Advanced Health (WOAH)	19,880
Willamette Valley Community Health (WVCH)	97,464
Yamhill Community Care Organization (YCCO)	24,711
Total	**876,218**

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

OHA's QI activities

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

OHA's Transformation Center is the innovation and QI hub for Oregon's health system transformation efforts. The center offers Transformation Fund Grant Awards to CCOs to support innovations in health care delivery. These grants have supported a wide range of CCO projects.[1] The center also administers the Patient-Centered Primary Care Home program, which offers technical assistance to help primary care clinics transform to PCPCHs. OHA requires the CCOs to include PCPCHs in their care delivery networks to the extent possible.

In addition to statewide performance measures that OHA must report to CMS, OHA uses 17 incentive metrics to evaluate CCOs' performance and to hold them accountable for improved outcomes. Under the pay-for-performance program, OHA holds back a percentage of monthly payments to CCOs to form a "quality pool" from which CCOs can earn incentive payments.

The Transformation Center provides targeted technical assistance to CCOs on specific incentive measures and publishes semiannual performance reports. The 2016 final performance report indicated continuing improvements in areas such as adolescent well-care visits, dental sealants, developmental screening for young children, effective contraceptive use among women at risk of unintended pregnancy, and health assessments for children in Department of Human Service (DHS) custody, while several other measures showed room for improvement.

As the quality pool model continues, the performance targets and benchmarks become harder for CCOs to meet or exceed. In 2016, the quality pool amount rose to 4.25% of monthly payments to CCOs, totaling almost $179 million. While all CCOs showed improvement on a majority of measures, only seven CCOs earned the full amount of their quality pool dollars.[2]

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[1] See http://www.oregon.gov/oha/hpa/csi-tc/pages/index.aspx.

[2] Oregon Health Authority, Office of Health Analytics. Oregon's Health System Transformation: CCO Metrics 2016 Mid-Year Report. Available online: http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2016-Final-Report.pdf.

OHA reports to the legislature regularly on the progress of Oregon's health care transformation. OHA's quarterly legislative report presents data related to OHP demographics, CCO performance on quality metrics, member satisfaction, health disparities, finance, PCPCHs, eligibility and enrollment and other topics.[3]

Managed care quality strategy

42 CFR §438.330 requires each state Medicaid agency contracting with managed care organizations to develop and implement a written strategy for assessing and improving the quality of managed care services.

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

OHA's Quality Strategy describes how CCOs will be held accountable for a model of care that relies on increased transparency, clear expectations and incentives for improvement. Key elements have included creation of the Transformation Center and Innovator Agents; learning collaboratives and technical assistance; health equity initiatives to reduce disparities; and use of PCPCHs, community advisory councils, community health workers (CHWs) and alternative payment models. In 2017, OHA developed a Transformation and Quality Strategy for CCOs to replace the CCO Transformation Plan and Quality Assessment and Performance Improvement deliverables, beginning in 2018. According to OHA, this streamlined approach aims to move health transformation by allowing CCOs to internally coordinate and align all of their transformation and quality work.[4]

Behavioral health initiatives

OHA developed its 2015–2018 Behavioral Health Strategic Plan with input from state mental health advisory committees and stakeholders across Oregon. The plan identifies six strategic initiatives aimed at building and expanding an

[3] Oregon Health Authority. Oregon's Health System Transformation Quarterly Legislative Report, Q4 2016. Available online: http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/1115Waiver/Second%20Quarter%202017.pdf.

[4] See http://www.oregon.gov/oha/HPA/CSI-TC/Pages/Transformation-Quality-Strategy.aspx.

integrated, coordinated and culturally competent behavioral health system. Key principles include health equity, access to care, behavioral health promotion and prevention, and supporting successful recovery in the community.[5]

In late 2016, OHA received a two-year demonstration grant award to establish Certified Community Behavioral Health Clinics (CCBHCs), as part of an eight-state demonstration program representing the single largest federal investment in community behavioral health in more than 50 years. The CCBCHs will serve adults with serious mental illness, children with serious emotional disturbance and those with long-term and serious substance use disorders, as well as others with behavioral health issues. Among other benefits, the program includes primary care delivery and coordination within CCBHCs.[6]

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

Consumer surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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

Mental health services surveys

On behalf of OHA, HealthInsight conducts the annual Mental Health Statistics Improvement Program (MHSIP) Consumer Survey for Adults, the Youth

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

6 See http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Community-BH-Clinics.aspx.

Services Survey for Families (YSS-F) and the Youth Services Survey (YSS).[7] OHA adds questions to each survey to collect additional data to help evaluate the progress of ongoing programs.

Adult survey results. In 2017, HealthInsight distributed a survey to adults who had received outpatient mental health services through OHP, and to adults in residential treatment or foster care, during July–December 2016. The survey was mailed to 10,946 adults who had received outpatient services and to 1,474 adults in residential or foster care. The outpatient survey received responses from 2,439 enrollees for a response rate of 22%, up from 18% in 2016.[8]

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

Overall domain satisfaction has risen significantly over the past five years in all domains except social connectedness. In 2017, women were more satisfied than men in six of the seven domains. The percentage of outpatient respondents who needed but did not receive services in the areas of corrections, developmental disabilities, drug and alcohol treatment, employment services and physical health services has trended significantly downward over the past five years.

Youth survey results. The overall sample size for the youth surveys increased by about 10,000 in 2017 with an increase in the YSS sample plus the first-time inclusion of CCBHCs.

The YSS-F asked about caregivers' perception of services delivered for their children during May–December 2016 in seven domains: access to services, appropriateness of services, cultural sensitivity, daily functioning, family participation in treatment, social connectedness and treatment outcomes. The YSS-F had an overall response rate of 22%, similar to previous years, with 4,305 responses from caregivers of 19,270 children.[9]

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[7] MHSIP is supported by the Substance Abuse & Mental Health Services Administration of the U.S. Department of Health and Human Services. The YSS-F is endorsed by the National Association of State Mental Health Program Directors.

8 HealthInsight. 2017 Oregon Mental Health Statistics Improvement Project Survey for Adults – Outpatient and Residential. January 2018.

9 HealthInsight. 2017 Oregon Youth Services Survey for Families and Youth Services Survey Report. December 2017.

The YSS asked young people age 14 to 18 years about their perceptions of services they received. The YSS, like the YSS-F, included a cluster of questions designed to assess the youths' perceptions of various aspects of access, appropriateness, cultural sensitivity, participation and outcomes. The YSS also asked young people about where they had lived in the past six months, school absences, utilization of health care services, medication for emotional/behavioral problems and arrest history. The YSS received 2,333 responses from 10,052 adolescents who received a survey, for an overall response rate of 23%, up from 22% in 2016.

Satisfaction levels reported by caregivers of children and youth in outpatient treatment trended significantly upward in the appropriateness, treatment outcomes and daily functioning domains. Caregivers of children and youth in psychiatric residential and day treatment reported significantly lower satisfaction in these domains. Satisfaction levels in some domains varied significantly according to the respondent's race or ethnicity.

Looking at the YSS, no domains showed a significant upward or downward trend in satisfaction reported by the young respondents. The outpatient group was more satisfied than the psychiatric residential and day treatment group in all domains, and significantly more so in the cultural sensitivity domain.

The YSS sample is pulled directly from the YSS-F sample; therefore, both the caregiver and young person could respond to their respective surveys. Comparing the responses of pairs of caregivers and youth, significantly more caregivers were satisfied than their adolescent children (ages 13–17) in the access, treatment outcomes and participation in treatment domains.

RESULTS

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

Access, as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined by federal regulations. Factors influencing access include availability of appointments, the enrollee's ability to see a specialist, adequacy of the health care network and availability of translation and transportation services.

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

Quality, as it pertains to EQR, means the degree to which a managed care entity increases the likelihood of desired outcomes for its enrollees through the entity's structural and operational characteristics; the provision of services consistent with current professional, evidence-based-knowledge; and interventions for performance improvement. Quality encompasses access and timeliness as well as the process of care delivery and the experience of receiving care.

Access

Strengths

- All CCOs experienced large increases in enrollment in 2014 due to Medicaid expansion. The CCOs continue to make progress in expanding access to and coordination of primary care, behavioral health care and dental care; in providing specialists to meet members' needs; and in providing NEMT services. Strategies for improving access include:
    - co-locating mental health and substance use disorder treatment practitioners in primary care clinics

  - co-locating physical health practitioners in mental health clinics (behavioral health home/CCBCH model)
  - co-locating dental care at some clinics and school-based health centers
  - authorizing timely out-of-network services when needed
  - using geo-access software to identify participating and non-participating providers in relation to members' addresses
  - expanding hours of operation for mental and physical health providers
  - analysis of emergency department (ED) utilization, out-of-network service utilization and second opinions to identify gaps, improve network adequacy and improve access
  - proactive calls to ensure that new members know their benefits and receive assistance in setting up appointments
  - home visits by dental, physical health and mental health providers
  - use of telemedicine

- As of March 2017, 495 PCPCHs were recognized under the revised standards,[10] with all CCOs working to increase the percentage of their members enrolled in a PCPCH. The program has transitioned from a three-tier to a five-tier designation to encourage clinics to continue to transform care. Many CCOs offer innovative payment incentives to recognized PCPCHs.
- All CCOs have focused on improving the timeliness of NEMT services. One CCO has developed an alternative payment structure with its NEMT provider to encourage timely access to high-quality services. Many CCOs use flexible funding to provide non-qualifying trips for their members that have a positive impact on members' health.
  One CCO worked with its NEMT provider to help transport people out of a major fire area. Several CCOs have developed corrective action plans or contracted with new NEMT providers to address challenges affecting access to Medicaid services for their members.
- All CCOs provide key materials in other languages and formats and linguistic services to non-English speaking members to help improve access to services.

[10] See http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/1115Waiver/Second%20Quarter%202017.pdf.

Areas for improvement

- CCOs continue to struggle with integrating dental care into their delivery systems. Many CCOs and DPNs have taken formal steps to work together to integrate care and meet managed care requirements.
- OHA's first quarter 2017 report to CMS identified access to providers and services as the category with the most grievances and complaints across CCOs.[11] More work is needed to improve access to care in rural areas, and to improve processes for identifying and coordinating care for members with special health care needs (SHCN). To address these needs, some CCOs have increased after-hours availability, recruited and retained additional providers and used mobile units to serve rural communities. A few CCOs have contracted with nonparticipating providers willing to serve members with SHCN.

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

- Most CCOs contract with most providers in their area, yet lack methods to analyze access to all required services. Some CCOs lack system-wide mechanisms to monitor network adequacy and capacity to ensure timely access to all required services.

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

- As of mid-2017, though appointments for adolescent well-care visits across the state continued to improve, only two CCOs met the benchmark for this incentive performance measure. OHA took a "deeper dive" into this topic to analyze and explore utilization patterns.[12]
- Health assessments for children in DHS custody have decreased slightly since 2016. Two CCOs met the benchmark for this incentive measure as of mid-2017.

[11] See http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/1115Waiver/CCO%20Complaints%20and%20Grievances%20Summary%2C%20January-March%202017.pdf.

[12] See http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/2017-mid-year-deeper-dive.pdf.

Timeliness

Strengths

- Several CCOs proactively contact members to make sure they know about their benefits and providers, including NEMT, dental and behavioral health, and to help members set up appointments.
- Statewide, the percentage of children receiving screening for developmental, behavioral and social delays has more than tripled since 2011. All CCOs showed improvements on this incentive performance measure by mid-2017 over the previous year.
- All CCOs have developed policies and procedures addressing the required time frames for informing members of service authorization decisions, and have begun monitoring their delegates to ensure the timeliness of routine and expedited authorization decisions.
- Member handbooks include information on the time frames related to CCO services.

Areas for improvement

- Most CCOs do not closely monitor the timeliness of access to routine, urgent and emergent mental health services, substance use disorder treatment, dental care or NEMT services.
- Most CCOs do not analyze their networks to ensure that they meet the standards for members' time and distance to appropriate providers.
- Avoidable ED utilization continues to require attention, to ensure that members are not visiting the ED due to inability to gain timely access to primary care, dental and mental health services.

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

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

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

Quality

Strengths

- All CCOs made progress on integrating physical, behavioral and dental health care during 2017.
  - Some CCOs have hired behavioral health managers, dental managers and administrative staff to help facilitate service integration. Although there is still much room for improvement, CCO policies and procedures are increasingly integrated to align expectations and operations across CCO services. Many CCOs continue to work with the contracted DPNs to coordinate expectations, regulations and requirements.
  - Several CCOs meet monthly with mental health and substance use disorder treatment providers and Aging and People with Disabilities staff. Some CCOs jointly develop care plans for enrollees engaged in care with multiple systems. All CCOs' care management staff follow up on enrollee referrals to specialists.
- Several CCOs are surveying their members to determine satisfaction with their providers and CCO services.
- Many CCOs have made strides in the areas of health equity and cultural considerations.
  - Some CCOs have recruited culturally specific providers to fill identified gaps in their service array.
  - Many CCOs have recognized the importance of using qualified and certified health care interpreters. Training has been provided statewide. Many CCOs use CHWs as certified health care interpreters.
  - One CCO has a comprehensive health equity program focusing on social determinants of health, which includes training for certified interpreters. The staff and community partners have participated in cultural humility training.
- All CCOs continue to take part in the Statewide PIP to improve the safety of opioid management. This PIP has assisted the CCOs in implementing strategies to reduce inappropriate prescribing of opioids, developing practice guidelines related to opioid prescribing and collaborating within their communities to reduce inappropriate use of opioids and offer alternative treatment options for members with chronic pain.

- All CCOs have begun work on their Transformation and Quality Strategy (TQS) plans to coordinate and streamline their efforts to meet the Triple Aim of better health, better care and lower costs. The TQS goals include working to support sharing of CCOs' best practices, health transformation through innovation and quality methods, and state monitoring of CCO progress.

Areas for improvement

- **Grievances**. OHA's second quarter (March 2017) report to CMS identified 1,737 complaints about access to providers and services; 1,240 complaints related to interactions with providers or plans; 283 quality-of-care issues and 110 quality-of-service issues, among 3,930 complaints received by all CCOs that quarter. In part, the reported increases in some categories are due to changes in how complaints are reported to CCOs.

  CCOs need to continue to work with OHA to gather and report grievances in a consistent manner to address member concerns related to the quality of care and services provided.

- **Care integration.** The CCOs have made progress toward care integration, but more work is needed.

  - *Policies/procedures and provider manuals.* More CCOs' policies and manuals address integrated care, but there is room for improvement. For example, policies and procedures need to address second opinions not only in primary care but in mental health, substance use disorder treatment and dental care. Many CCOs lack policies that cover all contractual and regulatory requirements. Policies need to be approved by a CCO-level authority, and all providers need guidance on how the CCO expects compliance issues to be handled.

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

  - *Mental health and dental care.* Policies and practices for integrating these services into the CCOs' delivery networks continue to lag. In many CCOs, mental health provider agencies amount to a separate specialty

care delivery system. In some cases, the DPNs are fully autonomous with little CCO oversight.

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

COMPLIANCE REVIEW

In 2014, HealthInsight (then Acumentra Health) reviewed the CCOs' compliance with enrollee rights, grievance systems and program integrity standards. In 2015, HealthInsight reviewed the CCOs' compliance with QA/PI standards. In 2016, HealthInsight followed up with each CCO regarding the steps it had taken to address its 2014 and 2015 compliance findings and recommendations.

In 2017, HealthInsight conducted its second full review of compliance with enrollee rights, grievance systems and program integrity standards. The annual review also followed up on 2015 findings that were not yet resolved as of the 2016 review date. Results of that review are reported below.

Review Procedures

The three compliance review sections in 2017 were:

1. **Enrollee Rights:** Assess the degree to which the CCO had written policies in place on enrollee rights, communicated annually with enrollees about those rights and made that information available in accessible formats and language that enrollees could understand.
2. **Grievance Systems:** Evaluate the CCO's policies and procedures regarding grievance and appeal processes and state fair hearings and the CCO's process for monitoring adherence to mandated timelines.
3. **Certifications and Program Integrity:** Assess whether the CCO had systems in place to avoid conflicts of interest; mechanisms to monitor for exclusion of persons and entities from participating in Medicaid programs; and administrative and management arrangements or procedures, including a compliance plan, designed to guard against fraud and abuse.

Each review section covered the specific review elements and corresponding sections of 42 CFR §438, OHA's contract with the CCOs, Oregon Administrative Rules and other state regulations where applicable. HealthInsight's review tool and scoring plan were adapted from CMS guidelines and approved by OHA. HealthInsight used each CCO's written documentation and responses to interview questions to score the CCO's performance on each review element on a scale from 1 to 4 (see Table 2).

Table 2. Scoring Scheme for Elements in the Compliance Review.	
Rating	**Score**
Fully met	4
Substantially met	3
Partially met	2
Not met	1

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

3.5 to 4.0 = Fully met

2.75 to 3.4 = Substantially met

1.75 to 2.74 = Partially met

< 1.75 = Not met

In scoring each section, HealthInsight assigned "findings" for areas in which the CCO did not fully comply with federal and/or state requirements.

Summary of CCO Review Results

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

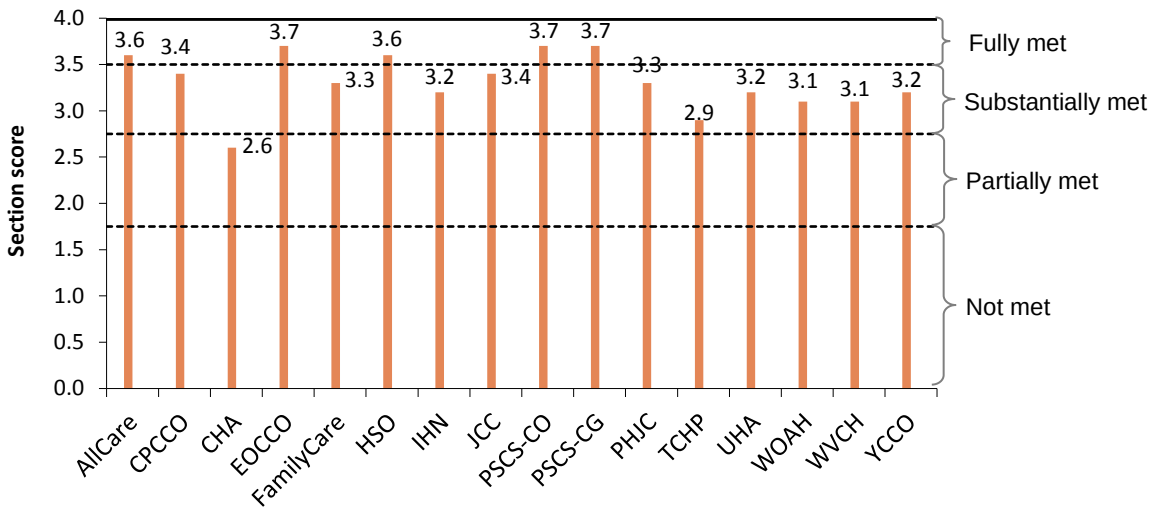
Table 3. Average CCO Compliance Scores.		
Section	**Score**	**Rating**
Enrollee Rights	3.2	Substantially met
Grievance Systems	3.5	Fully met
Certifications and Program Integrity	3.7	Fully met

Section 1: Enrollee Rights

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

As shown in Figure 1, the majority of CCOs substantially met the requirements for Enrollee Rights. Five CCOs fully met the requirements, while one CCO partially met the requirements.

Figure 1. CCO Compliance Scores: Enrollee Rights.



Major strengths

Member information. All CCOs use integrated member handbooks to communicate enrollee rights. All CCOs offer oral interpretation in prevalent non-English languages, whether in person or via a language line, and provide written information in non-English languages and in alternate formats. All CCOs notify their members of how to obtain this information. Most CCOs describe available benefits in sufficient detail to ensure that members understand the benefits to which they are entitled and how to obtain benefits. Most CCOs inform their members on the availability of out-of-network services.

All CCOs provide information to members on:

- emergency services and how to obtain them
- members' right to participate in decisions regarding their health care and to receive information on available treatment options and alternatives, including the right to refuse treatment
- advance directives
- upon request, information on the structure and operation of the CCO and physician incentive plans

Most CCOs provide customer service contact information in member handbooks, websites and other member materials.

Communications with providers. Most CCOs' contracts with providers do not prohibit or restrict providers from advising or advocating on behalf of members regarding treatment options. One CCO supplies all providers with an instruction card for over-the-phone interpreting services. This simple tool provides all the necessary information in an easily posted, half-page document. Most CCOs have developed information for providers on member rights and responsibilities, member benefits, authorizations, out-of-network services, etc.

Member satisfaction. CCOs use a variety of methods to gather input from members about their satisfaction with services and to identify service gaps. One CCO annually surveys member satisfaction with access to care and with CCO providers that take part in the CCO's alternative payment methodologies. One CCO proactively calls members who receive services from non-contracted providers to ensure that services were provided and that no billing concerns arose. The CCO contracts with these providers or develops letters of agreement to ensure a smooth process for access to care.

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

Cultural diversity and competency. Many CCOs have initiated cultural diversity and competency strategies. One CCO developed a comprehensive health equity program focusing on social determinants of health, which includes training for certified interpreters. All staff of this CCO attend cultural humility, cultural agility and gender identity training that is also available to staff of partner and

community organizations. This CCO has provided Adverse Childhood Experiences Survey training for local schools (including bus drivers).

Advance directives and declarations for mental health treatment. Some CCOs include physical and dental health providers when outlining the requirements for offering and executing advance directives. These CCOs specify why and when an advance directive may be required for dental services. All CCOs provide information to adult enrollees, or to the family or surrogate if the enrollee is incapacitated, about their right to make decisions about or formulate an advance directive. Most CCOs inform members and families that they can complain to OHA about noncompliance with directives.

Major areas for improvement

Monitoring enrollee rights. Many CCOs monitor enrollee rights through grievances, but do not gather complaints from every provider. Other than by monitoring through grievances, some CCOs lack processes for monitoring:

- the quality and timeliness of translation or interpretive services and information provided in alternate formats
- the existence of advance directives and declarations for mental health treatment in members' clinical records, or evidence that those directives have been offered
- the use of seclusion and restraint, to ensure the member's right to be free from coercion, discipline, convenience, or retaliation

OHA needs to encourage the CCOs to monitor enrollee rights in a manner that will inform the CCO of areas that need attention.

Member information. Most CCOs do not provide required information on all network providers in the member's service area, including providers' names, locations, telephone numbers and non-English languages spoken, and whether or not the providers are accepting new patients.

OHA needs to clarify which providers should be included in CCOs' provider directories, and continue to require the CCOs to provide all mandated information on all providers to ensure that members have access to the necessary information to make informed choices.

Moral or religious objections. No CCO stated any moral or religious objections to providing benefits as required by the contract. However, the CCOs do not request this information from their subcontractors or providers. The CCOs have received few, if any, complaints in this area, but contracts between CCOs and their providers are not clear about decisions made on moral or religious grounds, and the CCOs do not always collect grievances from providers.

OHA needs to clarify its expectations regarding the responsibility of first-tier, downstream and related entities to declare any moral or religious objections to providing covered services, to ensure that all benefits are available to members.

Free choice of providers. Although most CCOs provide free choice of physical health and dental care providers, most CCOs do not offer free choice of mental health providers. Rather, the CCO lists a mental health agency with which members can make appointments for intake and assessment, and providers are assigned at that time.

OHA needs to continue to work with CCOs to ensure members' free choice of providers, specifically mental health providers.

Emergency and post-stabilization services. Many CCOs lack definitions of dental and mental health emergencies and how to obtain these emergency services. Most CCOs' member materials fail to define and explain post-stabilization services.

OHA needs to continue to assist CCOs in defining dental and mental health emergencies (as well as physical health emergencies) and how members can obtain these emergency services.

OHA needs to clarify its expectation for CCOs regarding member information on post-stabilization services.

Services available through the State Plan but not available under the CCO contract. Most CCOs' member handbooks do not discuss the scope of services available through the State Plan but not available under the CCO contract, nor does the OHP member handbook. Most CCOs do not inform enrollees about how to obtain those services.

OHA needs to clarify the scope of services available through the State Plan but not available under the CCO contract, and OHA's expectations as to how CCOs' member handbooks are to address access to those services.

The state handbook for OHP members should furnish information about how and where to obtain services available through the State Plan but not available under the CCO contract.

Seclusion and restraint. Enrollees have the right to be free from seclusion or restraint used as a means of coercion, discipline, convenience or retaliation. Though CCOs may review their providers' policies and procedures in this area, most CCOs do not review the use of seclusion and restraint by contracted providers and facilities licensed to use these high-risk interventions.

OHA needs to clarify its expectations with respect to monitoring providers and facilities for the use of high-risk activities of seclusion and restraint.

Advance directives and declarations for mental health treatment. Most CCO policies on this topic are not comprehensive in addressing dental, physical and mental health and do not direct coordination of these directives among dental, physical and mental health providers. Many CCOs do not monitor clinical records for evidence that members have these directives in place or have been informed about these directives. Many CCOs do not provide specific direction through contracts or other documentation on expectations for dental providers regarding advance directives. Few CCOs provide community education, outside of member materials, related to advance directives and declarations for mental health treatment.

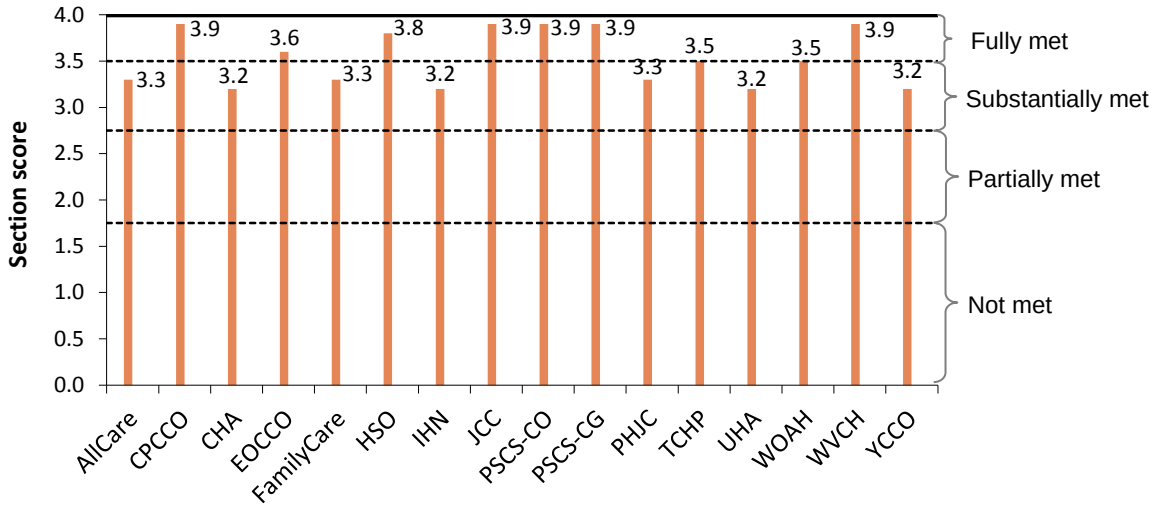
OHA needs to clarify expectations for the CCOs regarding integrated policies and coordination of advance directives and declarations for mental health treatment, including monitoring of members' clinical records.

Section 2: Grievance Systems

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

Figure 2 shows that nine CCOs fully met the requirements for this section, and the remaining CCOs substantially met the requirements.

Figure 2. CCO Compliance Scores: Grievance Systems.



Major strengths

Integrated policies and procedures. Most CCO grievance policies include expectations for physical, dental and mental health. All CCOs' policies provide for a grievance process, an appeal process and access to the state's fair hearing system, and CCOs ensure that members are notified of these processes. The policies include time frames for filing grievances, appeals and requests for a fair hearing. All CCOs have policies and procedures on time frames for authorization decisions, including expedited authorization decisions.

Enrollee notification. All CCOs monitor the enrollee notification process, including delegation of notices of action (NOAs). All CCOs provide enrollees with reasonable assistance in completing forms or taking procedural steps to file

grievances and appeals. All CCOs allow grievances and appeals both orally and in writing. All CCOs have a process for providing oral notices in the case of an expedited appeal resolution.

Working with providers. Most CCOs inform providers that they may act on behalf of enrollees and may file an appeal with the enrollee's written consent. Most CCOs address quality-of-care grievances with providers through their recredentialing processes.

Delegation and monitoring of grievances and appeals. All CCOs monitor the timing of notices and authorizations, and all CCOs but one have a process to address NOAs and authorizations that occur outside of acceptable time frame. All CCOs have a process to analyze grievance information as part of their QA/PI programs. All CCOs have processes in place to track requests for OHP services and denials. CCOs' QI committees routinely review grievance system data.

Major areas for improvement

Required content. Even though members receive general information about grievances and appeals through member handbooks, the actual NOAs do not include all required information. More than half of the CCOs (or their delegates) omitted some required content from their NOAs, such as:

- enrollee's or provider's right to file an appeal with the CCO
- enrollee's right to request a state fair hearing
- circumstances under which an expedited resolution is available and how to request it
- enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued and the circumstances under which the enrollee may be required to pay the costs of those services

NOAs delegated to subcontractors were not consistent; for example, NOAs issued by NEMT providers might omit content that other NOAs for the same CCO included.

Several CCOs did not meet the timelines for standard disposition of grievances or appeals.

> ***OHA needs to continue to support CCOs in ensuring that notices to members regarding grievances and appeals contain all required content and meet standard disposition timelines.***

Gathering grievances. Although most CCOs monitor enrollee rights via the grievance system, few CCOs gather grievances from all providers and delegates. Most CCOs review and act only on grievances they receive directly. Very few mental health grievances are gathered. If not all grievances are addressed and analyzed, it is difficult to know whether enrollee rights are being monitored adequately.

> ***OHA needs to continue to work with the CCOs to ensure that grievances are gathered and reported consistently as expected. OHA may need to define what constitutes a grievance, which grievances need to be reported and whether they need to be gathered from all providers.***

Member information. Most CCOs have had difficulty providing member-facing materials (grievance resolution letters, NOAs, notices of appeals resolution) in easily understood language, using common words and at most a 6th grade reading level.

> ***OHA needs to continue to assist CCOs in ensuring that member materials and communications are available in easily understood language.***

Provider information. At the time of contracting, several CCOs did not inform providers about appeal procedures and timelines. Several CCOs do not inform providers that assistance is available to enrollees for filing processes. A few CCOs do not inform providers of a toll-free number for enrollees to use to file a grievance or appeal.

> ***OHA needs to continue to assist CCOs in orienting their contracted providers regarding information on grievances and appeals, and on assistance available to enrollees in these processes.***

State fair hearing reversal. A few CCOs lack a mechanism to provide payment for services when a state fair hearing officer reverses a decision to deny an authorized service, or a mechanism to expeditiously deliver authorized services when a state fair hearing officer reverses a denial.

> ***OHA needs to clarify its expectations regarding CCO activities for payment and expeditious delivery of services when a state fair hearing officer reverses a decision to deny authorized services.***

Adjudication of final appeals. Nine CCOs do not perform adjudication of final appeals, as required by contract. Combined, these CCOs serve two-thirds of all OHP members. Some CCOs assign their delegates to adjudicate final appeals. Others consider the state fair hearing to be the final appeal.

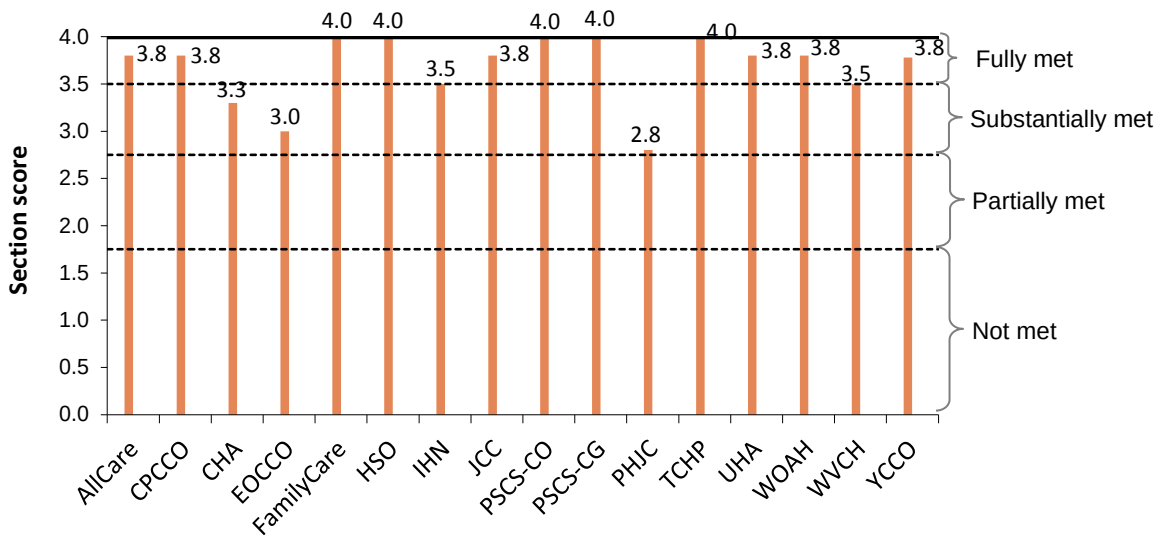
OHA needs to clarify the definition of, and who is responsible for, the adjudication of a final appeal.

Section 3: Certifications and Program Integrity

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

Figure 3 shows that most CCOs fully met the criteria for this section, and the remaining CCOs substantially met the requirements.

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



Major strengths

Compliance programs. The CCOs have compliance programs that address the required elements, including policies and procedures and management practices designed to guard against fraud and abuse. All CCOs periodically evaluate the effectiveness of their compliance plans and enforce compliance through well-publicized guidelines. Most CCOs were able to provide examples of promptly responding to compliance offenses and of developing corrective actions.

Compliance training and communication. The CCOs provide effective training and education for their compliance officers and employees, and they described effective lines of communication between the compliance officer and other staff.

Major areas for improvement

Certifications. Many CCOs did not provide documentation ensuring that providers, subcontractors, staff and governing board members disclose ownership or controlling interests in the business entities and suppliers that deliver services to the CCO members. A few CCOs do not require their subcontractors, staff and/or governing board members to disclose conflicts of interest related to the business of the CCO.

> ***OHA needs to clarify the obligation for CCO subcontractors, staff and/or governing board members to disclose conflicts of interest related to CCO business.***

Several CCOs do not require providers, subcontractors, staff and governing board members to disclose information related to vendor relations, gifts and other compensations.

> ***OHA needs to clarify its expectations for disclosure of information related to vendor relations, gifts, gratuities and other compensations.***

A few CCOs do not ensure that all providers and employees are screened monthly for exclusion from participation in federal health care programs.

> ***OHA needs to clarify the CCOs' obligation to ensure that employees, providers, subcontractors and volunteers are screened monthly for exclusion from participation in federal health care programs.***

A few CCOs do not ensure that NEMT providers, CHWs and other providers are screened for criminal conviction.

> ***OHA needs to clarify its expectation of who should undergo criminal background checks upon hire or credentialing.***

Program integrity. Several CCOs do not have a mechanism in place for routine monitoring and auditing of the CCO, providers and subcontractors, or their risk assessment does not assess fraud and abuse.

Almost half of the CCOs have no mechanism to report adverse actions that result in termination or suspension of providers, if appropriate, to OHA and the Office of Inspector General.

OHA needs to continue to support CCOs in developing effective compliance programs that include ongoing monitoring and auditing of the CCO, providers and subcontractors to address identified risks.

Review of 2015 compliance findings unresolved in 2016

In 2017, HealthInsight reviewed the CCOs' progress in addressing the findings of the 2015 compliance review that were unresolved as of 2016. The 2015 review covered the following standards:

- Delivery Network
- Primary Care and Coordination of Services
- Coverage and Authorization of Services
- Provider Selection
- Subcontractual Relationships and Delegation
- Practice Guidelines
- QA/PI General Rules and Basic Elements

The standards reviewed in 2015 will be reviewed again in 2018 and will include updated standards based on the revised federal regulations for managed care.

Figure 4 presents these follow-up review results.

Two CCOs had no 2015 findings to review in 2017.

Five CCOs resolved all of their previously unresolved 2015 findings.

- These CCOs made progress related to oversight and monitoring of subcontractors and delegated activities, including annual performance monitoring and updated agreements/contracts.
- Two CCOs resolved findings related to performing service authorizations, including ensuring that their delegates apply review criteria consistently when authorizing services, and using appropriate clinical expertise when denying authorization for services.
- One CCO resolved a finding related to lack of mechanisms to ensure that mental health and dental care providers meet standards for serving enrollees with SHCN.
- Two CCOs resolved findings related to not having performed monthly screening to ensure that staff, providers and subcontractors were not excluded from participation in federal health care programs.
- Additional findings resolved by this group of five CCOs included:
  - providing second opinions related to treatment options for mental health and dental care services
  - providing timely access to mental health and dental care services
  - disseminating practice guidelines to providers

Four additional CCOs fully resolved at least one previously unresolved finding, demonstrating progress in the following ways:

- The CCO now has mechanisms in place to ensure that all delegates have processes to perform service authorizations.
- The CCO governing board's oversight of QI activities now includes delegated functions.
- Dental services are now fully integrated into the CCO.
- The CCO's provider directory now includes required information.
- The CCOs developed integrated policies for second opinions and out-of-network services that define expectations for physical, behavioral and dental health services. Analysis of out-of-network services now assists in identifying gaps and trends for network planning purposes.

Partially resolved findings by nine CCOs show progress in these areas:

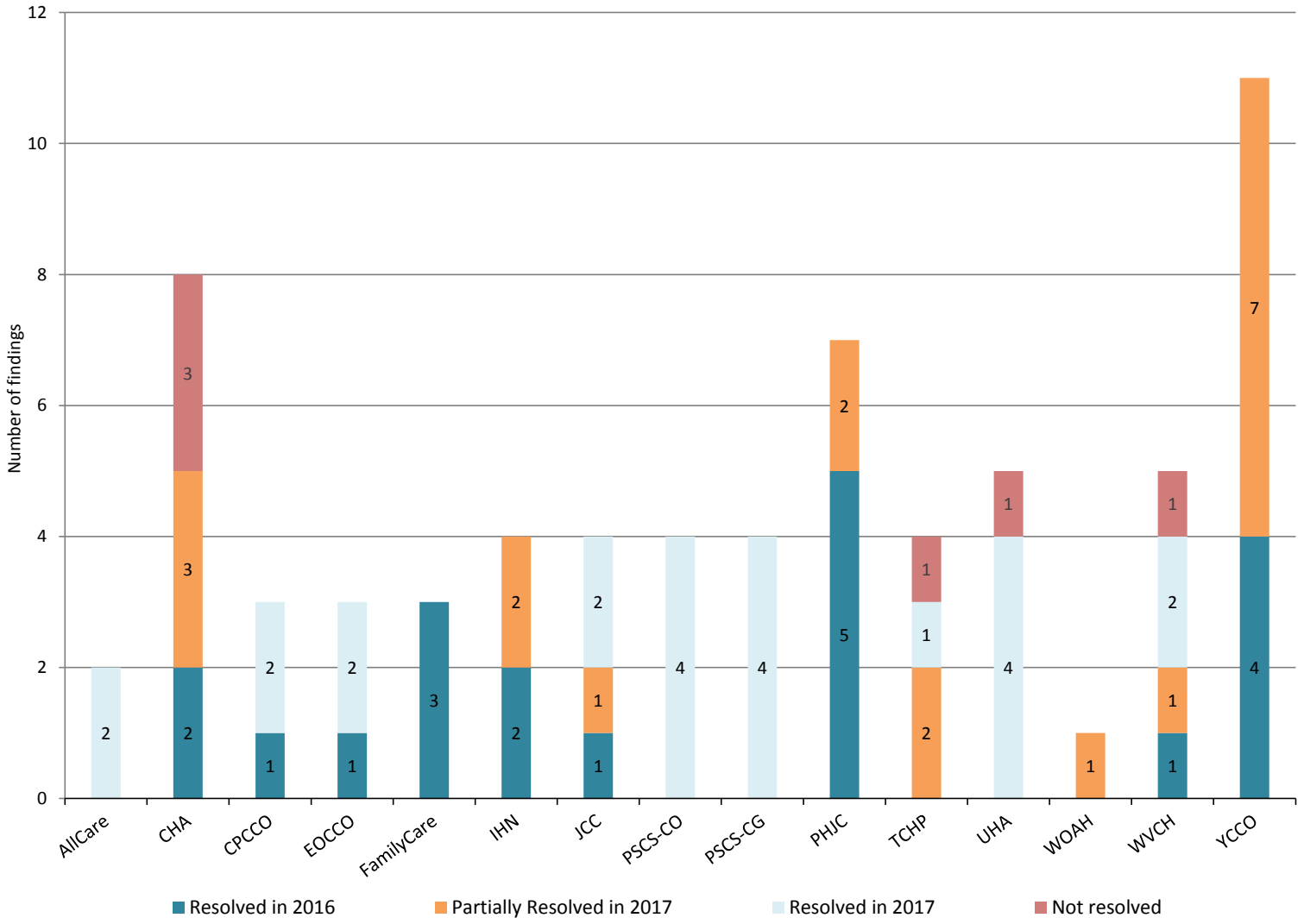
- One CCO has developed draft policies for second opinions and out-of-network services.
- Two CCOs are working on integrated policies on emergency services, including emergency dental health services.
- Five CCOs have demonstrated progress on monitoring delegated services, but may need to monitor all delegated entities, complete audits or take action on issues identified by monitoring activities.
- One CCO is working on mechanisms to monitor:
  - out-of-network service encounters
  - services provided to enrollees with SHCN
  - the service authorization process
- Three CCOs are working on issues related clinical practice guidelines:
  - developing and updating integrated policies
  - developing, adopting and/or disseminating practice guidelines and ensuring that they meet federal requirements
  - monitoring to ensure that decisions are consistent with guidelines, including decisions made by contracted/affiliated providers
- Two CCOs are working to ensure that all providers are screened monthly for exclusion from participation in federal health care programs.

Four CCOs made no progress in the past two years related to resolution of these 2015 findings:

- Quality Management Committee does not evaluate stakeholder input.
- Lack of documentation that delegates' practice guidelines meet federal requirements.
- No policy on dissemination of practice guidelines.
- No policy or procedure that ensures a non-discriminatory process for selecting and compensating providers.
- No progress on meeting requirements to provide access within required time frames.
- No mechanisms to monitor care coordination.
- No mechanisms to identify and assess enrollees with SHCN.
- No policy on utilization management activities.

Four CCOs did not fully resolve any previously unresolved findings, but at least partially resolved some of those findings.

Figure 4. Results of 2017 Follow-up Review of 2015 Compliance Findings.



Note: Health Share is not included in this graph because it did not have any findings in 2015.

PERFORMANCE MEASURE VALIDATION

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

OHA's Metrics and Scoring Committee uses CCO incentive metrics to evaluate Oregon's performance on health care quality and access, and to hold CCOs accountable for improved outcomes. In the 2016 performance measure calculation period, OHA added two measures and dropped one measure. Additional changes were made in 2017 and planned for 2018, but this review covers the 2016 calculation period only.

The 18 incentive measures used in 2016 are listed below. CCOs receive funds from a quality pool based on their performance on these measures and whether the CCOs meet state benchmarks or demonstrate improvement from their own baselines.

- Adolescent well-care visits
- Alcohol or other substance misuse (SBIRT)
- Ambulatory care: emergency department utilization
- CAHPS composite: access to care
- CAHPS composite: satisfaction with care
- Childhood immunization status *(new in 2016)*
- Cigarette smoking prevalence *(new in 2016)*
- Colorectal cancer screening
- Controlling high blood pressure
- Dental sealants
- Depression screening and follow-up plan
- Developmental screening (0–36 months)
- Diabetes: HbA1c poor control
- Effective contraceptive use
- Follow-up after hospitalization for mental illness
- Health assessments within 60 days for children in DHS custody
- PCPCH enrollment
- Timeliness of prenatal care

Scope of the Review

Seven of the 18 measures were calculated using *only* encounter data that OHA collects and maintains. Per OHA's instruction, HealthInsight validated only those seven measures. The remaining 11 measures are calculated with clinical data collected by record review or electronic health record (EHR) extraction, with non-encounter data from other systems, or with data from the CAHPS survey, administered by a contractor. Some measures combined encounter data with one or more of these alternate data sources.

Validation Results

Effective contraceptive use measure specifications were modified in August 2016 to add exclusions for congenital abnormality diagnosis codes; the measure was still undergoing full validation by OHA as of November 30, 2017. The other six measures examined by HealthInsight received a full validation by OHA with final approvals in April 2017. Measure validation occurred before OHA released the final data to CCOs for validation in April and May, and prior to publication of final measure results (and payment calculations) in June 2017.

The full validation process is quite comprehensive. First OHA sends complete encounter data files to the Providence Center for Outcomes Research and Education (CORE). Refresh data are sent monthly. CORE writes its own metric code, calculates the metrics using the data from OHA and sends the results back to OHA. OHA then validates the results by calculating the metrics using its own code and sends the same data to CORE. CORE and OHA use frequent email communication and weekly meetings to discuss agreement and discrepancies between results, and to troubleshoot any variation. This process continues until OHA's results are within 3% of CORE's results, at which point OHA approves the CORE code.

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

There have been no changes to the crosswalks that OHA created in October 2015 to accommodate CMS's release of the International Classification of Diseases, 10th Revision (ICD-10) for medical coding and reporting, replacing the ICD-9.

All seven performance measures are scored as "substantially met" this year (see Table 4), consistent with scoring for the measures that HealthInsight reviewed in 2016. The code review and measure calculation process for these measures is adequate, but the measures are not scored "fully met" because HealthInsight still has concerns about the validity of the data used to calculate the measures.

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

OHA has no system in place to determine the volume of encounter data that is not submitted or that is submitted but rejected by the EDI Translator. In addition, the CCOs' data submission processes vary widely. While some CCOs review their encounter data before submitting the data to the state, other CCOs and their partner organizations transmit the data directly to the state without review. This is important because performance measure calculations based on incomplete or inaccurate data will not yield valid results. OHA recognizes these deficiencies and has made progress in addressing them at the state level, as follows.

First, encounter data staff in the Service Data Reporting Unit of OHA's Health Systems Division were reorganized into entry-level and senior-level positions, performing data mining and providing better monitoring of incoming encounter data. This is commendable, but the CCOs are also responsible and should be held accountable. Conducting EDV would enable CCOs to identify and correct any anomalies before sending data to the state, and to identify encounters that were rejected. OHA does not currently require CCOs to conduct EDV.

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

to reduce the number of pended encounters, improving the completeness of OHA's encounter data.

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

OHA's measure validation process is not memorialized in any policy or procedure, nor are OHA staff with signatory power required to sign off on measure calculation and results. The workgroup as a whole agrees when measures are ready for release, but there is no documentation of director-level approval.

Table 4 shows the validation ratings for each of the seven performance measures reviewed from the 2016 measurement year.

Table 4. Performance Measure Validation Ratings, 2016.

Measure	Status	Compliance Rating
Adolescent well-care visits	Complete validation by OHA	Substantially met
Alcohol or other substance misuse (SBIRT)[13]	Complete validation by OHA	Substantially met
Ambulatory care: emergency department utilization	Complete validation by OHA	Substantially met
Dental sealants	Complete validation by OHA	Substantially met
Developmental screening (0-36 months)	Complete validation by OHA	Substantially met
Effective contraceptive use	Complete validation by OHA	Substantially met
Follow-up after hospitalization for mental illness	Complete validation by OHA	Substantially met

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

Recommendations

- OHA should define the performance measure requirements for GOBHI, the managed mental health organization.
- OHA should document processes, policies and procedures specific to each performance measure, specifying steps to ensure that:
    - OHA receives complete encounter data from all CCOs in a timely manner
    - the data flow between and within OHA systems, and the data flow with external partners, is documented and understood
    - OHA staff with authorization to sign off on measure calculation and validation do so, and document this in writing
    - OHA communication with CCOs is documented and consistent
    - current relationships with external partners are documented, as are any future changes in associations, roles or responsibilities
- OHA should either conduct an EDV or require the CCOs or a third party to conduct an EDV, to ensure submission of complete and valid encounter data to OHA.
- OHA should follow through with its plans to rework the withholding rule.
- OHA should require race and ethnicity fields to be completed on Medicaid enrollment forms.

Information Systems Capabilities Assessment (ISCA)

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

42 CFR §438.242 requires states to ensure that each managed care contractor "maintains a health information system that collects, analyzes, integrates, and reports data" to meet QA/PI objectives. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals and disenrollments for other than loss of Medicaid eligibility. The state must require each managed care contractor to:

- collect data on enrollee and provider characteristics as specified by the state, and on all services furnished to enrollees through an encounter data system or other methods the state may specify
- ensure that data received from providers is accurate and complete by—
  - verifying the accuracy and timeliness of reported data, including data from network providers the managed care contractor is compensating through capitation payments
  - screening the data for completeness, logic and consistency
  - collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for Medicaid QI and care coordination efforts
- make all collected data available to the state and upon request to CMS

In 2016, HealthInsight conducted full ISCA reviews of OHA, each CCO, GOBHI and Performance Health Technology (PH Tech), a third-party data administrator used by many CCOs. In 2017, HealthInsight completed follow-up reviews to assess forward movement on all 2016 findings. In addition, HealthInsight reviewed four DPNs in 2017 using the full ISCA protocol, with the expectation that the CCOs would follow up on any issues identified.

The 2016/2017 ISCA tool included 10 sections, ensuring a comprehensive review of hardware, software, utilization, security and supporting functions:

1. Information Systems
2. Staffing
3. Configuration Management (hardware systems)

4. Security
5. Administrative Data (claims and encounter data)
6. Enrollment Systems (Medicaid eligibility downloads)
7. Vendor Data Integration and Ancillary Systems
8. Report Production and Integration and Control of Data for Performance Measure Reporting
9. Provider Data
10. Meaningful Use of Electronic Health Records

During the 2017 follow-up year, HealthInsight completed telephone interviews with OHA, each CCO, GOBHI and PH Tech. Each organization reviewed had an opportunity to submit new or updated documentation showing progress toward resolving any findings.

State-level ISCA review results

In 2016, OHA had four findings. The 2017 ISCA follow-up interview with OHA identified resolution of one of the four findings and progress with the other three. To resolve Finding #1 (999 files not being sent to the CCOs), OHA developed a Submission Tracker report that displays encounter submission status. OHA's customer service representative sends the Submission Tracker report to each CCO for review and remediation.

OHA is still working to resolve Finding #2 (BC/DR plan in progress) and Finding #3 (CCO contract requirements for BC/DR plan). Completion of OHA's BC/DR plan depends on identifying all mission-critical functions and completing an overarching plan. OHA has evaluated BC/DR language to add into the CCO contract, but cannot add language into the 2018 contract.

OHA is addressing Finding #4 (CCOs not performing EDV) by researching how to implement EDV within the OHA Program Integrity Team.

Recommendations:

- ***OHA needs to continue progress on its BC/DR plan to fully implement and test the plan. Best practice would include a detailed, documented and fully communicated BC/DR plan, a documented test plan, documented test results and an action plan based on test results.***

- ***OHA needs to ensure that CCOs are completing their own EDV activities, or OHA needs to fully implement EDV within its Program Integrity Team. OHA needs to communicate its decision and expectations to each CCO and ensure agreement on responsibilities. Best practice would include a written agreement including service-level agreement aspects.***

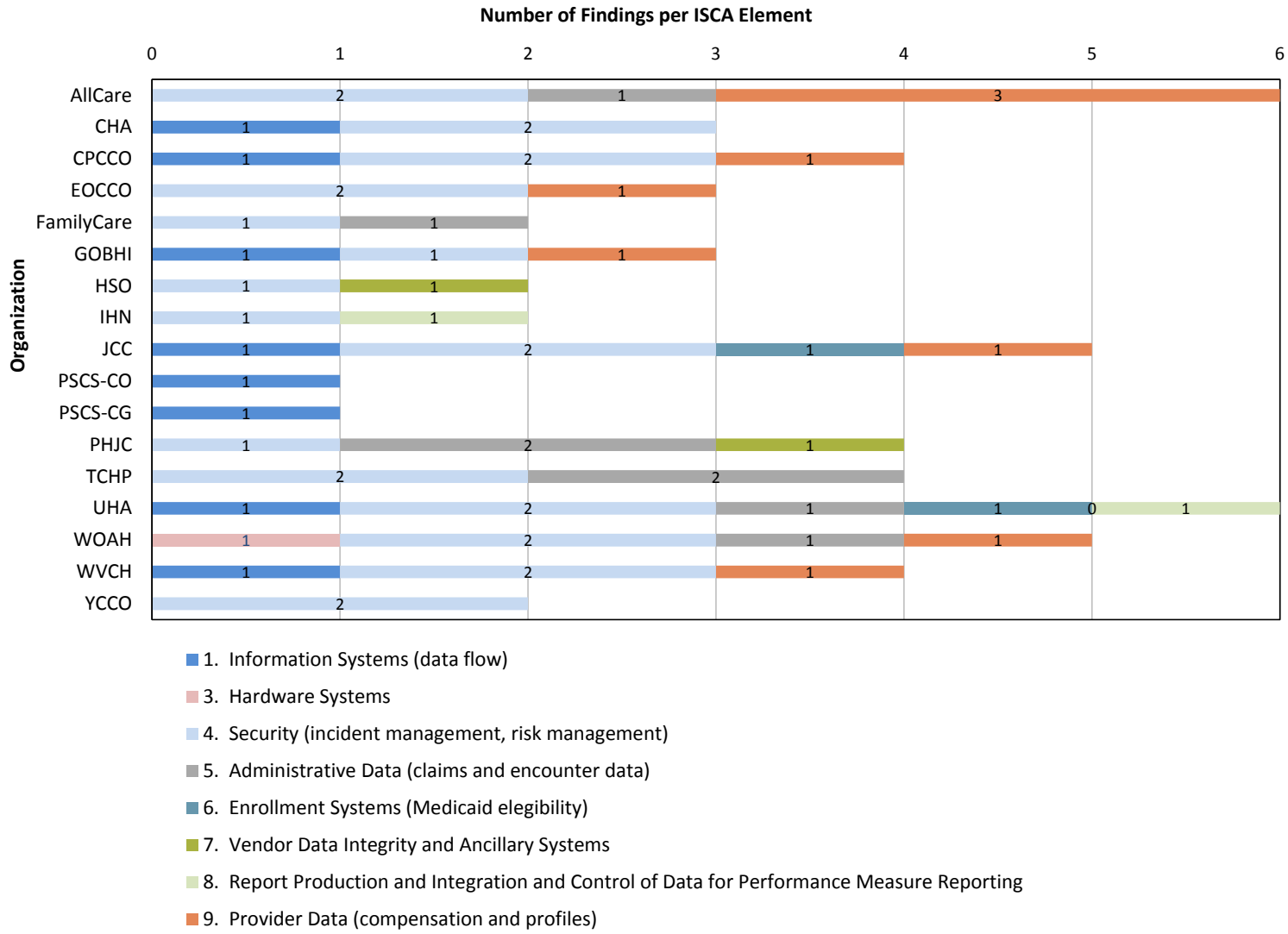
CCO, GOBHI and PH Tech ISCA trends

These organizations had the most challenge meeting requirements in the Security section, as shown in the following graphs. Specifically, the top issues involved BC/DR plans and monitoring of delegated organizations.

Figure 5 below shows the 2016 ISCA findings for each organization. Figure 6 shows the status of 2016 findings as revealed by the 2017 follow-up review.

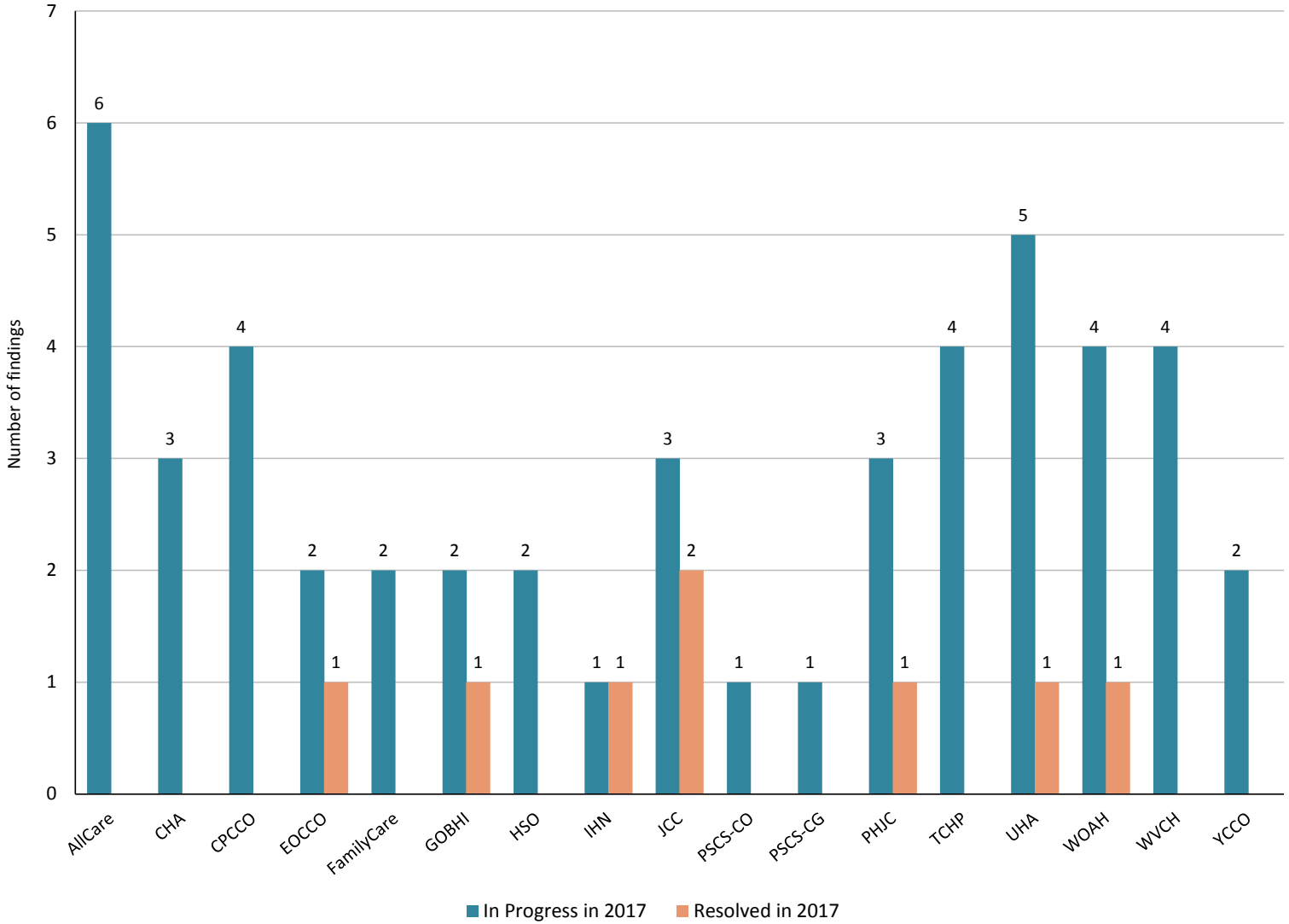
Note: ISCA sections where there were no findings are not included in the figures. Also, organizations (PH Tech) that did not have findings in 2015 are not included in the figures.

Figure 5. 2016 ISCA Findings for CCOs and GOBHI.



Note: PH Tech is not included in this graph because it did not have any findings in 2015.

Figure 6. Results of 2017 Follow-up Review of 2016 ISCA Findings.



Note: PH Tech is not included in this graph because it did not have any findings in 2015.

2016 Findings resolved during 2017

During 2017, most organizations showed progress toward resolving the 2016 ISCA findings. Seven organizations succeeded in resolving findings.

EOCCO resolved one of three findings, related to provider compensation. The 2016 ISCA identified a clarity gap regarding the organization authorized to pay for an encounter conducted by a noncredentialed practitioner (a practitioner that had not completed the credentialing process through GOBHI). In 2017, EOCCO, working in collaboration with GOBHI, provided policy/process documentation specifying that GOBHI is required to complete the credentialing process before provider claims are paid.

In 2016, GOBHI received three findings as a result of the ISCA. During 2017, GOBHI worked with EOCCO to resolve the finding described above.

IHN received two findings in 2016, and in 2017 resolved a finding in the Report Production and Integration and Control of Data for Performance Measure Reporting section, regarding historical gaps in mental health data. The CCO has implemented a data repository to facilitate reporting.

JCC received five findings in 2016 and resolved two during 2017. The CCO resolved an Information Systems finding by identifying its chief financial officer as the responsible person to sign attestations. JCC also resolved an Enrollment Systems (Medicaid eligibility) finding related to enrollment checks. In 2016, the CCO was not checking Medicaid eligibility at time of claims payment. In 2017, JCC transferred this responsibility to CareOregon, which has a mature eligibility check process and communicates expectations to personnel involved.

PHJC received four findings in 2016, and resolved a Vendor Data Integrity and Ancillary Services finding that the CCO was not submitting NEMT data to the state. The CCO has worked with its NEMT service provider to resolve issues. PHJC is now submitting NEMT data to OHA in a timely manner and has processed all backlog data.

In 2016, UHA was given six findings as a result of the ISCA. UHA resolved an Administrative Data (claims and encounter data) finding that a provider was not verifying enrollment at time of service. The 2016 ISCA revealed that a provider organization checked eligibility only during billing activities. UHA has resolved this finding by updating its provider handbook and onboarding processes regarding expectations to verify eligibility.

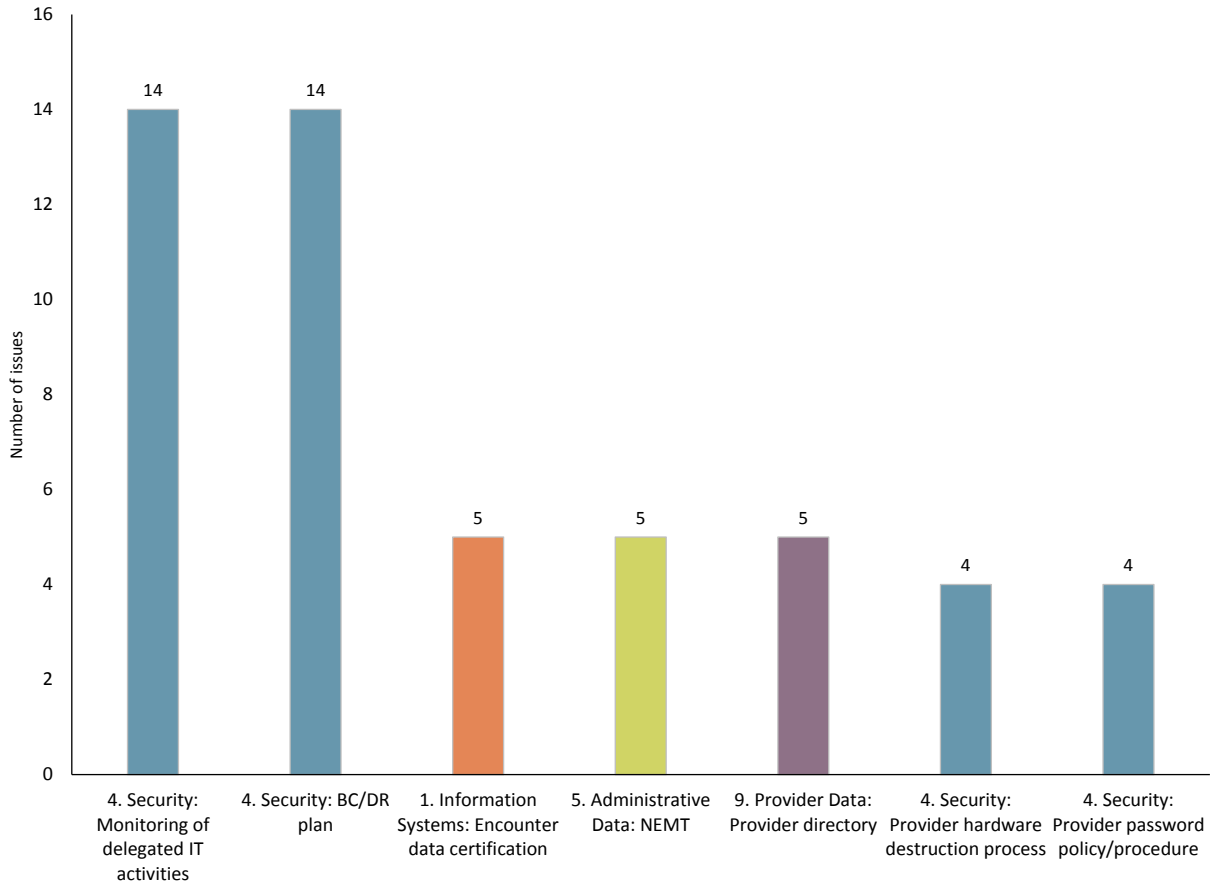
WOAH was given five findings as a result of the 2016 ISCA. WOAH resolved a Hardware Systems finding regarding remote access. In 2016, WOAH granted remote access to Doctors of the Oregon Coast South employees, including the ability to print and save locally, resulting in high risk of breach. In 2017, WOAH resolved this finding by disabling remote access print and save (to local drive or printer) functionality.

2016 Findings in progress during 2017

Review sections of major concern for the CCOs during 2016 included Security, Information Systems, Administrative Data and Provider Data. Within these sections, the ISCA identified specific weaknesses. Figure 7 below depicts items for which four or more CCOs had the same issue.

Areas of weakness in information system security outweighed all other areas. Overall, the CCOs need to improve their information system security and their monitoring of delegated providers' information system security. Significant aspects of security include BC/DR preparedness, system security and access controls such as password management.

Figure 7. Most Frequent Issues in 2016 ISCA for CCOs, GOBHI and PH Tech.



Security: Monitoring of delegated IT activities. While CCOs have made progress in monitoring their delegates' IT activities, no CCO has implemented a monitoring system that fully resolves this finding. All CCOs interviewed in 2017 reported progress by partially implementing delegate oversight or by adding components and questions to further develop a delegate oversight process. CCOs working with CareOregon have adopted CareOregon's methodology for delegate oversight.

The value of delegate oversight lies in full understanding of delegate systems, policies and procedures for all aspects of IT systems, data security and processing, and ensuring that delegates operate within expected standards and contract requirements.

OHA needs to:

- ***Continue to encourage CCOs to implement a well-structured and documented delegate oversight process that meets IT requirements such as a tested BC/DR plan, system security and data processing norms.***
- ***Ensure that CCOs communicate these expectations to their delegates and regularly monitor delegates to ensure that they actively follow requirements.***

Security: BC/DR plan. Many CCOs and related organizations (GOBHI and PH Tech) are still in the process of developing BC/DR plans. The value of a detailed, documented, finalized BC/DR plan that has been tested and updated based on test results is that during an actual disaster, personnel know exactly whom to contact, how to contact, what actions to take and in what time frame, so that if needed, an external IT professional could work to bring systems back up to operational functionality. A well-developed BC/DR plan also provides a list of prioritized systems, especially identifying those critical to operations systems, thus minimizing downtime and disruption of patient services.

OHA needs to encourage each CCO to finish developing and testing its BC/DR plan. The BC/DR plan should ensure that each business has thought through details of keeping services running during a disaster and ensuring that key personnel are trained and knowledgeable of their responsibilities during a disaster.

Information Systems: Encounter data certification. The OHA contract requires each CCO to certify the accuracy, completeness and truthfulness of claims and encounter data submitted to OHA. Many CCOs are combining encounter/claims data from multiple sources without a process to validate the data. Some CCOs receive a copy of the data after or at the same time the data is submitted to OHA. Many CCOs lack adequate understanding or documentation of the different sources and flow of encounter data. Some CCOs continue to work on enhancing their documentation and processes for certifying encounter data.

OHA needs to ensure that each CCO understands its responsibilities for encounter data certification per the OHA contract and acts in accordance with the contract.

Administrative Data: NEMT data. In 2016, several CCOs were unable to ensure that NEMT provider organizations submitted all claims/encounter data. One CCO resolved its finding. The other CCOs were developing policy/procedure documents related to NEMT services and including language related to submission of all claims/encounter data.

The value of submitting 100% of NEMT claims/encounter data includes the CCO's ability to report accurate NEMT-related volume and demographic data and to increase understanding of the CCO's service area.

OHA needs to:

- ***Ensure that each CCO understands the definition of all claims and encounter data, including NEMT data.***
- ***Encourage each CCO to develop policies, procedures and processes regarding NEMT claims/encounter data, communicate these to NEMT providers and ensure that the providers submit all NEMT data.***

Provider Data: Provider directory. In general, CCOs are building meaningful provider directories that list delegated organizations and individual providers in their service areas. CCOs reported developing or updating provider directory websites, including adding NEMT service information and improved search capabilities.

The value of a complete provider directory that is up to date and easy to navigate is the assurance that consumers can identify their most appropriate provider quickly and obtain service without delay.

OHA needs to:

- ***Encourage each CCO to build an online provider directory that lists individual providers and their contact information.***
- ***Encourage each CCO to develop and implement policies, procedures and processes regarding provider directory updates.***

Security: Provider hardware destruction process. The 2016 ISCA uncovered gaps in CCO oversight of these processes, including lack of policies, procedures and processes and non-documented destruction activities or validation certificates. In 2017, most CCOs worked on or started a delegate oversight assessment or process that includes hardware destruction activities.

The purpose of a documented hardware destruction process is to ensure that outdated or unused equipment is properly and quickly removed from access and destroyed in a manner that ensures it cannot be reconstituted for use.

> ***OHA needs to encourage CCOs to continue to develop strong delegate and provider oversight processes to ensure that information system functions, including hardware destruction processes, adhere to industry norms and CCO expectations.***

Security: Provider password policy/procedure. The 2016 ISCA reviews identified weak password policies and norms. Delegated organizations used a variety of password strategies, few of which met industry norms. One agency required password changes on an annual basis. Another organization required only a six-character password. In 2017, most CCOs implemented oversight of information system functions such as password requirements meeting industry norms and policy/procedure.

Password policy/procedure is important to minimize risk of hacking, data theft and inadvertent access to systems.

> ***OHA needs to ensure that CCOs communicate information system requirements to their delegates, including policy/procedure/process.***

Detailed ISCA data for each CCO appear in Appendix A.

Dental Provider Network ISCA

In 2017, HealthInsight reviewed four DPNs as part of a thorough ISCA. These four DPNs contract with the majority of CCOs. OHA requested that HealthInsight review them as the CCOs and DPNs had expressed concerns about multiple CCOs reviewing the DPNs' information systems.

DPN ISCA interviews followed the same process as the CCO ISCA reviews. A list of required documentation was provided to each DPN ahead of the review. The DPN submitted the completed REDCap questionnaire and supporting documentation to HealthInsight six weeks ahead of the onsite review. The site visit addressed gaps or questions that arose from review of the REDCap questionnaire and documentation. Following the onsite interviews, HealthInsight staff provided an exit summary to identify possible issues and follow-up opportunities. The DPNs were given two weeks to resubmit any

documentation to support areas of concern. HealthInsight sent a detailed report to each DPN and attached it to the report of each CCO contracting with these four DPNs. As part of delegation oversight, the CCOs are to follow up with the DPNs to ensure they meet expectations.

Advantage Dental, headquartered in Redmond, was acquired by DentaQuest, a Massachusetts dental insurance plan and dental benefits administrator, in 2016. Advantage Dental uses the Advanced Dental Information Network (ADIN) certified EHR system, which connects physical, behavioral and oral health records, allowing dentists to make best-practice decisions on medications and oral health care.

Capitol Dental Care is a wholly owned subsidiary of InterDent, Inc., which provides all staffing for Capitol Dental Care's operational, administrative and IT functions. Capitol Dental Care contracts with PH Tech for claims processing and has access to a portal into PH Tech's internal IT system, CIM, for authorization and member eligibility tasks. Dental providers use clearinghouses or submit claims directly to PH Tech for data processing. PH Tech submits the claims to OHA.

ODS (Moda Health's dental plan) uses Dentists Management Corp. to provide DAISY software to affiliated practices. In 2017, providers were given access to Delta Dental's Electronic Benefit Tracker provider portal to review patient data such as eligibility. ODS has a mixed claim processing environment. Some claims are submitted directly to OHA and some are processed and submitted through PH Tech. One CCO (TCHP) submits claims data directly to the state.

Willamette Dental Group, headquartered in Hillsboro, provides dental care, insurance and business management/administration in three states. The organization's business model is a closed panel model employing all dental provider types.

Major areas of concern for the four DPNs reviewed in 2017 included Security, Staffing and Provider Data. Weaknesses in IS security mirrored those of CCOs. Figure 8 depicts the 2017 ISCA findings for each DPN. Figure 9 identifies the most frequent issues, including proper staff planning, ensuring an adequate level of fully trained and available backup staff for IT functions, BC/DR plans and provider directory issues. Note: sections that did not have findings are not included in these figures.

Figure 8. 2017 ISCA Findings for Dental Provider Networks.

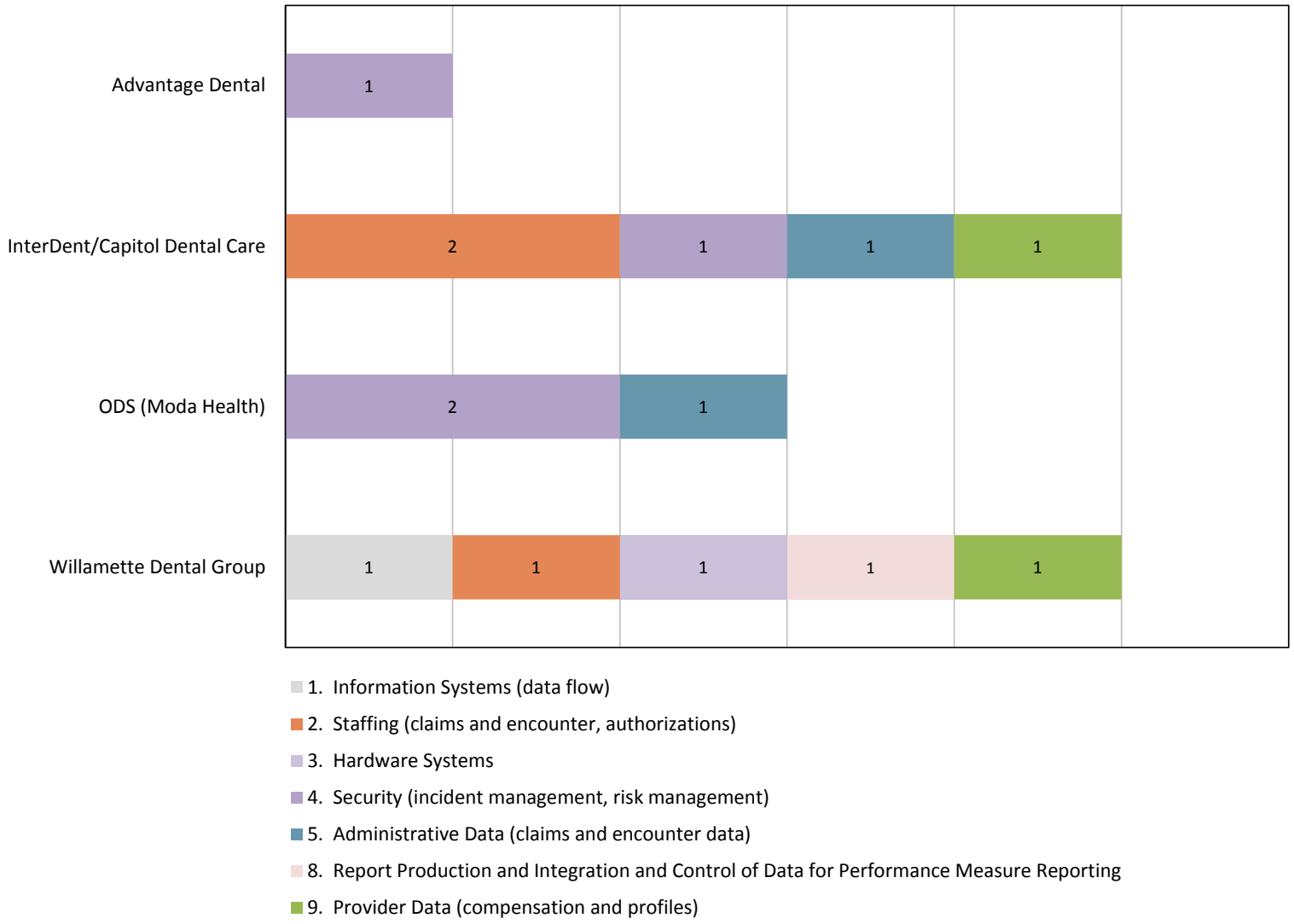
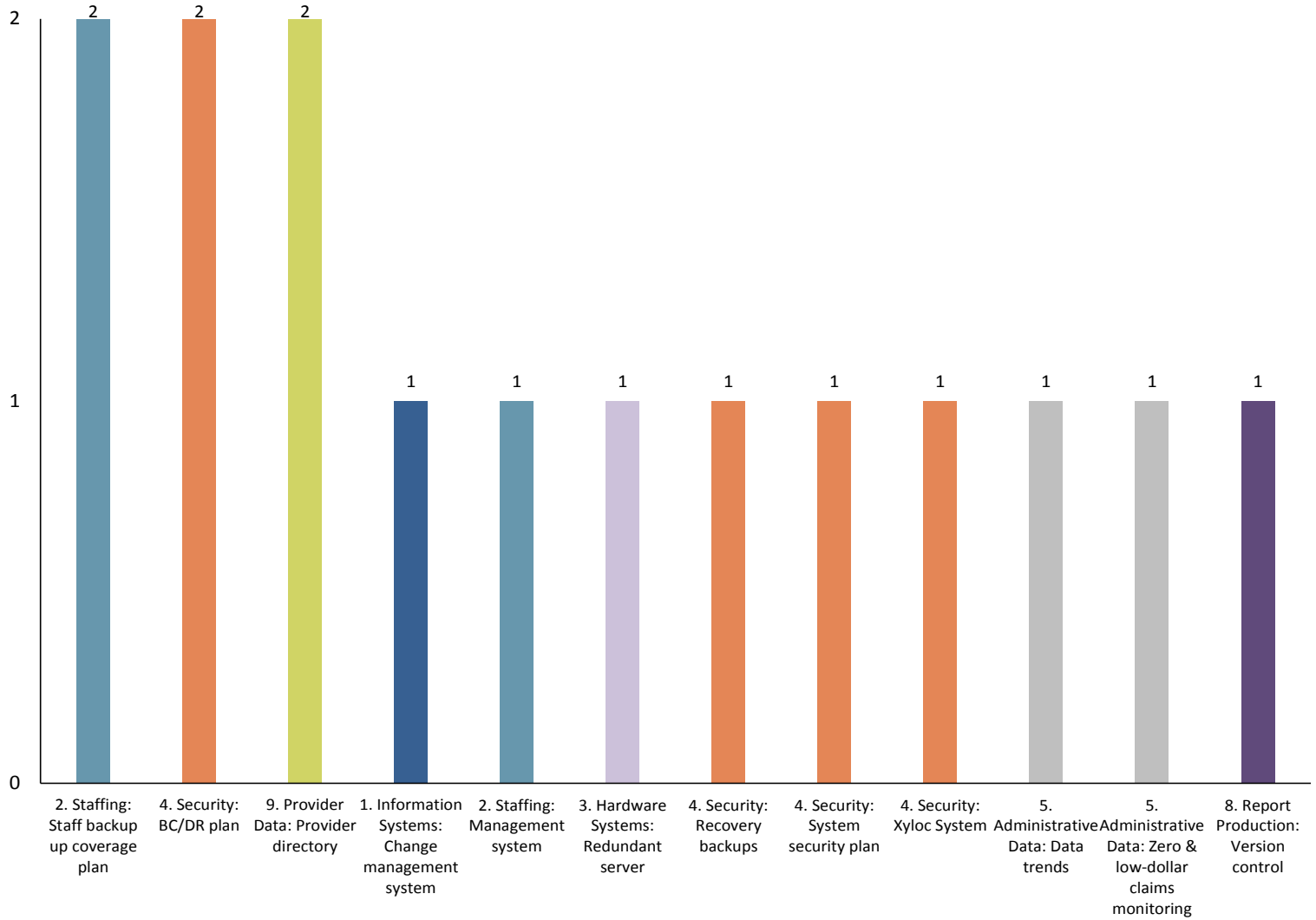


Figure 9. Most Frequent Issues in 2017 ISCA for Dental Provider Networks.



Staffing: Staff backup coverage plan. Two DPNs did not have properly documented or operational staff backup plans, putting them at risk for daily operations and service to patients.

> ***OHA needs to ensure that CCOs oversee their delegate organizations to ensure that their staffing models are adequate to meet contract requirements.***

Security: BC/DR plan. The DPNs lacked formal, detailed and tested BC/DR plans, leaving them at risk of longer out-of-operation times during and after disaster.

> ***OHA needs to encourage CCOs to require the DPNs to develop, maintain and regularly test a BC/DR plan ensuring minimal service downtime during or after disaster.***

Provider Data: Provider directory. Provider directories must be updated on a regular and frequent basis to ensure that patients have access to accurate and usable data on information changes, new providers or providers that have left the organization. Search mechanisms should include the provider's location, specialty and whether the provider is accepting or not accepting new patients.

> ***OHA needs to ensure that CCOs require DPNs to meet provider directory requirements and monitor the DPNs' formal policies, procedures and processes regarding provider directory maintenance.***

PERFORMANCE IMPROVEMENT PROJECTS

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

CCOs are required to conduct three PIPs and one focus study designed to improve care in at least four of the seven QI focus areas:

1. Reducing preventable rehospitalizations
2. Addressing population health issues (such as diabetes, hypertension, and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, and aligned federal and state programs
3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by "super-users"
4. Integrating primary care and behavioral health
5. Ensuring that appropriate care is delivered in appropriate settings
6. Improving perinatal and maternity care
7. Improving primary care for all populations through increased adoption of the PCPCH model of care throughout the CCO network

One of the required PIPs is conducted as a statewide collaborative project addressing the integration of primary care and behavioral health. The Statewide PIP is conducted in accordance with the 2012 CMS protocol. HealthInsight is responsible for facilitating and documenting the PIP. The CCOs are responsible for developing interventions that meet local community needs (Standard 8 of the PIP protocol) and for documenting the development and implementation of their interventions in quarterly reports to OHA.

In addition to the Statewide PIP, CCOs are required to conduct three projects of their choice on topics from the list of seven QI focus areas. HealthInsight reviews

these CCO-specific projects and provides OHA with recommendations for follow-up.

Statewide PIP: Improving the Safety of Opioid Management

The second Statewide PIP topic and metric were discussed in depth by CCO medical directors, QI directors and OHA Quality Leadership beginning in spring of 2015. After reviewing CCO feedback, data provided by the Office of Health Analytics and a literature search and analyses by HealthInsight and OHA, the stakeholders selected the following Statewide PIP study metrics to be implemented beginning January 1, 2016:

- Primary: *Percentage of Medicaid enrollees who filled prescriptions totaling ≥120 or ≥90 morphine milligram equivalents (MME) on at least one day within the measurement year*
- Secondary: *Percentage of Medicaid enrollees who filled prescriptions totaling ≥120 or ≥90 morphine milligram equivalents (MME) for 30 or more consecutive days within the measurement year*

In spring 2017, HealthInsight facilitated several discussions about next steps for the Statewide PIP with medical and QI directors at the QHOC meetings. There was consensus among stakeholders to extend the Statewide PIP on opioid safety to a third remeasurement period (calendar year 2018) and to adopt study metrics more closely aligned with the 2016 Centers for Disease Control and Prevention guidelines on prescribing opioids. The study metrics for the third remeasurement period (January 1–December 31, 2018) will be:

- Primary: *Percentage of Medicaid enrollees who filled prescriptions totaling ≥90 or ≥50 morphine milligram equivalents (MME) on at least one day within the measurement year*
- Secondary: *Percentage of Medicaid enrollees who filled prescriptions totaling ≥90 or ≥50 morphine milligram equivalents (MME) for thirty or more consecutive days within the measurement year*

HealthInsight evaluates the Statewide PIP for improvement by testing for statistically significant differences between the aggregate baseline and measurement periods. CCOs are responsible for selecting their own target goals and time frames for measuring improvement.

Technical assistance

HealthInsight continues to provide support and technical assistance to the CCOs by conducting presentations at monthly QHOC meetings and scheduling technical assistance meetings and calls with individual CCOs. QHOC meeting topics have included development and implementation of non-opioid therapies, overview of medication-assisted treatment (MAT), elements of a successful MAT program, updates from Oregon researchers on opioid prescribing, how to develop a measurement plan and how to interpret study results.

From the inception of the Statewide PIP, HealthInsight has offered CCOs individualized technical assistance meetings quarterly or upon request. In 2017, HealthInsight met with representatives from all CCOs at least once, and most CCOs took part in several technical assistance meetings.

Validation and scoring

Following the first remeasurement period (January 1–December 31, 2016), CCOs submitted their Standard 8 Part 1 and January 2017 quarterly report for evaluation. HealthInsight evaluated the submissions as to their degree of completeness of each of the Standard 8 criteria. At the end of the second remeasurement period (January 1–December 31, 2017), CCOs were asked to summarize their progress on this PIP, including achievement of study targets. At the time of this annual report, HealthInsight is reviewing the CCO reports. Each CCO will receive an evaluation (met, partially met or not met) for the degree of completeness, clarity and consistency in addressing each of the evaluation criteria. Results of the second remeasurement evaluation will be documented in next year's annual report.

Interventions

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

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

The OHA Guideline Note 60 (opioids for conditions of the back and spine), implemented in July 2016, mandates that members on long-term opioids have a taper plan with a medication termination date of January 1, 2018. All CCOs developed their own tapering processes and forms in order to comply with this requirement. Other common interventions included:

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

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

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

Statewide PIP results

Study time periods.

- Baseline measurement: January 1–December 31, 2014
- First remeasurement: January 1–December 31, 2016
- Second remeasurement: January 1–December 31, 2017
- Third remeasurement: January 1–December 31, 2018

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

At the time of this report, complete second remeasurement (calendar year 2017) results were not available due to lag in receipt of claims data.

Interpretation of results. The remeasurement period analyzed for the Statewide PIP report (November 1, 2016–October 31, 2017) is not strictly comparable to the other measurement periods as it is not a complete calendar year. However, tentative conclusions can still be drawn about the data.

Data analyses showed that the percentage of enrollees aged 12 and older who filled opioid prescriptions for both ≥120 and ≥90 MME for at least one day fell significantly ($p<.001$) between baseline and current remeasurement, and between first and current remeasurement ($p<.001$).

As shown in Figures 10 and 11, the study denominator (number of enrollees aged 12 and older who filled any opioid prescriptions during the measurement period) increased from December 2014 to March 2016, decreased steadily month-to-month through January–February 2017 (below the 2014 baseline period numbers) and then levelled off through October 2017.

As no national or state benchmarks exist for opioid prescribing, it is difficult to determine when optimal improvement will have been achieved. As this project (and intensive effort by CCOs) continues through a third remeasurement period, additional data points will contribute to a better understanding of any trends, and perhaps will help to establish statewide expectations.

Figure 10. Aggregated statewide results for ≥120 MME/day metric from baseline to current remeasurement period.

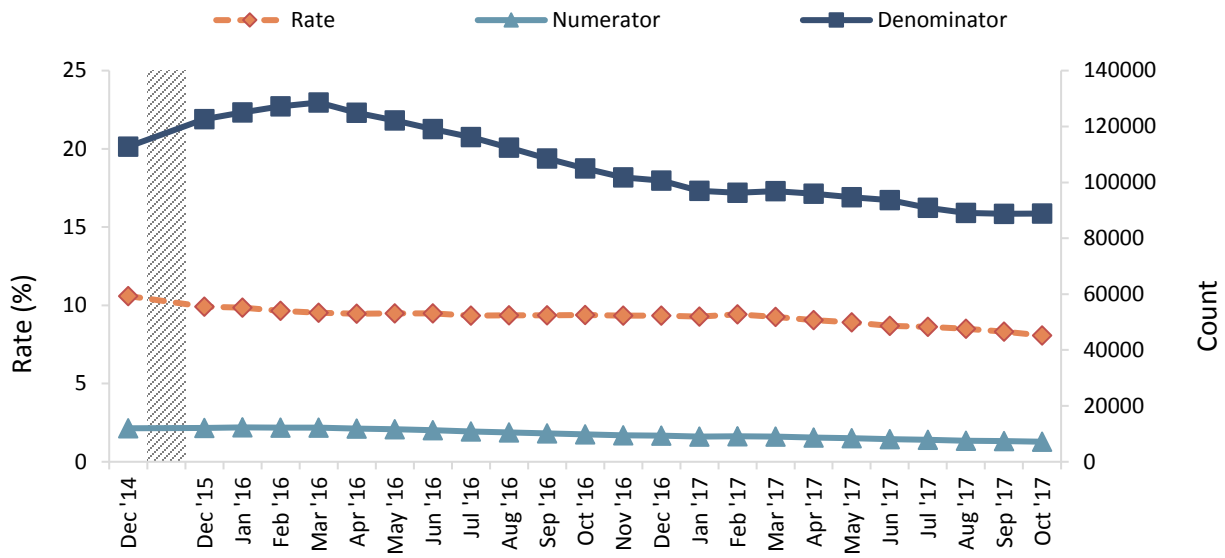
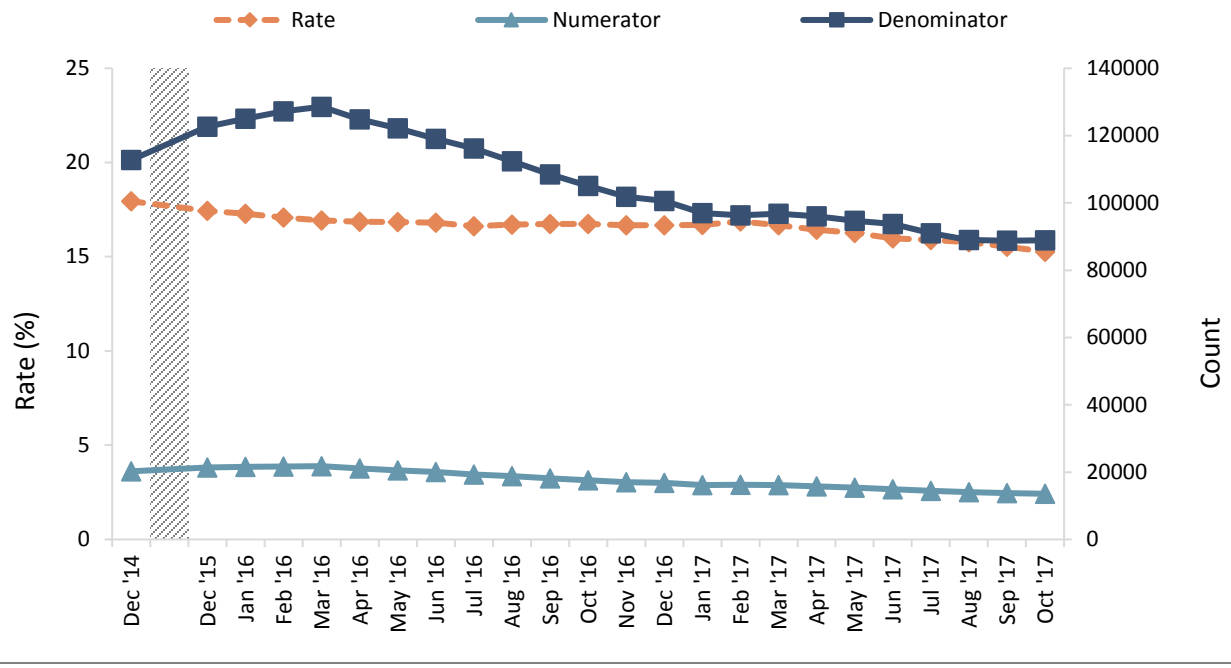


Figure 11. Aggregated statewide results for ≥90 MME/day metric from baseline to current remeasurement period.



Data analyses of the two secondary measures showed that the percentage of enrollees age 12 and older who filled opioid prescriptions for both ≥120 and ≥90 MME/day for consecutive 30 days or more declined significantly ($p<.001$) between baseline and current remeasurement and between first and current remeasurement ($p<.001$). There has been a steady decrease in the number of enrollees in both the 120 MME numerator (from 3,129 at baseline to 1,350 at last remeasurement) and the 90 MME numerator (from 4,448 at baseline to 2,527 at last remeasurement).

Because of the disproportionate decreases in the study denominator versus the numerators, it is important to examine both the counts as well as the rates when interpreting results, especially in the case of CCO-level data. For example, a few CCOs saw a very small increase in both study metric rates from baseline to current measurement, yet data analyses showed a decrease in both the number of enrollees in their denominators and ≥120 and ≥90 MME/day numerators. The amount of opioids in circulation would be expected to fall more quickly than the number of members being tapered off chronic doses of high opioids.

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

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

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

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

Future steps

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

Recommendation

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

CCO-Specific PIPs and Focus Projects

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

Table 5 lists the topics of CCO-specific PIPs conducted in 2017, which sought to address various issues of health care access, timeliness and quality. These topics are also shown in the individual CCO profiles in Appendix A.

Table 5. CCO-Specific PIP Topics and Objectives.	
PIP Topic (CCO)	**Objective**
Access (CHA)	Increase access at selected clinics by decreasing the no-show rate.
Addicted Newborns (UHA)	Increase the number of women receiving first trimester prenatal visits and drug screenings, and reduce the number of newborns born with substance issues.
Adolescent Well Care (AllCare, CHA, EOCCO, PSCS-CG, PSCS-CO, YCCO,)	Increase the number of adolescents having an adolescent well-care visit during the measurement year.
Back Pain Surgeries (JCC)	Reduce unnecessary back pain surgeries by decreasing the number of inappropriate spine MRI procedures (JCC is still collecting data on this topic).
Colorectal Cancer Screening (AllCare, EOCCO, PHJC, WVCH, WOAH)	Increase the number of members with a colorectal cancer screening test within the clinically recommended age group. EOCCO expected to retire this PIP 12/31/2017.
Community Health Workers (PHJC)	Standardize community health worker processes and tools to provide more efficient and effective case management.
Comprehensive Case Management (WVCH)	Use comprehensive case management to reduce polypharmacy, improve members' hemoglobin A1c rates and blood pressure and reduce costs in two pilot clinics.
Dental Visit During Pregnancy (IHN, PSCS-CO , PSCS-CG)	Increase the percentage of pregnant members who have a dental visit.
Depression Screening (TCHP)	Increase identification and treatment of depression screening for adults in primary care by administering the PHQ-9 screening tool and tracking members with clinical-level results.
ED Utilization (CPCCO, IHN, JCC, UHA, YCCO)	Reduce member use of the ED by increasing access to and use of primary care.
Effective Contraceptive Use (AllCare, HSO, PSCS-CO, PSCS-CG, WOAH)	Reduce unintended pregnancy in women of child-bearing age by increasing effective contraceptive use.
Foster Care/APC Collaborative (Health Share)	Design effective models of care for children in foster care so as to improve quality and utilization measures for these children.
Hospital Readmissions (IHN, TCHP, UHA, WOAH)	Prevent inpatient readmission through improved discharge and transition planning and closer communication with primary care.
Maternal and Perinatal Health (FamilyCare, HSO, JCC, PHJC, TCHP, UHA)	Improve maternal and perinatal outcomes through case management, health education and outreach/incentives.
Patient-Centered Primary Care Home (YCCO)	Increase the number of providers certified as PCPCHs and increase the percentage of enrollees affiliated with a PCPCH.

Table 5. CCO-Specific PIP Topics and Objectives.	
Serious and Persistent Mental Illness/Metabolic Screening (FamilyCare)	Increase screening rates for hyperlipidemia and diabetes among members with serious and persistent mental illness who are prescribed two indicator mental illness medications.
Tobacco Use/Cessation (CHA, CPCCO, FamilyCare, WVCH)	Reduce tobacco use prevalence among CCO members by increasing the use of tobacco cessation programs.
Trauma-Informed Care (CPCCO)	Conduct provider training to increase the number of providers who practice trauma-informed care.

DELIVERY SYSTEM NETWORK REPORTING

Federal and state regulations governing Medicaid services require each managed care contractor to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. Each contractor must submit documentation to the state Medicaid authority demonstrating the contractor's capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care.[14]

Exhibit G of the CCO contract outlines the required content of the Delivery System Network (DSN) reports that each CCO must submit for state review by July 1 every year.

In April 2017, OHA collaborated with HealthInsight to provide training for the CCOs regarding the expectations for DSN reporting, including the use of a new format for DSN reports. The CCOs were encouraged to use this tool to evaluate the adequacy of their DSNs. The new format asked for more detailed information related to the Exhibit G contract requirements, specifically regarding delivery network adequacy and access to meet enrollee needs. The format included five indicator categories and a "pilot" score to measure the CCO's response to each question within each indicator.

CCOs were asked to submit a narrative for each topic area and supporting documentation to OHA's Contract Administration Unit by July 1, 2017. OHA reviewed these documents, checking for progress on the transformation metrics, and forwarded the documents to HealthInsight for comparison and analysis.

OHA asked HealthInsight to review the CCOs' 2017 DSN reports. HealthInsight looked at responses that covered all services delivered:

- physical health care
- mental health care
- substance use disorder services
- dental care
- NEMT services
- acute care
- specialty care

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

The CCOs received a score for each of five indicator categories, chosen on the basis of contract requirements and identified needs 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

In addition to the DSN Provider Narrative Reports, HealthInsight reviewed the CCOs' DSN Provider Capacity Reports (CCO contract Exhibit G 1.b). This section of the contract requires all providers (practitioners and facilities) to be listed with required data elements.

Review Results

All 16 CCOs submitted their DSN Provider Narrative Reports and DSN Provider Capacity Reports. In reviewing the reports, HealthInsight considered each component of the contract requirements. HealthInsight delivered summary analysis and recommendations to OHA in the DSN report for each indicator, as well as a review of each CCO's submission.

In a step toward modernizing network adequacy, new federal regulations for Medicaid managed care require the EQRO to validate network adequacy using protocols to be developed by CMS in the near future. OHA is preparing for this upcoming requirement and is working to ensure that CCOs are analyzing and improving their networks according to up-to-date criteria and methods.

GOBHI REVIEW RESULTS

GOBHI has roughly 4,000 MHO members living in 22 Oregon counties. GOBHI has contracts for services in 16 counties. GOBHI's enrollees are eligible for Medicaid but are not enrolled in a CCO in GOBHI's service area.

GOBHI contracts with community mental health programs (CMHPs), other private nonprofit agencies, individual providers and hospitals to deliver treatment services. The MHO is responsible for ensuring that services are delivered in a manner that complies with legal, contractual and regulatory obligations to provide effective care.

Compliance Review Summary

In 2017, HealthInsight reviewed GOBHI's compliance with regulatory and contractual standards in three areas: enrollee rights, grievance systems and certifications and program integrity. The review found that GOBHI

- partially met requirements for the enrollee rights section
- fully met criteria for grievance systems
- fully met the certifications and program integrity section

Overall strengths

GOBHI has demonstrated improvements in meeting the requirements of the MHO contract and federal regulations related to enrollee rights, grievance systems and certifications and program integrity.

- GOBHI has implemented various tools for tracking electronic data and analysis of care coordination, utilization, grievances, claims management and processes for employee training, contracting and compliance).
- GOBHI has taken the process for service denials and appeals in-house, ensuring consistency of decisions, communications and reporting.
- GOBHI has conducted in-person site visits of many of its contracted CMHPs. These visits have included clinical record reviews, training and oversight of contract expectations.
- GOBHI is working to strengthen its compliance program and to increase monitoring of its delegates' compliance programs.

- In 2016, GOBHI surveyed its adult and youth populations to identify strengths and areas for improvement. This survey included questions related to enrollee rights and quality of care.

Major areas for improvement

- GOBHI does not monitor all providers in all counties where MHO members reside to ensure that enrollee rights are respected.
- There is a gap in monitoring providers who do not contract with GOBHI with regard to enrollee rights, grievance systems and certifications and program integrity requirements.
- GOBHI's member handbook does not identify processes for MHO members who receive services outside of the contracted CMHPs.

HealthInsight also followed up with GOBHI regarding results of the 2015 compliance review, which covered QA/PI standards. Of the 19 compliance findings from 2015 that were unresolved after the 2016 review, GOBHI has resolved 14 and partially resolved 5.

Recommendations for OHA:

- *OHA is encouraged to help GOBHI meet its MHO contract and federal regulatory requirements by facilitating opportunities for GOBHI to develop oversight and monitoring agreements with CCOs, or directly with providers, in areas with few GOBHI members and without GOBHI contracts.*
- *OHA needs to update GOBHI's MHO contract to include updated federal regulatory requirements.*

PIP Validation Summary

As required by OHA, GOBHI conducted two PIPs in 2017, one clinical and one nonclinical.

1. **Improving mental health access for older adults**

   This PIP focuses on improving the mental health service penetration rate for older adults in Umatilla and Malheur counties. The overall weighted score for this PIP was 50 on a scale of 85, resulting in a compliance rating of Partially Met. GOBHI needs to address several significant challenges in continuing with this project, now in its second year: clarify the numerator and denominator definitions to ensure accurate and consistent data

collection; revise the data analysis plan measurement periods to aid in interpreting results; document a root cause analysis of the local problem; and describe specific PIP activities (including tracking and monitoring data) over time.

2. **Children 0–6 Years Old Primary Care PIP**

   In response to HealthInsight's 2015 recommendation to select a new PIP topic for 2016 that would affect a significant number of MHO enrollees, GOBHI analyzed its MHO-only member population and discovered underutilization of services by young Hispanic children (0–6 years of age). This PIP, now in its second year, focuses on improving the service penetration rate for young Hispanic children in Umatilla and Malheur counties, the GOBHI counties with the highest percentage of the target population. The overall weighted score for this PIP was 50 on a scale of 85, resulting in a compliance rating of Partially Met.

   If GOBHI decides to continue this PIP, the MHO needs to improve its documentation by clarifying the numerator and denominator definitions to ensure accurate and consistent data collection; revise the data analysis plan measurement periods to aid in interpreting results; document a root cause analysis of the local problem; and provide details about intervention activities (including tracking and monitoring data) over time.

ISCA Follow-up Summary

In 2017, HealthInsight followed up on the results of GOBHI's full ISCA review in 2016. GOBHI has resolved one of the three findings from 2016 and is in the process of resolving two findings.

GOBHI outsources claims processing, encounter data verification and submission, enrollment verification and fee-for-service payments to PH Tech. The MHO staff continues to use PH Tech's Community Integration Manager (CIM) to handle authorization decisions, but does not have a process in place to monitor these activities.

GOBHI provides and hosts email services for its provider network. Provider agencies can choose to have a GOBHI email address or to have their domain hosted by GOBHI. GOBHI has redesigned its web page to better support the

members. The MHO has also set up a provider portal for the providers to use for eligibility checking and other functions.

GOBHI's encounter data liaison signs the certification of claims and encounter data. The encounter data liaison reports to the data manager who reports to the controller. The controller reports to GOBHI's CEO. The encounter data coordinator is the encounter data liaison's backup for the attestation of claims/encounter data. PH Tech submits mental health data to OHA, then submits a copy of the submitted data to GOBHI. GOBHI signs the certification of claims and encounter data after receiving the copy of the mental health data that PH Tech has submitted to OHA.

GOBHI has begun using Pre-Manage and Altruista Health for utilization management reporting. GOBHI is migrating to Tableau software for reporting and other changes to data report production and display.

GOBHI reported continued progress in its efforts to implement a data warehouse using Arcadia Solutions products and services. Arcadia is a hosted solution that will receive data from GOBHI, PH Tech and GOBHI provider agencies. GOBHI plans to supplement in-house generated reporting capabilities with Arcadia. GOBHI continues to work toward using this new data warehouse to contain claims and encounter data and clinical data from provider EHR systems. GOBHI continues to work to develop capabilities to verify completeness of encounters and perform timely clinical record reviews.

For more detail on the results of GOBHI's ISCA review, please see the MHO's profile in Appendix A.

DISCUSSION AND OVERALL RECOMMENDATIONS

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

HealthInsight offers the following recommendations for OHA to help the CCOs address the program areas in greatest need of improvement at the end of 2017.

Access to Care

The CCOs continue to make progress in expanding access to and coordination of primary care, behavioral health care and dental care; in providing specialists to meet members' needs; and in providing NEMT services. CCOs continue to struggle with integrating dental care into their delivery systems.

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

Most CCOs lack methods to analyze access to all required services. Some CCOs lack system-wide mechanisms to monitor network adequacy and capacity to ensure timely access to all required services.

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

Most CCOs do not closely monitor the timeliness of access to routine, urgent and emergent mental health services, substance use disorder treatment services, dental care or NEMT services. Most CCOs do not analyze their networks to ensure that they meet the standards for members' time and distance to appropriate providers.

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

Oversight of Delegated Functions

Though CCOs may subcontract many activities to outside entities, the CCO is responsible for all duties and responsibilities in the managed care contract, and must monitor subcontractors' performance. Many CCOs lack mechanisms to monitor certain activities that are delegated to partners and providers.

Although most CCOs monitor enrollee rights via their grievance systems, few CCOs gather grievances from all providers and delegates. Most CCOs review and act only on grievances they receive directly. Very few mental health grievances are gathered. If not all grievances are addressed and analyzed, it is difficult to know whether enrollee rights are being monitored adequately. More work is needed to ensure that CCO grievance systems are implemented consistently across all service categories, including NEMT.

> ***OHA needs to continue to work with the CCOs to ensure that grievances are gathered and reported consistently as expected. OHA may need to define what constitutes a grievance, which grievances need to be reported and whether they need to be gathered from all providers.***

Most CCOs did not provide evidence of monitoring and overseeing their contracted organizations' performance with respect to encounter data submission and IT security.

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

Certifications and Program Integrity

Most CCOs face challenges in ensuring that certifications are in place for all appropriate individuals (providers, subcontractors, staff, governing board members, volunteers, etc.), including:

- disclosure of ownership or controlling interests in the business entities and suppliers that deliver services to CCO members
- disclosure of conflicts of interest
- disclosure of vendor relations, gifts and other compensations
- criminal background checks for required individuals

- monthly screening for exclusion from participation in federal health care programs

OHA needs to clarify expectations for CCOs regarding which certifications are required and which individuals need to be included.

Some CCOs do not have mechanisms in place for routine monitoring and auditing of the CCO, providers and subcontractors, or their risk assessment does not assess fraud and abuse.

OHA needs to continue to support CCOs in developing effective compliance programs that include ongoing monitoring and auditing of the CCO, providers and subcontractors to address identified risks.

Performance Measures

OHA has made substantial improvements in resolving concerns about the integrity and completeness of encounter data in the Medicaid Management Information System (MMIS). However, HealthInsight remains concerned about the validity of the data OHA uses to calculate the CCO performance measures.

- ***OHA should define the performance measure requirements for GOBHI, the managed mental health organization.***
- ***OHA should document processes, policies and procedures specific to each performance measure, specifying steps to ensure that:***
  - ***OHA receives complete encounter data from all CCOs in a timely manner***
  - ***the data flow between and within OHA systems, and the data flow with external partners, is documented and understood***
  - ***OHA staff with authorization to sign off on measure calculation and validation do so, and document this in writing***
  - ***OHA communication with CCOs is documented and consistent***
  - ***current relationships with external partners are documented, as are any future changes in associations, roles or responsibilities***
- ***OHA should either conduct an EDV or require the CCOs or a third party to conduct an EDV, to ensure submission of complete and valid encounter data to OHA.***

- ***OHA should require race and ethnicity fields to be completed on Medicaid enrollment forms.***

Information System Security

OHA continues to expand and enhance its BC/DR plan for the MMIS, which was still in draft form at the time of the ISCA review. Completion of OHA's BC/DR plan depends on identifying all mission-critical functions and completing an overarching plan.

- ***OHA needs to continue progress on its BC/DR plan to fully implement and test the plan. Best practice would include a detailed, documented and fully communicated BC/DR plan, a documented test plan, documented test results and an action plan based on test results.***

OHA does not require the CCOs by contract to maintain BC/DR plans, without which the CCOs risk being unable to fulfill their contractual obligations. OHA has evaluated BC/DR language to add into the CCO contract, but cannot add language into the 2018 contract.

- ***OHA needs to encourage each CCO to finish developing and testing its BC/DR plan. The BC/DR plan should ensure that each business has thought through details of keeping services running during a disaster and ensuring that key personnel are trained and knowledgeable of their responsibilities during a disaster.***

Member Information

Most CCOs have had difficulty providing member-facing materials in easily understood language, including grievance response letters, notices of action and notices of appeals resolution.

OHA needs to provide guidance and support to the CCOs to meet information readability standards.

Many CCOs do not provide required information to their members about all providers, particularly mental health providers.

OHA needs to clarify which providers should be included in CCOs' provider directories, and continue to require the CCOs to provide all mandated information on all providers to ensure that members have access to the necessary information to make informed choices of providers.

APPENDIX A: CCO PROFILES

These profiles briefly describe each CCO's organizational structure and summarize the CCO's performance in the review areas covered by the 2017 EQR:

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

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

Profiles are presented for the 16 CCOs and one managed mental health organization (GOBHI) that served OHP enrollees during 2017.

AllCare Health Plan

AllCare contracts with OHA to provide services to OHP members under the health plan services contract. Headquartered in Grants Pass, the CCO provides physical, behavioral and dental health services for members in Curry, Jackson and Josephine counties. AllCare contracts with Options for Southern Oregon and Curry Community Health to provide mental health services for CCO members; with Advantage Dental Services, Capitol Dental Care, ODS, Willamette Dental Group and La Clinica for dental services; ReadyRide for non-emergent medical transportation (NEMT); and with MedImpact for pharmacy benefit management.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Fully met (3.6)
Grievance Systems	Substantially met (3.3)
Certifications and Program Integrity	Fully met (3.8)

Key Findings and Areas for Improvement

The CCO needs to ensure that member materials are written in easily understood language (i.e., using common words, written in at most sixth-grade language).

AllCare needs to provide members an annual notification of required information and ensure that all required information is available through the provider directory.

The CCO needs to provide enrollees with information on how to obtain all services that are available under the state plan but not covered under the CCO contract.

AllCare needs to ensure that the clinical expertise of the decision makers for grievances and appeals is appropriate to the decisions being made.

The CCO needs to ensure timely resolution of appeals.

AllCare needs to ensure that at the time of contracting, all providers are given information on appeal procedures and timelines and ensure that providers are informed that assistance is available to members for the grievance systems filing processes.

The CCO should develop a mechanism to report adverse actions that result in terminations or suspensions of providers, if appropriate, to OHA and the Office of Inspector General (OIG).

HealthInsight followed up with AllCare regarding steps taken to address findings from 2015 that were unresolved in 2016. AllCare resolved both of the 2015 findings and one related recommendation that were unresolved in 2016.

Information Systems Capabilities Assessment

AllCare has made several organizational and technological changes during 2017. The organization is strategically bringing business functions in-house, and has moved to new office facilities. Physical health authorizations are an in-house function and will remain in-house. The organization is planning to replace an application (EZ-CAP) that is utilized for administering Medicaid eligibility, claims, authorizations, reports and to process and pay physical and mental health claims.

Many AllCare delegates subcontract with Availity LLC or Emdeon (now Change Healthcare) to submit claim/encounter data to AllCare. AllCare then submits the data to OHA.

AllCare subcontracts with PH Tech to process dental claim/encounter data and submit the data to OHA. PH Tech provides dental provider networks with a copy of Medicaid enrollment data. AllCare's director of claims reviews and certifies dental data prior to the data being submitted.

ISCA Section	2016 ISCA Results	2017 ISCA Follow-Up Results
Information Systems (data flow)	No findings noted	NA
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	2 findings noted	2 findings in progress
Administrative Data claims and Encounter Data	1 finding noted	1 finding in progress
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	3 findings noted	3 findings in progress
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Security (Incident management, risk management) - CCO monitoring of delegated IT activities. AllCare needs to communicate monitoring expectations to delegate organizations and providers.
2017 progress update: AllCare is in the process of adding questions to their delegate oversight/audit tool relating to IT systems. The tool is not finalized, but has been used with one mental and one dental provider. This finding is in progress.

Finding #2: Security (Incident management, risk management) - Business Continuity/Disaster Recovery (BC/DR) plans and testing plans. AllCare needs to finalize a detailed BC/DR plan and ensure delegated organizations and providers have a BC/DR plan, encryption is used, a formal hardware/media destruction process is in place and passwords follow industry norms and comply with AllCare's expectations.
2017 progress update: AllCare completed a table test of a draft BC/DR plan after moving to a new facility. AllCare now contracts with Atmosera in Beaverton, Oregon, to provide disaster recovery site services. AllCare added questions in their delegate oversight process addressing encryption, hardware/media destruction and passwords. This finding is in progress.

Finding #3: Administrative Data Claims and Encounter Data - Zero and low-dollar claims expectations and monitoring process. AllCare should formalize and document its procedure for monitoring NEMT activities, communicate expectations regarding collection and submission of all zero

and low-dollar claims to delegates and providers, and ensure delegates monitor and accurately process all Medicaid claims/encounter data.
2017 progress update: AllCare is communicating expectations regarding collection and submission of zero and low-dollar claims to delegates. AllCare is continuing to develop validation and submission monitoring processes. This finding is in progress.

Finding #4: Provider Data (compensation and profiles) - Unclear if AllCare is notified when provider leaves Curry Community Health. AllCare needs to communicate to delegated organizations and providers expectations regarding providers joining or leaving the organization. AllCare should implement a formal evaluation process for reviewing provider data in its data repositories.
2017 progress update: AllCare updated the provider manual requiring delegates to inform AllCare when a provider joins or leaves the delegate organization. AllCare is developing a process/procedure to maintain provider data. This finding is in progress.

Finding #5: Provider Data (compensation and profiles) - Provider Directory. AllCare needs to ensure the provider directory includes all services provided, and including practitioner demographic information. AllCare needs to search functions fully work including search functionality on unique aspects such as specialty or gender.
2017 progress update: AllCare now has an online provider directory including nightly updates. This finding is in progress.

Finding #6: Provider interview issues. AllCare needs to develop and implement a policy/procedure ensuring delegate organizations and providers are aware of expectations. AllCare needs to include language regarding expectations in contracts between AllCare and delegate organizations and providers to ensure participation in ISCA provider interview activities.
2017 progress update: AllCare developed a process to manage provider participation. AllCare plans to make executives responsible for contacting providers and ensuring participation for future ISCA activities. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Sent standardized tapering letters (developed by the Southern Oregon Regional Collaborative) to providers and members
- Participated in the Regional Collaborative Community Media campaign
- Co-sponsored an annual pain summit

Barriers:

- Providers and members are not providing required documentation for treatment requests or appeals

Next steps:

- Continue participation in the SW Regional Collaborative
- Continue to monitor and review denials and appeals

CCO-Specific Project Topics

- Increase rate of adolescent well-child visits
- Increase colorectal cancer screening
- Increase us of effective contraception.

Cascade Health Alliance (CHA)

CHA, a wholly owned subsidiary of Cascade Comprehensive Care (CCC), has no employees but leases employees from CCC to perform CCO administrative and operational functions. CHA contracts with Klamath Basin Behavioral Health and Lutheran Community Services and individual practitioners to deliver mental health and substance use disorder services. As of July 1, 2017, CHA began contracting directly with dentists rather than using the dental plan networks (DPNs) in the CCO's service area. CHA contracts with Sky Lakes Medical Center to provide non-emergent medical transportation (NEMT) services, using a capitation rate.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Partially met (2.6)
Grievance Systems	Substantially met (3.2)
Certifications and Program Integrity	Substantially met (3.3)

Key Findings and Areas for Improvement

Although CHA has many processes in place to communicate with staff, providers, delegates and members, not all processes are documented as required in the CCO's policies and procedures, member handbook, meeting minutes, provider manuals, contracts, training agendas, etc.

CHA does not provide training for staff in all areas in which they need to be knowledgeable to assist members (e.g., emergencies, post-stabilization services, advance directives and declarations for mental health treatment). The CCO is developing a customer service department and should be able to discuss authorizations, benefits, etc.

The CCO needs to review its member-facing materials to ensure that appropriate and required information is communicated in easily understandable formats.

CHA needs to ensure that it comprehensively addresses conflicts of interest related to CCO business. If CHA delegates responsibility for credentialing and screening for criminal conviction and exclusion from participation in federal health care programs, the CCO needs to monitor the delegate or partner to ensure that those functions are being performed as required.

HealthInsight reviewed the status of CHA's 2015 compliance findings that were unresolved in 2016. The CCO has partially resolved three findings but has yet to resolve five additional findings. These standards will be reviewed again in 2018.

Information Systems Capabilities Assessment

CHA uses a mix of in-house and contracted IT services. In-house applications include Plexis, a claims management system used for dental claim/encounter processing and submittal. EZ-CAP software is used to process physical health claims/encounter data. Goodale Systems software is used to allow providers to verify eligibility and authorization status. Contracted IT services include LightPoint NW (infrastructure support and offsite backup services), PH Tech provides data submission activities for physical, mental and NEMT data. CHA contracts with Milliman to provide reporting and analysis.
CHA has hired Software Business Solutions Consulting to assist in implementing provider monitoring strategies and assist CHA and CHA delegate organization and provider daily information systems operations tasks.

CHA continues to work to add pharmacy data feeds to its data warehouse to increase reporting and data analysis accuracy.
CHA's NEMT provider verifies patient Medicaid eligibility through OHA's MMIS application.
CHA works directly with mental health providers for claims payment. Internal CHA staff perform authorization decisions. CHA submits claims and encounter data to OHA.
CHA's claims director certifies data submission for physical, mental and dental health.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	1 finding noted	In progress
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	2 findings noted	2 findings in progress
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	No findings noted	NA
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Information Systems (data flow), data flow diagrams and documentation. The data flow diagram did not agree with CHA's list of applications, description of data flow or submission of data.
2017 Progress Update: CHA is developing an accurate and detailed data flow diagram that depicts their current state of data flow including all applications and data submission. The organization submitted an improved diagram. This finding remains in progress.

Finding #2: Security (Incident management, risk management), CCO monitoring of delegated IT activities. CHA lacked a formal process to monitor IT activities of its delegates or partners. Varied levels of encryption, hardware destruction processes and passwords were identified across delegate organizations. All low and zero dollar claims were not reported by delegate organizations.
2017 Progress Update: CHA continues to lack a formal process to monitor delegated IT activities, although CHA does review submitted documentation and communicates expectations to organizations not meeting CHA's requirements. CHA hosts monthly meetings with delegate organizations and providers and includes low and zero dollar claims as an agenda item. Finding remains in progress.

Finding #3: Business Continuity/Disaster Recovery (BC/DR) plan. CHA has developed a BC/DR plan and continues to refine it. It was unclear whether this plan covers all CCO functions and services. CHA reported that it has not yet developed a testing plan. **2017 Progress Update:** The BC/DR plan continues to be in draft status, with an expected completion date of Q1 2018.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Pharmacy department is developing guidelines for an opioid prescribing threshold of 50 mg MED
- Quality Management staff is tracking members on ≥ 50 mg MED for > 30 days.
- Distributed safe prescribing fliers to all providers and clinics.
- Implemented a tool to track taper plans

Barriers:

- Requirements for contracting and credentialing massage therapists and acupuncturists are not clear

Next steps:

- Continue to track and monitor high opioid users
- Implement a prior authorization stop for 50 mg MED at local pharmacies

CCO-Specific Project Topics

- Increase smoking cessation
- Increase rate of adolescent well child visits
- Decrease rate of no-show appointments and ED utilization

Columbia Pacific CCO (CPCCO)

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

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Substantially met (3.4)
Grievance Systems	Fully met (3.9)
Certifications and Program Integrity	Fully met (3.8)

Key Findings and Areas for Improvement

CPCCO's online provider directory needs to include all required information for all service providers.

The CCO's does not have a policy, procedure or site visit audit that addresses reviewing the clinical record for the presence of declarations for mental health treatment. The CCO does not monitor clinical records for presence of declarations for mental health treatment.

The CCO's notices of action, appeals resolution and grievance resolution letters require attention to ensure members receive this documentation in easy-to-understand language (i.e., using common words with a maximum sixth-grade reading level).

The CCO needs to have a mechanism to report actions taken on provider applications to OHA and the OIG that resulted in terminations or suspensions of providers, if appropriate.

HealthInsight followed up with CPCCO regarding steps taken to address findings from 2015 that were unresolved in 2016. CPCCO resolved both of the 2015 findings that were unresolved in 2016.

Information Systems Capabilities Assessment

CareOregon handles authorization decisions for physical health. CareOregon receives eligibility files and distributes them to the partner organizations. CareOregon is responsible for physical health authorization decisions, receiving eligibility files and distributing information to partner and delegate organizations. CareOregon's data warehouse holds physical, mental, vision, dental, substance use, pharmacy and 711 pharmacy claim data. A copy of 837 files and monthly all-payer all-claims (APAC) files are archived in this data warehouse.

CPCCO delegates mental health services to GOBHI. GOBHI submits mental health services claims directly to CareOregon, and CareOregon submits mental health claims/encounters to OHA.

CPCCO delegates dental services four dental networks all of which submit dental claims directly to OHA with copies sent to CareOregon. Advantage Dental, ODS Community Health and Willamette Dental process and submit claims using in-house staff and technology. Capitol Dental contracts with PH Tech for claims processing and submission.

CPCCO delegates vision services to Vision Service Plan (VSP), pharmacy services to OptumRX and Sunset Empire Transport District (RideCare) provides NEMT services. All three organizations send claims data directly to CareOregon. CareOregon submits data to OHA.
CPCCO's chief financial officer signs the certification of claims and encounter data for CPCCO. It is unclear when CPCCO receives copies of submitted claims.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	1 finding noted	1 finding in progress
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	2 findings noted	2 findings in progress
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	1 finding noted	1 finding in progress
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Information Systems (data flow), encounter data certification. It was unclear how the data received from partner organizations would be monitored to ensure completeness and accuracy. **2017 Progress Update:** CPCCO has assigned the CFO attestation responsibilities. A delegate monitoring process is still being developed but now includes processes to compare submitted data to APAC data. The finding remains in progress.

Finding #2: Security (incident management, risk management), CCO Monitoring of delegated IT activities. CPCCO did not provide evidence of monitoring and oversight of contracted or partner organization's IT systems, policies and procedures. **2017 Progress Update:** CareOregon developed and implemented a delegation oversight policy/procedure that applies to CareOregon's CCOs. The policy is weak in that it does not require all delegate or partner organizations to be reviewed and does not include a deep review of all IT systems. CPCCO communicates expectations regarding IT systems to delegated organizations during contract review.
The finding remains in progress.

Finding #3: Business Continuity/Disaster Recovery (BC/DR) plan. Neither CPCCO nor CareOregon maintained a CCO-level BC/DR plan.

2017 Progress Update: CareOregon continues to work on developing and refining its BC/DR plan. This plan covers all the IT functions and infrastructure that the CCO uses. The CCO delegates responsibilities for BC/DR planning and testing to CareOregon. As a result, the CCO uses CareOregon's BC/DR plan. CareOregon has conducted table-top tests of its BC/DR plan. CareOregon has additional BC/DR plan testing scheduled for 2017. CareOregon continues to work on developing and refining its BC/DR plan. This plan covers all the IT functions and infrastructure that the CCO uses.
This finding remains in progress.

Finding #4: Provider Directory. CPCCO's provider directory only lists facility level information for mental health providers and does not contain practitioner details. It is unclear how a member would request NEMT services from CPCCO using their website.
2017 Progress Update: The CCO continues to improve its online provider directory. The CCO contracts with CareOregon to host and maintain the online provider directory. The CCO continues to explore how to provide individual mental health provider information in the online provider directory.
The CCO continues to work with its dental provider networks to list the provider-level detail information in the provider directory. The CCO has updated its website making it easy for members to find information about and request NEMT services.
This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Conducted provider education sessions and a pain summit
- Continue to conduct pain management classes
- Partnered with OHSU to provide medication-assisted treatment (MAT) services
- Developed a brochure advertising pain clinics

Barriers:

- OHSU clinic is at capacity for MAT services
- High opioid using members have complex high risk health issues
- Undecided how to divide up tasks between the new Prescription Drug Overdose (PDO) Coordinator and CPCCO

Next steps:

- Transfer responsibility for future community of practice dinner and other tasks to the new PDO coordinator
- Plan for a Pain Summit in April 2018
- Develop a prior authorization process for acute prescribing
- Develop a plan on how to target remaining members on >120 mg MED

CCO-Specific Project Topics

- Decrease ED utilization
- Increase utilization of the tobacco cessation benefit and decrease smoking prevalence
- Evaluate the feasibility of conducting trauma-informed care training within major clinics

Eastern Oregon CCO (EOCCO)

EOCCO provides physical health, dental health and behavioral health care to OHP members in 12 Oregon counties (in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler). EOCCO is administered by Greater Oregon Behavioral Health, Inc. (GOBHI), which oversees behavioral health care and non-emergent medical transportation (NEMT), and Moda Health, which provides physical health, pharmacy and substance use disorder treatment services. EOCCO contracts with Advantage Dental, Capitol Dental and ODS (Moda) to provide dental services.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Fully met (3.7)
Grievance Systems	Fully met (3.6)
Certifications and Program Integrity	Substantially met (3.0)

Key Findings and Areas for Improvement

The CCO's notices of action, appeals resolution and grievance resolution letters require attention to ensure members receive this documentation in easy-to-understand language (i.e., using common words with a maximum sixth-grade reading level).

Information for members should include the extent to which and how to access out-of-network services. Member information also needs to include clear instructions about who to contact to access services available under the state plan but not covered by the CCO.

In order to avoid program integrity concerns, the CCO needs to require providers, subcontractors, staff and governing board members to disclose information related to vendor relations, gifts and other compensations.

The CCO needs to establish a policy and procedure to monitor delegated entities for compliance with monthly Office of Inspector General (OIG) screenings. EOCCO may wish to immediately receive reports of positive OIG screenings completed by delegates in order to decrease the potential payback period.

HealthInsight followed up with EOCCO regarding steps taken to address findings from 2015 that were unresolved in 2016. EOCCO resolved both of the 2015 findings that were unresolved in 2016.

Information Systems Capabilities Assessment

EOCCO has no employees. Moda Health or GOBHI employees act on behalf of EOCCO and handle all functions and activities. This includes attestation and data submission to the state. Moda Health utilizes the Trizetto Facets application to manage claims/encounter data.

GOBHI provides mental health services for EOCCO, and subcontracts data administration to PH Tech, including submitting data to the state. PH Tech sends a copy to Moda Health. PH Tech receives eligibility data from Moda, on behalf of GOBHI. Authorization decisions are made by GOBHI in the PH Tech Community Integration Manager (CIM) system.

MedImpact is EOCCO's pharmacy benefits manager. MedImpact submits pharmacy data to Moda Health, Moda Health sends pharmacy data to PH Tech and PH Tech submits the data to OHA.

GOBHI, on behalf of EOCCO, administers the contract for NEMT services. Moda Health receives and processes NEMT claims and encounters and submits the data to OHA on behalf of the CCO.

EOCCO maintains a provider database, which staff update when changes to credentials or contracts occur. The online provider directory is updated automatically on a regular basis.

PH Tech submits Capitol Dental data to OHA on behalf of EOCCO. Moda submits its dental data (under the ODS name) to OHA. Advantage Dental submits encounter data to OHA. Moda receives a copy of all dental data submitted to OHA on behalf of EOCCO.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	No findings noted	NA
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	2 findings noted	2 findings in progress
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	1 finding noted	1 finding resolved
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Security (incident management, risk management), Business Continuity/Disaster Recovery (BC/DR) plan. BC/DR plans appear to be limited for loss of the key data center, but there are offsite data replicas. It was unclear if any BC/DR planning has occurred that includes the CCO partners or all CCO services. GOBHI has a contingency policy in place, but it is high level and focused on IT. It was unclear how data flows through GOBHI's information systems and in what order information systems need to be restored.

2017 Progress Update: The BC/DR plan continues to be a work in progress. EOCCO plans to ensure that the BC/DR plan has sufficient detail to enable the CCO to return to operations in a timely manner. The finding remains in progress.

Finding #2: Monitoring providers and other partner organizations. A process to monitor contracted and partner organizations is in process but not complete. At the time of the review, GOBHI was in the process of hiring an individual would cover this responsibility.

2017 Progress Update: EOCCO implemented a compliance oversight program in 2016. This monitoring program consists of quarterly delegation monitoring, annual delegation audits of each partner

organization and an annual risk assessment of EOCCO. EOCCO is evaluating how monitoring of IT policies, processes and procedures can be integrated into the compliance oversight program.

Finding #3: Provider Data (compensation and profiles), provider payment and updates process. It was unclear if PH Tech could pay for an encounter conducted by a practitioner who has not completed the GOBHI credentialing process.

2017 Progress Updates: GOBHI submitted policies and processes related to credentialing. The credentialing process specifically requires GOBHI to complete the credentialing processes before PH Tech is given permission to pay the provider's claims.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Notified members and providers about tapering requirements
- Conducted community and provider forums
- Distributed lists to providers of members on >90 mg MED
- Developing a community health worker (CHW) program
- Conducted pain schools

Barriers:

- Staff turnover delayed intervention implementation
- Limited availability and access to existing pain schools
- Implementation of the CHW program was delayed

Next steps:

- Develop an online pain school and CHW support process
- Promote training module on chronic pain to CHWs
- Hire an analyst to produce dental provider reports
- Continue to modify existing and develop new pain schools

CCO-Specific Project Topics

- Increase colorectal screening rates
- Address substance use disorder in older adults
- Increase adolescent well child visits

FamilyCare CCO

FamilyCare, a 501(c)(4) public benefit corporation, contracted with OHA as a CCO to provide physical, behavioral and dental health services to OHP members in Clackamas, Marion, Multnomah and Washington counties. FamilyCare ceased operating as a CCO as of February 2018.

For dental services, FamilyCare contracted with eight dental plans. FamilyCare contracts with VSP to manage vision services, and with CVS Caremark as its pharmacy benefit manager. For non-emergent medical transportation (NEMT) services, FamilyCare contracted with Access2Care.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Substantially met (3.3)
Grievance Systems	Substantially met (3.3)
Certifications and Program Integrity	Fully met (4.0)

Key Findings and Areas for Improvement

The CCO needs to ensure that all required information is available to members in the provider directories.

With respect to advance directives and declarations for mental health treatment, the CCO needs to monitor compliance concerning documentation in the clinical record of whether enrollees have executed an advance directive or mental health treatment declaration and needs to provide community education materials (outside of member materials).

The CCO needs to review the use of seclusion and restraint by contracted providers and facilities, at a minimum, during credentialing and recredentialing, to ensure member rights are protected.

The CCO needs to ensure that member-facing materials (notices of action, notices of appeals resolution and grievance resolution) are written in easily understood language (at most, 6th grade reading level).

The CCO needs to meet criteria for standard disposition of grievances and appeals, ensure individuals making decisions have appropriate clinical expertise and have not been involved in previous reviews, and have a process to address notices of action and authorizations that occur outside of the acceptable timeframes.

The CCO needs to be the final adjudicator of all appeals.

Information Systems Capabilities Assessment

FamilyCare contracted with PH Tech for much of its data processing and submission services. Some organizations submitted data directly to PH Tech, while some used clearinghouses. PH Tech created claims and encounter files and sent FamilyCare the certification form, which was reviewed by FamilyCare and sent to OHA. PH Tech also provided FamilyCare with copies of the 837 files that were submitted to OHA. PH Tech submitted all dental claims and encounter data to OHA on behalf of FamilyCare.

FamilyCare replicated data for critical systems nightly to a Boise-based location. The CCO configured and tested access to this location for recovery purposes.

FamilyCare updated its data warehouse with a copy of PH Tech's CIM data nightly. The data warehouse also serves as a data source for a series of monthly, weekly and ad hoc reports. The CCO's reporting team developed reports to verify data for the OHA performance measures. FamilyCare uses Milliman for additional reporting capabilities. On a monthly basis, FamilyCare sends Milliman a copy of the PH Tech CIM data and data from FamilyCare's data warehouse.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	No findings noted	NA
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	1 finding noted	1 finding in progress
Administrative Data claims and Encounter Data	1 finding noted	1 finding in progress
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	No findings noted	NA
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Security (incident management, risk management), CCO monitoring of delegated IT activities. FamilyCare reported that it does not currently conduct monitoring and oversight of contracted or partner organizations. FamilyCare has developed a Provider Office Site Review Checklist which was submitted for review after the ISCA interview.
2017 Progress Update: FamilyCare submitted its provider site review checklist, and expects to complete the implementation by end of 2017. One quarter of providers were reviewed using the new checklist. This finding is in progress.

Finding #2: Administrative Data Claims and Encounter Data, Encounter data certification, NEMT monitoring. It was unclear if FamilyCare is receiving copies of the actual 837 files that PH Tech submits to OHA. FamilyCare has not yet determined policies and procedures for monitoring NEMT data.

2017 Progress Update: FamilyCare has begun receiving 837 copies from PH Tech. An audit of the NEMT partner was completed in late 2016 and FamilyCare is monitoring the NEMT data. Formal policy/procedure are a work in progress. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Continue to conduct on-site visits with high prescribers
- Conducted provider trainings, including Suboxone prescribing training
- Contract with Providence Health to provide access to Persistent Pain Classes
- Continue to disseminate lists of high opioid users to providers and FQHC clinics

Barriers:

- Competing priorities for the medical management team
- Unable to completely automate the quantity limit process as anticipated

Next steps:

- Continue to provide trainings for providers
- Continue to conduct visits to high prescribers
- Align quantity limit policies and processes with OHA Guideline Note 60

CCO-Specific Project Topics

- Improve maternity care and reduce health disparities using traditional health workers and doulas
- Increase metabolic testing in the SPMI population
- Decrease the rate of tobacco use

Greater Oregon Behavioral Health, Inc. (GOBHI)

GOBHI, a managed mental health organization (MHO), manages the OHP mental health benefit in many Oregon counties. GOBHI has contracts for services in 16 counties. The MHO contracts with community mental health programs (CMHPs), other private nonprofit agencies, individual providers and hospitals to deliver treatment services. GOBHI's enrollees are individuals who are eligible for Medicaid, but are not enrolled in one of the CCOs in GOBHI's service area.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Partially met (2.7)
Grievance Systems	Fully met (4.0)
Certifications and Program Integrity	Fully met (3.5)

Key Findings and Areas for Improvement

The MHO does not monitor providers who they do not contract with. As such, they are not ensuring enrollee rights, grievance systems and certification and program integrity requirements are being met.

GOBHI's member handbook needs to identify processes for MHO members who receive services outside of the contracted CMHPs.

HealthInsight also followed up with GOBHI regarding results of the 2015 compliance review, which covered quality assessment and performance improvement. Of the 19 compliance findings from 2015 that were unresolved after the 2016 review, GOBHI has resolved 14 and partially resolved five.

Information Systems Capabilities Assessment (ISCA)

GOBHI outsources claims processing, encounter verification and data submission, enrollment verification, and fee-for-service payments to PH Tech. GOBHI completes authorization activities by accessing PH Tech's CIM application. PH Tech submits data to OHA and sends a copy to GOBHI. GOBHI certifies the data after receiving a copy from PH Tech.

GOBHI has started using Pre-Manage and Altruista for utilization management reporting. GOBHI is migrating to Tableau for reporting and other changes to how data reports are created and viewed.

GOBHI reported continued progress in its efforts to implement a data warehouse using Arcadia Solutions products and services. GOBHI continues to work towards using this new data warehouse to include claims and encounter data, clinical data from provider EHR systems. GOBHI continues to work to develop capabilities to verify completeness of encounters and perform timely clinical record reviews.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	1 finding noted	1 finding in progress
Staffing (claims and encounter, authorization)	No findings noted	NA

Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	1 finding noted	1 finding in progress
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	1 finding noted	1 finding resolved
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Information Systems (data flow), Encounter data Certification. GOBHI signs the attestation that data are accurate based on PH Tech's data submission to OHA. GOBHI is working with PH Tech and providers on processes to ensure the completeness and timeliness of the data.

2017 Progress Update: GOBHI hired an encounter data coordinator responsible for encounter data oversight, monitoring of data trends, handling reconciliation of rejected claims and encounter data validation. GOBHI has developed and is in the process of implementing and documenting an encounter data validation process. GOBHI continues to sign the attestation statement after the data have been submitted to OHA by PH Tech. This finding is in progress.

Finding #2: Security, monitoring Providers and Other Partner Organizations. GOBHI is developing a process for monitoring contracted and partner organizations policies, procedures, and practices related to information systems.

2017 Progress Update: GOBHI has developed and is in the process of documenting the tools used in the new oversight process. GOBHI reported that it has started performing reviews of contracted mental health providers using the oversight process. GOBHI reported that four providers had participated in the new oversight process at the time of the ISCA interview. This finding is in progress.

Finding #3: Provider Data (compensation and profiles), Provider Payment and Updates Process. It was unclear if PH Tech could pay for an encounter conducted by a practitioner who has not completed the GOBHI credentialing process.

2017 Progress Update: GOBHI submitted policies and processes that specifically requires GOBHI to complete the credentialing processes prior to PH Tech being given permission to pay the provider's claims. ***Resolved***

Performance Improvement Projects (PIPs)

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

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

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

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

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

Health Share of Oregon

Health Share of Oregon contracts with OHA to provide services to OHP members under the health plan services contract. The CCO provides physical, behavioral and dental health services primarily in Clackamas, Multnomah and Washington counties.

Health Share, the largest CCO in Oregon, is a private, not-for-profit organization that contracts with 16 risk-accepting entities. The CCO has established a regional behavioral health system called Health Share Pathways to better integrate and coordinate mental health and addictions services for CCO members. Rather than delegating the contracting for these behavioral health services to risk-accepting entities, Health Share contracts directly with the service providers.

Health Share has four physical health business partners—CareOregon, Kaiser Permanente Northwest, Tuality Health Alliance and Providence Health & Services; three mental health business partners—Clackamas, Multnomah and Washington counties; and nine dental health business partners. The CCO contracts with Access2Care to provide non-emergent medical transportation as a capitated service.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Fully met (3.6)
Grievance Systems	Fully met (3.8)
Certifications and Program Integrity	Fully met (4.0)

Key Findings and Areas for Improvement

Health Share needs to ensure that all member materials are written in easily understood language.

Health Share needs to ensure that all required information is provided for all CCO providers.

The CCO needs to provide information on the extent to which and how enrollees may obtain dental and mental health services from out-of-network providers.

The CCO needs to provide members with information on how to obtain services that are available under the state plan but not covered under the CCO contract.

Health Share needs to perform the final adjudication of appeals rather than delegate this function.

Information Systems Capabilities Assessment (ISCA)

Health Share contracts administrative and infrastructure functions. Each business partner is responsible for submitting claims/encounter data to OHA. HealthShare receives copies and stores them at CareOregon, Atmosera data center and other locations. HealthShare contracts with Providence Health & Services to create a data repository and provide reports.
HealthInsight conducted ISCAs of the four DPNs (Advantage Dental, Capitol Dental Care, ODS and Willamette Dental Group) that contract with a majority of the CCOs, including Health Share. Health Share has been working to improve collection of encounter data related to the dental sealants administered in schools. This effort is helping to improve Health Share's performance metrics related to dental sealants.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	No findings noted	NA
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	1 finding noted	1 finding in progress
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	1 finding noted	1 finding in progress
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	No findings noted	NA
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Security (incident management, risk management), Business Continuity/Disaster Recovery (BC/DR) plan. Health Share is developing a CCO-level BC/DR plan. Health Share also reported that a plan has been developed for supporting the phone systems and network infrastructure during a disaster. The CCO is evaluating how the use of virtual workstations could facilitate disaster recovery and business continuity plans.

2017 Progress Update: The BC/DR plan continues to be in progress with more detail continually being added. Health Share expects to complete the BC/DR plan by the end of 2017. Health Share is evaluating how to conduct a tabletop test of the BC/DR plan in the first quarter of 2018. This finding remains in progress.

Finding #2: Vendor Data Integrity and Ancillary Systems, Monitoring of business partners and PH Tech. Evidence of monitoring and oversight of PH Tech for processing of claims and encounter data was not provided. Several of Health Share's business partners contract with PH Tech for handling claims and encounter data processing. PH Tech submits claims and encounter data to Health Share on behalf of these business partners. It was unclear if Health Share would be able to ensure the completeness and accuracy of business partner data being submitted to Health Share by PH Tech based on the current level of monitoring.

2017 Progress Update: Health Share is working with a consultant to develop a vendor oversight program. The CCO expects to finish developing standards and supporting policies by the end of 2017. Health Share intends to monitor all business partners during the course of 2018 using the newly developed monitoring standards and policies. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Health Share – Care Oregon
  - Distributed dashboards and member lists to clinics every quarter
  - Conducted a Persistent Pain Collaborative
- Health Share – Providence Medical Group
  - Mailed letters to providers of members on > 90 mg MED
  - Conducted pain education classes and offered patient education videos
- Health Share – Kaiser Permanente
  - Established guidelines and disseminated provider and member materials on co-prescribing
  - Developed post-surgical opioid prescribing guidelines
- Health Share – Tuality Health Plan
  - Developed an opioid usage report
  - Evaluated effectiveness of alternative treatment services
- Health Share CCO
  - Developed a medication-assisted treatment program in collaboration with CODA and Central City Concern
  - Created a dashboard using OHA data and distributed to health plan members

Barriers:

- Interventions require consistent plan staff and additional training
- Difficult to get all stakeholders together to work on guidelines
- Competing organizational priorities

Next steps:

- Health Share-Care Oregon will develop and implement interventions that align with the OHA opioid back pain guidelines and refine the opioid dashboard
- Health Share–Kaiser Permanente will continue to have pharmacists work with providers to implement taper plans, review members on high doses of opioids and provide opioid and co-prescribing toolkits to providers
- Health Share-Providence Medical Group will complete an alternative therapy utilization review, continue to distribute lists to providers with members on >90 mg for 90 days and continue to review difficult cases at the clinic level.
- Health Share-Tuality Health Plan will continue working with members and providers to align with the OHA opioid back pain guidelines and analyzing plan data
- Health Share will continue to share data reports with health plan partners and to participate in the Tri-County Opioid Safety Coalition

CCO-Specific Project Topics

- Improve maternal and infant outcomes using a new model of care (Project Nurture)
- Increase the rate of effective contraception use
- Design and implement foster care medical home models of care

InterCommunity Health Network (IHN)

IHN provides physical, behavioral and dental health services for OHP members in Benton, Lincoln and Linn counties. IHN is a wholly owned subsidiary of Samaritan Health Services and is managed by Samaritan Health Plan Operations. The CCO partners with four dental plan networks (DPNs): Advantage Dental, Capitol Dental Care, ODS Community Health and Willamette Dental Group. The CCO contracts with Benton, Lincoln and Linn counties for behavioral health services, in addition to Mid-Valley Behavioral Care Network and Accountable Behavioral Health Alliance. The Oregon Cascades West Council of Governments provides non-emergent medical transportation (NEMT) services for IHN members.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Substantially met (3.2)
Grievance Systems	Substantially met (3.2)
Certifications and Program Integrity	Fully met (3.5)

Key Findings and Areas for Improvement

IHN needs to ensure that advance directives and declarations for mental health treatment meet regulatory and contractual requirements.

IHN needs to review the policies and procedures of all providers/facilities that use seclusion or restraint, and review their use of these high-risk procedures, to ensure that members are free from seclusion or restraint used as a means of coercion, discipline, convenience or retaliation.

Many member materials do not meet contract requirements for readability. Details related to member notices require attention, including timing and content. Provider materials presented no guidance for members in accessing or understanding the CCO's grievance system.

The CCO, rather than a delegate, needs to adjudicate all final appeals.

The CCO's policies on conflicts of interest related to CCO business do not address subcontractors. IHN does not require subcontractors or providers to disclose ownership or controlling interests in the business entities and suppliers who deliver services to CCO members.

At the time of review, IHN had no mechanism in place to report appropriate adverse actions taken with providers to OHA and the Office of Inspector General.

IHN needs to implement regular auditing and monitoring of the CCO, providers and subcontractors.

The CCO partially resolved both of the 2015 findings that were unresolved in 2016. These include: 1) The CCO has identified the need to monitor provider compliance and continues to work on how best to move forward. 2) The CCO plans to update its Clinical Practice Guidelines policy to include dental care when describing how clinical practice guidelines are developed, adopted and disseminated.

Information Systems Capabilities Assessment (ISCA)

IHN uses Samaritan Health Services IT infrastructure, systems and processes including support service employees. IHN receives data directly from providers and submits data to OHA. For dental data, PH Tech provides IHN a copy of Capitol Dental's data and submits data to OHA. For the other three

dental provider networks, IHN receives copies of submitted data. IHN utilizes Trizetto Facets to process physical, mental, vision and pharmacy data. IHN submits data to OHA using VisibilEDI.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	No findings noted	NA
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	1 finding noted	1 finding in progress
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	1 finding noted	1 finding resolved
Provider Data (compensation and profiles)	No findings noted	NA
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Security (incident management, risk management), Business Continuity/Disaster Recovery (BC/DR) plan. IHN's parent company had a BC/DR plan but IHN did not have their own BC/DR plan.

2017 Progress Update: IHN conducted an IT disaster recovery test in the fall of 2017. No issues were detected. A formal BC plan is lacking. This finding is in progress.

Finding #2: Report Production and Integration and Control of Data for Performance Measure Reporting, historical gaps in mental health data. Mental health claims/encounters were not in a database and not available for reporting after IHN stopped contracting with PH Tech.

2017 Progress Update: Historical mental health data are now available in a data repository. This finding is resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Provided computer-based learning for all Samaritan Health System employees
- Conducted pilot project on improving pain management by PCPCH providers
- Developed and maintained the PainWise website for providers and members

Barriers:

- Difficulty getting tapering data from pharmacy benefit manager
- Developing an internal opioid report has been challenging
- Member-specific data is not available form Living Well With Chronic Pain classes

• Conducted a variety of different pain classes and programs
Next steps: • Continue to disseminate educational videos to staff and new providers • Regularly update the PainWise website • Continue to sponsor educational and training opportunities for providers • Conduct provider surveys in order to understand how training affects beliefs and behaviors
CCO-Specific Project Topics
• Reduce preventable re-hospitalizations • Improve dental care of pregnant women • Reduce frequent and costly ED usage

Jackson Care Connect (JCC)

JCC, a wholly owned subsidiary of CareOregon, contracts with OHA to provide physical, behavioral and dental health services for OHP members in Jackson and Josephine counties. CareOregon provides oversight of mental health and physical health services. Prior to January 2017, CareOregon delegated utilization management of behavioral health services to Jackson County Health and Human Services. CareOregon performs many administrative and operational activities on the CCO's behalf. JCC delegates dental service delivery to Willamette Dental Group, Capitol Dental Care, ODS and Advantage Dental; and NEMT services to TransLink. JCC's medical partners include Addictions Recovery Center, Asante Rogue Regional Medical Center, La Clinica, OnTrack, PrimeCare, Providence Medical Center and Medical Group, and Rogue Community Health Center.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Substantially met (3.4)
Grievance Systems	Fully met (3.9)
Certifications and Program Integrity	Fully met (3.8)

Key Findings and Areas for Improvement

JCC needs to monitor clinical records for the presence of mental health declarations.

JCC needs to monitor the use of seclusion and restraint in order to ensure that members are free from seclusion or restraint used as a means of coercion, discipline, convenience or retaliation.

The CCO needs to ensure that member materials are written at an appropriate reading level.

JCC needs to ensure criminal background checks conducted for appropriate providers.

HealthInsight also followed up with the CCO regarding its 2015 compliance findings. JCC has resolved two and partially resolved one of the three 2015 findings that were unresolved in 2016. The partially resolved finding is a result of the CCO's Member Handbook not including dental emergencies.

Information Systems Capabilities Assessment

JCC has a management services agreement with CareOregon to process physical, substance use, mental health and NEMT data. Dental services use their own data processing systems and submit directly to OHA, sending a copy to CareOregon. Capitol Dental is unique in contracting with PH Tech to process and submit data. Pharmacy, NEMT and vision data is submitted to CareOregon, who submits to the state. CareOregon's data warehouse maintains physical, mental, vision, dental, substance and pharmacy data.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	1 finding noted	1 finding resolved
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA

Security (Incident management, risk management)	2 findings noted	2 findings in progress
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	1 finding noted	1 finding resolved
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	1 finding noted	1 finding in progress
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Information Systems, encounter data certification. It was not clear how the organization monitors data from partner organizations to ensure complete and accurate data.

2017 Progress Update: JCC's CFO now signs the attestation. JCC is working with parent company CareOregon to refine processes. This finding is resolved.

Finding #2: Security, CCO monitoring of delegated IT activities. No evidence of monitoring/oversight of contracted/partner organizations was provided.

2017 Progress Update: Parent company CareOregon developed and implemented an oversight policy/procedure applicable to all CCOs and partners. The CCO is adding delegate review and partner reviews in 2017. This finding is in progress.

Finding #3: Security, BC/DR. The organization does not have a BC/DR plan.

2017 Progress Update: Parent company CareOregon is developing a BC/DR plan. This finding is in progress.

Finding #4: Enrollment Systems, JC-UMT enrollment checks. Those responsible for checking enrollment and eligibility are not using a system with access to 834 enrollment data.

2017 Progress Update: CareOregon has taken over administration of mental health services and instructs providers to use the CareOregon portal to check eligibility. This finding is resolved.

Finding #5: Provider Data, provider directory. The provider directory does not include mental or dental practitioners.

2017 Progress Update: The organization is improving its provider directory and now lists mental health provider information. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Sent standardized tapering letters (developed by the Southern Oregon Regional Collaborative) to providers and members
- Participated in the Regional Collaborative Community Media campaign
- Hosted continuing medical events throughout the year
- Behavioral Health Specialists conducted support calls and in-person visit with providers
- Supported the Oregon Pain Guidance (OPG) buprenorphine X-waiver group

Barriers:

- Older data not completely accurate
- Competing organizational priorities
- Pharmacy position had been vacant
- Continuing medical education meetings were too long

Next steps:

- Continue to participate in the Southern Oregon Regional Collaborative workgroups and interventions
- Continue to offer support to clinics
- Refine the opioid prescribing practices Tableau dashboard
- Evaluate the environmental scan of clinics offering MAT services

CCO-Specific Project Topics

- Decrease spine MRI rates in adult members
- Improve maternal and neonatal outcomes
- Reduce emergency department utilization

PacificSource Central Oregon (PSCS-CO)

PacificSource Community Solutions, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-CO and PSCS-Columbia Gorge. PSCS-CO provides physical, behavioral and dental health services to OHP members in Deschutes, Jefferson and Crook counties. Each CCO has its own governing council with oversight from a subsidiary board of directors. PacificSource contracts with Deschutes County Health Services for mental health services and substance use disorders; with Caremark for pharmacy benefit management; and with Advantage Dental, Capitol Dental Care, Willamette Dental Group and ODS for dental services.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Fully met (3.7)
Grievance Systems	Fully met (3.9)
Certifications and Program Integrity	Fully met (4.0)

Key Findings and Areas for Improvement

The CCO needs to be the final adjudicator of all appeals.

The CCO's processes lack integration. Although the CCO has provided additional leadership/management to address the dental and behavioral health needs of its members, physical health, dental health and behavioral health do not follow the same processes to ensure a consistent approach and that policies are followed.

The CCO has resolved all four of its findings from 2015 that were not resolved in 2016.

Information Systems Capabilities Assessment

The organization processes data through the Trizetto Facets application, internally certifying the data and sending data to PH Tech. PH Tech is contracted to submit data to OHA on behalf of the organization.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	1 finding noted	1 finding in progress
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	No findings noted	NA
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA

Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	No findings noted	NA
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Information Systems, encounter data certification. The organization does not receive a copy of data submitted by PH Tech.

2017 update: PacificSource Central Oregon is developing processes to validate data for all lines of business before data is submitted to OHA. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Implemented a new graduated pharmacy benefit
- Conducted the Second Annual Chronic Non-cancer Pain 101 Workshop, including buprenorphine prescribing training
- Offered PDMP registration at educational events
- Sent taper letters to members on high dosages chronic opioids

Barriers:

- Lack of pharmacy staff and resources
- Difficult to increase PDMP enrollment outside of Jefferson County
- Provider training and toolkits are expensive

Next steps:

- Create enhanced opioid reports that focus on specialty and regional data
- Participate in the Pain Standards Task Force's discussion and strategizing on co-prescribing
- Continue the new quantity limits rollout

CCO-Specific Project Topics

- Increase rate of adolescent well-care visits
- Improve effective contraceptive use
- Improve dental care for pregnant women

PacificSource Columbia Gorge (PSCS-CG)

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

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Fully met (3.7)
Grievance Systems	Fully met (3.9)
Certifications and Program Integrity	Fully met (4.0)

Key Findings and Areas for Improvement

The CCO needs to be the final adjudicator of all appeals.

The CCO's processes lack integration. Although the CCO has provided additional leadership/management to address the dental and behavioral health needs of its members, physical health, dental health and behavioral health do not follow the same processes to ensure a consistent approach and that policies are followed.

The CCO has resolved all four of its findings from 2015 that were not resolved in 2016.

Information Systems Capabilities Assessment

The organization processes data through the Trizetto Facets application, internally certifying the data and sending data to PH Tech. PH Tech is contracted to submit data to OHA on behalf of the organization.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	1 finding noted	1 finding resolved
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	No findings noted	NA
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	No findings noted	NA

Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	No findings noted	NA
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Information Systems, encounter data certification. The organization does not receive a copy of data submitted by PH Tech.

2017 update: PacificSource Central Oregon is developing processes to validate data for all lines of business before data is submitted to OHA. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Approved new pharmacy benefits, including a graduated hard stop roll out
- Added language to provider portal about risks of co-prescribing
- Generated data reports for the Clinical Advisory Panel
- Pharmacy identified and contacted members who exceeded threshold and their providers

Barriers:

- Burdensome opioid treatment program administrative requirements
- Lack of pharmacy staff and resources
- Primary care providers are concerned about the demands of being a MAT provider

Next steps:

- Create enhanced opioid reports that focus on specialty and regional data
- Increase awareness of non-opioid treatment services among providers and members
- Continue the new quantity limits rollout
- Train all regional clinicians on the Providence Persistent Pain toolkit

CCO-Specific Project Topics

- Increase rate of adolescent well-care visits
- Improve effective contraceptive use
- Improve dental care for pregnant women

PrimaryHealth of Josephine County (PHJC)

PHJC, owned by Oregon Health Management Services (OHMS), provides physical, behavioral and dental health services for OHP members in Josephine County. OHMS sub-delegates mental health service delivery to Options for Southern Oregon; dental services to Capitol Dental Care, Advantage Dental, Willamette Dental Group, and ODS; and NEMT to TransLink. Additional CCO partners include, Grants Pass Clinic, Choices, Siskiyou Community Health Center, Asante Three Rivers Medical Center, Asante Rogue Regional Medical Center and Asante Physician Partners.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Substantially met (3.3)
Grievance Systems	Substantially met (3.2)
Certifications and Program Integrity	Substantially met (2.75)

Key Findings and Areas for Improvement

The CCO needs to ensure that all materials for members are written in easily understood language.
PHJC should inform providers on where to refer members who have difficulty understanding materials and ensure that interpreter services are provided by certified or qualified health care interpreters for non-English-speaking members.
The CCO needs to include all required information for all providers in the provider directory.
The CCO needs to review the use of seclusion and restraint by contracted providers and facilities during the credentialing and recredentialing process, and review the use of these high-risk practices in facilities licensed to use them, to ensure that members are free from seclusion or restraint used as a means of coercion, discipline, convenience or retaliation.
The notice-of-action letters need to inform members about how to request an expedited resolution.
The CCO needs to ensure timeliness for appeals.
PHJC needs to inform enrollees in the notice of appeal resolution of their right to request benefits while the hearing is pending, how to request continuation of benefits and when the enrollee may be liable for the cost of any continued benefit.
The CCO needs to ensure that subcontractors are informed at the time of contracting about the grievance system, appeal procedures and appeal timelines.
The CCO needs to be the adjudicator of all final appeals.
PHJC needs to ensure that the CCO provides payment for services and has a mechanism to expeditiously deliver authorized services when a state fair hearing officer reverses a decision to deny an authorized service.
The CCO needs to ensure that conflict-of-interest policies apply to subcontractors. Policies regarding vendor relations and gifts need to address providers, subcontractors and board members.
PHJC needs to screen for criminal conviction for transportation service providers and other providers mandated to receive a criminal background checks.

The CCO needs to obtain information about disclosure of ownership or controlling interests in the business entities and suppliers that deliver services to CCO enrollees.
PHJC needs to have a documented process and monitor to ensure that all staff, board members, providers and subcontractors are screened monthly for exclusion from participating in federal health care programs.
The CCO's compliance officer should report to the chief executive officer and have unrestricted access to the board of directors.
HealthInsight followed up with PHJC regarding its 2015 compliance findings. The CCO has partially resolved both of the two 2015 findings that were unresolved in 2016. These findings include: 1) The CCO needs to ensure all providers are screened monthly for exclusion from participation in federal health care programs. 2) PHJC needs to conduct oversight of its delegates' performance.

Information Systems Capabilities Assessment

The organization is a subsidiary of Oregon Health Management Services (OHM). All staff and administrative activities are serviced by OHM. PHJC contracted with Providence Health & Services to provide It support such as desktop, network, management and installation. CareOregon is contracted with to provide credentialing services. Data processing for physical health and substance use are outsourced to EZ-Cap, however PHJC is migrating these services to PH Tech. Data analysis and reporting is serviced through Inteligenz.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	No findings noted	NA
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	1 finding noted	1 finding in progress
Administrative Data claims and Encounter Data	2 findings noted	2 findings in progress
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	1 finding noted	1 finding resolved
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	No findings noted	NA
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Security, lack of integrated BC/DR plan. The organization has a draft plan.

2017 update: The BC/DR plan is in progress but now includes more detailed information. This finding is in progress.

Finding #2: Administrative Data Claims and Encounter Data, informal process for monitoring data flow to ensure submission of all data. A formal process is needed.

2017 update: This work is in progress with improvements to monitoring occurring after migration to PH Tech.

Finding #3: Administrative Data Claims and Encounter Data, monitoring IT policies and procedures of providers and other partner organizations. The organization has developed a monitoring process but it is not in full use.

2017 update: Initial monitoring of some organizations has occurred using new monitoring processes. This finding is in progress.

Finding #4: Vendor Data Integrity and Ancillary Systems, NEMT data not being submitted to OHA. PHJC is working with its NEMT provider to resolve submission issues.

2017 update: NEMT data are now being submitted to OHA in a timely manner. Data is handled by PH Tech and being monitored. This finding is resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Sent standardized tapering letters (developed by the Southern Oregon Regional Collaborative) to providers and members
- Participated in the Regional Collaborative Community Media campaign
- Transitioned members from Jackson County's facility to the Grant's Pass Treatment Center
- Participated in monthly Oregon Pain Guidance group meetings
- Developed a panel of alternative service providers

Barriers:

- Increased MAT costs
- OHA policies make offering non-opioid treatment services difficult

Next steps:

- Continue to participate in the Southern Oregon Regional Collaborative workgroups and interventions
- Follow up on contracting with acupuncturists
- Evaluate cost effectiveness of Grant's Pass Treatment Center

CCO-Specific Project Topics

- Improve maternal and perinatal health outcomes through use of a Maternal Medical Care Home
- Increase colorectal cancer screening rates
- Standardize community health worker tools and processes

Trillium Community Health Plan (TCHP)

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

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Substantially met (2.9)
Grievance Systems	Fully met (3.5)
Certifications and Program Integrity	Fully met (4.0)

Key Findings and Areas for Improvement

TCHP's member-facing written materials need to meet readability standards.

The CCO needs to send annual notification of required information to enrollees.

TCHP needs to provide information to enrollees on the extent to which and how they may obtain benefits from out-of-network providers and how to obtain any services that are available under the state plan but are not covered under the CCO contract.

TCHP's policies do not include expectations for dental and mental health providers regarding advance directives and declarations for mental health treatment. The CCO needs to monitor compliance with the requirement to include in the clinical record whether the member has executed an advance directive and/or declaration for mental health treatment. The CCO needs to inform members or their families or surrogates that complaints concerning non-compliance with directives may be filed with OHA. The CCO should provide community education on these topics.

The CCO needs to review the use of seclusion and restraint by contracted providers and facilities during the credentialing and recredentialing process, and review the use of these high-risk practices in facilities licensed to use them, to ensure that members are free from seclusion or restraint used as a means of coercion, discipline, convenience or retaliation.

The CCO's notice of action (NOA) letters and notice of appeal resolution (NOAR) letters to members need to include all required information.

TCHP needs to ensure that appeals are resolved within the required time frames.

The CCO needs to serve as the final adjudicator of all appeals.

HealthInsight also followed up with the CCO regarding its 2015 compliance findings. The CCO has resolved one finding and partially resolved two other findings that were unresolved in 2016, but has made no progress on a fourth finding from 2015. The partially resolved findings include: 1) The CCO has begun auditing the delegated dental provider networks. 2) The DPN audits included ensuring

practice guidelines meet requirements. One of the DPNs was not in compliance, yet no corrective action plan was provided. The CCO has made no progress in ensuring all stakeholders (i.e., dental) are represented in the QMIC.

Information Systems Capabilities Assessment

Trillium utilizes Centene's IT infrastructure and operations. All IT operations were migrated in June 2016. Trillium handles data processing for physical and mental health through the Amisys application in Centene's corporate data center. Physical, mental and vision providers or their clearinghouses can submit data to the Amisys software as well. Trillium Behavioral Health completes prior authorization tasks for mental health services. Three of the four dental providers process data themselves and submit the data to Trillium. One dental provider contracts with PH Tech for data processing and data submission. Amisys is also used (as well as other applications) for tracking metrics.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	No findings noted	NA
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	2 findings noted	2 findings in progress
Administrative Data claims and Encounter Data	2 findings noted	2 findings in progress
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	No findings noted	NA
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Security, BC/DR plan. A BC/DR plan was being updated. Parent company Centene has a BC/DR plan for the enterprise data center. Trillium is continuing to work on their BC/DR plan. Provider agencies reported various stages of having a BC/DR plan.

2017 update: Trillium continues work on its BGC/DR plan and tested some of the plan in 2017. This finding is in progress.

Finding #2: Security, CCO monitoring of delegated IT activities. Parent company Centene, is developing a vendor oversight program. Providers reported being unclear how backups were handled, various encryption strategies, and various hardware destruction processes. **2017 update:** Trillium is using a vendor questionnaire developed by Centene to review partners. At the time of the review

many of the partners had been reviewed. Trillium continues to refine policy/procedure/process related to communicating expectations and compliance to BC/DR plans. This finding is in progress.

Finding #3: Administrative Data Claims and Encounter Data, attestation process. It was not clear how Trillium monitored claims/encounter submission. Trillium was also not clear how CCOs or parent company Centene would be aware of trends and trend changes.

2017 update: Trillium continues to develop policy/procedure/process regarding data submitted to OHA. Attestation has been assigned to the CFO. This finding is in progress.

Finding #4: Administrative Data Claims and Encounter Data, NEMT data not monitored to submitted to OHA. Due to the migration to Centene's data center, NEMT data was not being submitted. A strategy to monitor NEMT data has not been determined.

2017 update: Trillium has worked with the NEMT provider to identify issues preventing data submission. NEMT backlog data has been processed. Trillium is continuing to document policy/procedure/process. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Sent letters to members with back/spine diagnoses who are on >120 mg and their providers
- Offered Living Well with Chronic Pain classes
- Offered physical and occupational therapy with each denial or partial approval of opioids
- Conducted quarterly lunch and learn sessions for staff

Barriers:

- Lack of staff
- Providers unresponsive to request for taper letters
- Providers are reluctant to obtain an X-waiver and begin prescribing Naloxone
- Addiction treatment providers are reluctant to work with chronic pain patients

Next steps:

- Continue to work with providers about tapering
- Continue to conduct education for staff and providers
- Develop reports on naloxone utilization

CCO-Specific Project Topics

- Reduce hospital re-admissions
- Increase depression screening
- Improve timeliness of prenatal and postnatal care using the Start Smart for Baby program

Umpqua Health Alliance (UHA)

Umpqua Health Alliance provides physical, behavioral and dental health services for OHP members in Douglas County. Adapt (the local Federally Qualified Health Center) and independent mental health practitioners provide outpatient mental health services for UHA enrollees. The CCO authorizes inpatient mental health services. UHA contracts with Adapt for substance use disorder treatment as well as physical and mental health services; with Bay Cities Ambulance for non-emergent medical transportation (NEMT) services; and with Cow Creek Health and Wellness Center to provide health services for members of the Cow Creek Band of the Umpqua Tribe of Indians. The CCO delegates dental service provision to Advantage Dental and Willamette Dental Group, and contracts with MedImpact to act as a pharmacy benefit manager.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Substantially met (3.2)
Grievance Systems	Substantially met (3.2)
Certifications and Program Integrity	Fully met (3.8)

Key Findings and Areas for Improvement

UHA needs to provide written material for enrollees in easily understood language
The CCO needs to require providers to ask members about advance directives and mental health treatment declarations, needs to monitor compliance concerning documentation of mental health directives in the clinical record and needs to provide community education on advance directives and mental health treatment declarations.
The CCO needs to review the use of seclusion and restraint by contracted providers and facilities during the credentialing and recredentialing process, and review the use of these high-risk practices in facilities licensed to use them, to ensure that members are free from seclusion or restraint used as a means of coercion, discipline, convenience or retaliation.
The CCO needs to notify members of their right to amend or correct their clinical records.
The CCO's notices of action need to include the enrollee's or provider's right to file an appeal with the CCO, how to request an expedited resolution, and information on continuation of benefits.
The CCO needs to have documentation demonstrating that the decision makers on grievances and appeals have not been involved in earlier decisions or reviews and ensure that individuals who make decisions on appeals have appropriate clinical expertise in treating the enrollee's condition.
The CCO needs to ensure that enrollees receive information on their right to examine medical records or other documents and to present evidence orally or in writing during appeals and hearings.
The CCO needs to ensure that a member receives a grievance acknowledgement letter if the resolution surpasses the 5-day requirement.
The CCO needs to ensure when denials are upheld that the member receives information on continuation of benefits and on the right to a state fair hearing.

The CCO needs to have a mechanism in place to deliver authorized services when a denial has been reversed by a state fair hearing officer.
The CCO needs to provide guidance on limitations of vendor relations, gifts and other compensations, when requiring governing board members to disclose information.
The CCO needs to have a mechanism in place to report adverse actions to OHA and the Office of Inspector General that result in terminations or suspensions of providers, if appropriate.
HealthInsight also followed up with the CCO regarding its 2015 compliance findings that were unresolved in 2016. UHA has resolved four findings related to the Delivery Network and to Subcontractual Relationships and Delegation, but has not yet resolved the remaining finding regarding Practice Guidelines.

Information Systems Capabilities Assessment

Umpqua started contracting with PH Tech and migration began in November 2017. PH Tech receives mental health data and submits to OHA, providing a copy to UHA. Dental service providers submit data to Umpqua. Pharmacy, NEMT and dental data are submitted to OHA via UHA.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	1 finding noted	1 finding in progress
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	2 findings noted	2 findings in progress
Administrative Data claims and Encounter Data	1 finding noted	1 finding resolved
Enrollment Systems (Medicaid eligibility)	1 finding noted	1 finding in progress
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	1 finding noted	1 finding in progress
Provider Data (compensation and profiles)	No findings noted	NA
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Information Systems, attestation sign off. UHA signs attestation based on reports, but it is not clear who is monitoring the data to ensure completeness and accuracy of the reports.

2017 update: New policy/procedure was developed with an intention to review data prior to submittal. This finding is in progress.

Finding #2: Security, CCO recovery planning. A BC/DR was developed but it was unclear wither the plan includes all functions and services.

2017 update: The BC/DR plan is in draft with an expectation to finalize it by end of 2017. This finding is in progress.

Finding #3: Security, provider monitoring. No documentation was provided for delegate monitoring. **2017 update:** Policy/process/procedure continue to be developed and documentation was submitted regarding an audit of the mental health provider. This finding is in progress.

Finding #4: Administrative Data Claims and Encounter Data, provider is not verifying enrollment at time of service. A provider stated eligibility checks were done at time of billing. **2017 update:** Umpqua has updated the provider handbook and onboarding process regarding eligibility verification tasks. This finding is resolved.

Finding #5: Enrollment systems, enrollment data components received from OHA "unloadable" in Plexis CM. Some components of 834 files were unloadable. It was unclear how resolution was occurring. **2017 update:** Race and ethnicity components were unloadable. UHA has contracted with PH Tech to obtain these elements and the elements are currently being merged successfully. This is a short-term solution, a permanent solution is not yet in place. This finding remains in progress.

Finding #6: Reconciliation issues due to full capitation payment not being received by CHA.

2017 update: UHA reported that it is moving mental health services to a full fee-for-service payment model to address this issue. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Developed new benzodiazepine prior authorization guidelines
- Developed and implemented a quantity limit guideline that calculates a member's cumulative MED across multiple medications
- Joined the Southern Oregon Regional Collaborative's community media campaign
- Participated in the Douglas County Pain Management Committee

Barriers:

- Members will be "disrupted" with implementation of a benzodiazepine policy

Next steps:

- Plan an Opioid Summit for 2018
- Continue participation in the Douglas County Pain Management Committee meetings
- Implement new benzodiazepine prior authorization guidelines

CCO-Specific Project Topics

- Decrease substance use disorders in pregnant women and neonatal abstinence syndrome in newborns through the New Day Program
- Decrease emergency department utilization
- Decrease all-cause 30-day readmissions

Western Oregon Advanced Health (WOAH)

Based in Coos Bay, WOAH provides physical, behavioral and dental health services to OHP members in Coos and Curry counties. Southwest Oregon IPA, doing business as Doctors of the Oregon Coast South (DOCS), administers all CCO activities for WOAH. DOCS employs the staff performing all CCO functions. WOAH delegates mental health administration to Curry Community Health and Coos Health & Wellness, and delegates chemical dependency and residential addiction treatment to ADAPT. Advantage Dental is delegated to provide dental services, manage the dental network, conduct utilization review and provide training, credentialing and oversight of dental care providers. WOAH contracts with MedImpact as the pharmacy benefit manager. The CCO is transitioning to a new non-emergent medical transportation (NEMT) provider, Bay City Brokerage.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Substantially met (3.1)
Grievance Systems	Fully met (3.5)
Certifications and Program Integrity	Fully met (3.8)

Key Findings and Areas for Improvement

Member-facing materials (member handbook, notice of action, notice of appeal resolution and grievance letters) do not meet the readability standards.

The CCO's policies and procedures do not include information about declarations for mental health treatment. The CCO sets no clear expectation for its dental providers regarding advance directives. The CCO does not monitor for compliance concerning documentation in the clinical record of whether the member has executed an advance directive or declaration for mental health treatment.

The CCO needs to review the use of seclusion and restraint by contracted providers and facilities during the credentialing and recredentialing process, and review the use of these high-risk practices in facilities licensed to use them, to ensure that members are free from seclusion or restraint used as a means of coercion, discipline, convenience or retaliation.

Not all of the notice of action letters include the right to file an appeal with the CCO. The notice of action letters do not include how to request an expedited resolution.

The CCO does not meet timeliness requirements for standard disposition of grievances, appeals or resolution of expedited appeals.

Not all notice of appeal resolution letters submitted included information about the enrollee's right to request benefits while the hearing is pending, how to request continuation of benefits and when the enrollee may be liable for the cost of any continued benefits.

The CCO submitted no documentation related to ensuring that no punitive action is taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

The CCO did not provide documentation to demonstrate that it follows it processes to determine whether individuals or organizations are excluded from participating in federal health care programs.

HealthInsight also followed up with the CCO regarding its 2015 compliance findings. WOAH has not yet resolved its sole finding from 2015, which was partially resolved in 2016 regarding screening for exclusions from participation in federal health care programs.

Information Systems Capabilities Assessment

SOIPA/DOCS provides WOAH staff to perform all necessary functions. WOAH uses DOCS' IT infrastructure, systems and processes for physical and vision data. Mental health administration is delegated to two organizations. They each have their own process for managing and submitting data. The pharmacy benefit manager organization submits data to WOAH, who then submits data to OHA. WOAH is using a new NEMT provider and is developing process/procedure for handling data.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	No findings noted	NA
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	1 finding noted	1 finding resolved
Security (Incident management, risk management)	2 findings noted	2 findings in progress
Administrative Data claims and Encounter Data	1 finding noted	1 finding in progress
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	1 finding noted	1 finding in progress
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Hardware Systems, remote access. Staff have remote user access when sharing hardware, saving to local device and printing.

2017 update: Remote print and save ability has been turned off. This finding is resolved.

Finding #2: Security, lack of current policies and procedures. WOAH and delegates have some policies in draft, but not finalized. The CCO is determining if some policies can be CCO level and not duplicated by delegates.

2017 update: Ongoing evaluation is occurring to determine policies that can be CCO level. This finding is in progress.

Finding #3: Security, CCO monitoring of delegated IT activities. No evidence was provided regarding oversight of provider agencies.

2017 update: In May 2017, WOAH notified delegates they must have an independent ISCA review. WOAH is evaluating how to monitor delegates after the ISCA review is complete. This finding is in progress.

Finding #4: Administrative Data Claims and Encounter Data, NEMT monitoring and data submission to OHA. WOAH has not finalized policy/procedure to monitor NEMT data.

2017 update: WOAH is reviewing and updating policy/procedure related to NEMT. This finding is in progress.

Finding #5: Provider Data, provider directory. The organization contracted with a vendor to redesign and support its website including improving provider search capabilities. Members are redirected to dental provider network websites for information and cannot search on required search elements such as specialty. WOAH has informal processing for adding/removing providers from the provider directory.
2017 update: WOAH has collected all required data for all providers and has a project in progress for improving the provider directory website including search functionality. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Sent standardized tapering letters (developed by the Southern Oregon Regional Collaborative) to providers and members
- Participated in the Regional Collaborative Community Media campaign
- Supported provider education events hosted by partners
- Provided a teleconnection to monthly OPG meetings for Coos and Curry County providers
- Developed an internal opioid dashboard

Barriers:

- Some providers do not accept the CDC guidelines
- Lack of response to Naloxone training in Curry County
- OHA policies prevent CCOs from offering non-opioid treatments as a member benefit

Next steps:

- Continue to participate in the Southern Oregon Regional Collaborative workgroups and interventions
- Continue educational activities
- Continue to use internal dashboard to identify high-risk opioid users

CCO-Specific Project Topics

- Decrease all-cause hospital readmission rate
- Improve effective contraceptive use
- Increase colorectal cancer screening

Willamette Valley Community Health (WVCH)

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

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Substantially met (3.1)
Grievance Systems	Fully met (3.9)
Certifications and Program Integrity	Fully met (3.5)

Key Findings and Areas for Improvement

The CCO lacks integration of expectations for all physical health, behavioral health, dental health and NEMT providers and delegates. Although the strengths and issues among the providers and delegates are not all the same, WVCH's policies and practices needs to ensure all CCO expectations and contract requirements are conveyed and contractors are held accountable.

The CCO's compliance plan needs to include a risk assessment and regular monitoring and auditing schedule to ensure fraud and abuse are prevented, detected and reported.

HealthInsight also followed up with the CCO regarding its 2015 compliance findings. The CCO has resolved one, partially resolved one, and has not resolved one of the 2015 findings that were not yet resolved in 2016. The partially resolved finding relates to the CCO's credentialing policy and the need to describe its monitoring of any delegated credentialing process. The unresolved finding relates to The lack of a policy or procedure that ensures a non-discriminatory process for selecting and compensating providers.

Information Systems Capabilities Assessment

WVCH employs 10 staff and contracts with WVP Health Authority for onsite IT services including network, email, servers and IT support. PH Tech provides benefit management, data extracts and customer service. Three of the four dental providers submit data directly to PH Tech who then submits data to OHA on behalf of WVCH.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	1 finding noted	1 finding in progress
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA

Security (Incident management, risk management)	2 findings noted	2 findings in progress
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	1 finding noted	1 finding in progress
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Information Systems, encounter data certification. It is not clear if WVCH is obtaining copies of 837 data submitted on their behalf. It is not clear how WVCH is monitoring data received from partner organizations to then ensure completeness and accuracy.

2017 update: The organization has developed a process to receive copies of data being submitted to OHA on behalf of WVCH. The organization is also developing an EDV process for all types of claim/encounter data. This finding is in progress.

Finding #2: Security, BC/DR plan. WVCH delegates have BC/DR plans in draft and WVCH needs to mature their BC/DR plan.

2017 update: WVCH is developing a mature BC/DR plan including detail such as technological risks. This finding is in progress.

Finding #3: Security, CCO monitoring of delegated IT activities. WVCH has begun holding communication meetings to increase oversight with delegates. The organization needs to increase IT oversight with delegates and providers.

2017 update: WVCH is continuing to formalize the oversight process and develop policy/procedure. This finding is in progress.

Finding #4: Provider Data, provider directory. WVCH has updated the provider directory, but needs to include improved search functionality.

2017 update: WVCH is updating the online directory, and has moved it to a new platform. Mental health providers are not listed individually. A dental provider search transfers the end user to a dental organization, rather than ability to search on individual dentists. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Developed tapering letter
- Hired a public relations firm to help with community campaign efforts
- Co-sponsored a Pain Summit in 2017
- Replaced previous opioid work group with the WVCH transformation and Quality Committee (TraQ)
  - Sponsored clinician training
  - Developed and distributed dental opioid prescribing guidelines

Barriers:

- Difficult to target Marion and Polk counties as TV networks also cover the Portland metro area
- Clinics prefer to conduct their own interventions and monitoring
- Staff changes

Next steps:

- Discuss potential areas for partnership with Woodburn Police Department
- Continue to provide clinician trainings, including a X-waiver training
- Compile and send monthly prescribing reports to all dental care organizations

CCO-Specific Project Topics

- Increase enrollment in WVCH's tobacco cessation program
- Increase colorectal cancer screening
- Decrease polypharmacy and improve health outcomes using medication therapy management

Yamhill Community Care Organization (YCCO)

YCCO provides physical, behavioral and dental health services for OHP members, primarily in Yamhill County. YCCO has a management services agreement with CareOregon to administer physical health services and to provide administrative and management support for CCO operations. YCCO contracts with Yamhill County Health and Human Services to provide behavioral health services and delegates dental service delivery to Capitol Dental Care, Advantage Dental and ODS. CareOregon contracts with VSP to deliver vision services and with OptumRx for pharmacy benefit management. First Transit provides non-emergent medical transportation for YCCO members.

Compliance with Regulatory and Contractual Standards

Section	Score (out of 4.0)
Enrollee Rights	Substantially met (3.2)
Grievance Systems	Substantially met (3.2)
Certifications and Program Integrity	Fully met (3.8)

Key Findings and Areas for Improvement

The CCO needs to provide written material for members in easily understood language.
The CCO needs to provide members with information on how to obtain any services that are available under the state plan but are not covered under the CCO contract.
The CCO needs to ensure that all required provider information is available to members.
The CCO needs to ensure that provider contracts do not prohibit or restrict the provider from advising or advocating on behalf of a member regarding treatment options.
The CCO needs to require providers to document in clinical records of adult members whether or not the member has executed an advance directive or declaration for mental health treatment, and needs to monitor for compliance with this requirement.
The CCO needs a mechanism to inform enrollees that complaints concerning non-compliance with an advance directive or declaration for mental health treatment may be filed with OHA.
The CCO needs to review the use of seclusion and restraint by contracted providers and facilities during the credentialing and recredentialing process, and review the use of these high-risk practices in facilities licensed to use them, to ensure that members are free from seclusion or restraint used as a means of coercion, discipline, convenience or retaliation.
Not all of the CCO's notices of action include all the required information.
The CCO's policies need to state clearly that no punitive action is taken against a provider who requests an expedited resolution or supports an enrollee's appeal.
The CCO must act as the final adjudicator of all appeals.
The CCO needs to have a mechanism in place to deliver authorized services when a denial has been reversed by a state fair hearing officer.

The CCO needs to have a mechanism in place to report adverse actions to OHA and the Office of Inspector General (OIG) that result in terminations or suspensions of providers, if appropriate.

YCCO is still working to resolve seven findings that were not fully resolved in 2016. Follow up on the status of outstanding findings related to delivery network, care coordination, authorizations and practice guidelines will occur in 2018.

Information Systems Capabilities Assessment

CareOregon provides support services such as enrollment, claims payment, network management, pharmacy benefit and customer service, as well as reporting to OHA. CareOregon performs eligibility verification on all claims/encounters.

ISCA Section	2016 ISCA Results	2017 ISCA Follow Up Results
Information Systems (data flow)	No findings noted	NA
Staffing (claims and encounter, authorization)	No findings noted	NA
Hardware Systems	No findings noted	NA
Security (Incident management, risk management)	2 findings noted	2 findings in progress
Administrative Data claims and Encounter Data	No findings noted	NA
Enrollment Systems (Medicaid eligibility)	No findings noted	NA
Vendor Data Integrity and Ancillary Systems	No findings noted	NA
Report Production and Integration and Control of Data for Performance Measure Reporting	No findings noted	NA
Provider Data (compensation and profiles)	No findings noted	NA
Meaningful Use of Electronic Health Records (EHR)	No findings noted	NA

Findings and 2017 Progress Updates

Finding #1: Security, backup media improperly handled. Backup media are not being encrypted, offsite storage is not being used and provider agencies are not clear about YCCO expectations.

2017 update: YCCO is holding discussions with partners/delegates about expectations and has implemented a cloud based backup/store process. All workstations have been upgraded to Windows 10 and Bitlocker encryption is configured on each workstation. Policy/procedure are in progress. This finding is in progress.

Finding #2: Security, CCO monitoring of delegated IT activities. No evidence was provided regarding oversight of contracted/delegate organizations.

2017 update: YCCO reviewed CareOregon's policies and is working to address monitoring delegate/contracted organizations. This finding is in progress.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Continue to implement an alternative payment methodology for practices
- Conducted an Opioid Summit in 2017
- Continued quarterly distribution of opioid prescribing patient level data to providers
- Piloted a new persistent pain group
- Sent letters to providers and organizations encouraging enrollment in the PDMP

Barriers:

- Referrals to pain programs have been decreasing
- Community sensitivity around MAT limits data collection
- Confusion about which health entity has responsibility for content and distribution of member materials

Next steps:

- Continue implementing the alternative payment methodology
- Continue to promote PDMP enrollment
- Share post-op prescribing protocols with area surgeons

CCO-Specific Project Topics

- Increase adolescent well-child visits and preventive care
- Increase the number of patient-centered primary care home (PCPCH) clinics and member assignment to PCPCH clinics
- Reduce emergency department utilization

APPENDIX B: STATEWIDE PIP ON OPIOID SAFETY

Oregon Statewide PIP on Opioid Safety: Reducing Prescribing of High Morphine Milligram Equivalent/Day Doses

Prepared by HealthInsight

Standard 1: Study Topic

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

Status of PIPs in Oregon

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

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

Topic overview

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

Data collected at a national level reveal that from 1999 through 2006, opioid-analgesic deaths increased about 18% on average. The rate stabilized from 2006 to 2011, then

[1] Report of the International Narcotics Control Board for 2007. https://www.incb.org/documents/Publications/AnnualReports/AR2007/AR_07_English.pdf. Accessed February 28, 2018.

began to decline in 2012.[2] A recent report by the Centers for Disease Control and Prevention (CDC) indicates that the decline has not been sustained. Data show that although overdose deaths due to natural and semisynthetic opioids (which include most of the prescribed opioid pain relievers) remained similar from 2012 to 2013, there was a 9% increase from 2013 to 2014.[3]

Overdose and death are not the only adverse effects of the abuse and misuse of prescription opioids. CDC estimated that prescription opioid abuse costs (e.g., lost workplace productivity, medical treatment and criminal justice costs), totaled about $55.7 billion in 2007.[4]

Studies by Washington State and New York State demonstrated that the Medicaid population is disproportionately affected by the opioid epidemic. In Washington, a Medicaid enrollee was 5.7 times more likely to die due to prescription opioid overdose than a person not enrolled in Medicaid.[5] A similar increased death rate among Medicaid enrollees was observed in New York from 2003 to 2012.[6] In response to the particular vulnerability of the Medicaid population, CMS issued a bulletin describing Medicaid pharmacy benefit management and naloxone provision strategies states could employ to reduce opioid-related overdose deaths.[7]

As part of a national initiative to address the opioid problem, CDC awarded 16 states (including Oregon) grants to assist those states in their efforts to prevent opioid misuse and overdose. In addition, CDC issued opioid prescribing guidelines for primary care providers in early 2016. Although state, regional and professional guidelines and resource guides have been published, the CDC guidelines are the first set of standards on prescription opioids from a federal agency. Among other recommendations, CDC proposed that providers should avoid increasing opioid dosages to ≥90 mg/day

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[2] Chen LH, Hedegaard H, Warner M. Drug-poisoning Deaths Involving Opioid Analgesics: United States, 1999–2011. NCHS Data Brief No. 166, September 2014. http://www.cdc.gov/nchs/data/databriefs/db166.pdf. Accessed February 28, 2018.

[3] Centers for Disease Control and Prevention. Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. *MMWR*, December 18, 2015. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm64e1218a1.htm?s_cid=mm64e1218a1_e. Accessed Accessed February 28, 2018.

[4] Centers for Disease Control and Prevention. Injury Prevention & Control: Prescription Drug Overdose. http://www.cdc.gov/drugoverdose/data/overdose.html. Accessed February 28, 2018.

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

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

[7] Centers for Medicare & Medicaid Services. CMS Informational Bulletin: Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-02-02-16.pdf. Accessed February 28, 2018.

morphine milligram equivalent (MEE)/day and "carefully reassess benefits and risks" when increasing opioid dosages to ≥50 MME[8] . Other guidelines (Washington State, Medicare) have established a target of <120 mg/day MED.

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

Oregon

Statewide, Oregon had the highest rate of nonmedical use of prescription opioids for people age 18 years and older in 2011–2012, according to the National Survey on Drug Use Health. Oregon tied for second place in 2012–2013.[10]

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

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

[8] Centers for Disease Control and Prevention. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. *MMWR*, March 18, 2016. http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm. Accessed February 28, 2018.

[9] White House press release: Fact Sheet: Obama Administration Announces Additional Actions to Address the Prescription Opioid Abuse and Heroin Epidemic. March 29, 2016. https://www.whitehouse.gov/the-press-office/2016/03/29/fact-sheet-obama-administration-announces-additional-actions-address. Accessed February 28, 2018.

[10] National Survey on Drug Use and Health. http://www.icpsr.umich.edu/icpsrweb/ICPSR/series/64. Accessed February 28, 2018.

[11] Oregon Health Authority, Public Health Division. Injury and Violence Prevention Program. Prescription Drug Poisoning/Overdose in Oregon. http://www.orpdmp.com/PDO_2015v04242015.pdf. Accessed February 28, 2018.

[12] See note 9 above.

- Unintentional and undetermined prescription opioid poisoning death rates followed a similar trend, increasing from 1.4 per 100,000 in 2000 to 6.5 per 100,000 in 2006. In 2012, the rate was 4.2 per 100,000.[13]
- The PHD reported that while the prescription drug poisoning/overdose death rates in 2013 and 2014 had declined to about 4.0 per 100,000, the 2013 rate was still 2.8 times higher than in 2000.[14]
- Recent CDC data showed an increase in all drug overdose deaths in Oregon: from 11.3 deaths per 100,000 persons in 2013 to 12.8 deaths per 100,000 persons in 2014. Since the CDC data do not distinguish between deaths due to heroin and those due to natural and semisynthetic opioids (associated with the more commonly prescribed opioid pain relievers), further analyses are needed to determine if there is consistency between the national and state data.

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

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

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

[13] Oregon Health Authority, Center for Prevention & Health Prevention. Injury & Violence Prevention section. Drug Overdose Deaths, Hospitalizations, Abuse & Dependency among Oregonians. http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/oregon-drug-overdose-report.pdf. Accessed February 28, 2018.

[14] Oregon Health Authority, Public Health Division. Injury and Violence Prevention Program. Prescription Drug Poisoning/Overdose in Oregon. http://www.orpdmp.com/PDO_2015v04242015.pdf. Accessed February 28, 2018.

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

- In 2012 and 2013, the Prescription Drug Task Force, appointed by Governor John Kitzhaber, hosted meetings for stakeholders interested in developing and implementing a prescription drug strategy. Interested stakeholders formed the Oregon Coalition for Responsible Use of Meds (OrCRM), whose mission is to "prevent overdose, misuse and abuse of amphetamines and opioids, both prescription and illicit."[15] OrCRM has been active in sponsoring Opioid Summits throughout the state, trying to engage a range of stakeholders in developing collaborative regional action plans.
- In 2014, the Healthy Columbia Willamette Collaborative convened a workgroup to develop opioid prescribing standards. The workgroup represented four Portland area public health departments (Clackamas, Multnomah and Washington counties, OR, and Clark County, WA), safety net clinics, two CCOs (FamilyCare and Health Share of Oregon), local hospitals and professional organizations. After nearly a year's work, the workgroup released the Portland Metro Regional Safe Opioid Prescribing Standards in December 2015, guidelines towards a minimum started of care for safe prescribing of opioids. In 2017, the workgroup began work on developing a list of standardized metrics.
- In 2015, the Tri-County Opioid Safety Coalition was formed in response to a community health needs assessment that identified drug use and drug-related deaths as a significant regional health problem. The Coalition, which includes representatives from health plans, public health departments, substance use treatment programs, judicial system, higher learning institutions and community-based organizations, developed interventions to address multiple aspects of the opioid epidemic.
- After reviewing the existing research on back pain treatments, including surgery and opioids, OHA's Health Evidence Research Commission presented a back pain guideline (Guideline Note 60) to the Quality and Health Outcomes Committee (QHOC) meeting in February 2015. Key changes in the treatment of back pain included limiting coverage on the prescription of opioids and adding

[15] Oregon Coalition for Responsible Use of Meds. http://orcrm.org. Accessed February 28, 2018.

coverage for non-opioid therapies such as physical therapy, chiropractic, acupuncture and massage. In May 2016, HERC approved additional changes to the guidelines, including a requirement that by January 1, 2017, all members with a diagnosis of back or spine pain on long-term opioids have an individualized treatment plan for tapering off opioids. Plans were required to include nonpharmalogic treatments for chronic pain and a quite date no later than January 1, 2108. The new back and spine pain guidelines were originally scheduled for implementation on January 1, 2016, but implementation was delayed until July 2016.

- In 2015, the PHD received a Prescription Drug Overdose Prevention for States grant from CDC. The purpose of the grant was to help states enhance their PDMPs and work with communities, health systems and providers to develop and implement interventions to prevent prescription drug overdose. As part of this effort, the PHD developed a toolkit to help CCOs develop a more comprehensive approach to reducing opioid overdose and misuse (https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Documents/reducing-opioid-overdose-cco-guide.pdf).
- In November 2016, the Oregon Opioid Prescribing Guidelines Task Force, representing the PHD, CCOs, physical health, mental health, oral health and addiction medicine professional organizations, pharmacists, federally qualified health centers and other opioid task forces, adopted the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain as "the foundation for opioid prescribing for Oregon" and provided additional recommendations to address Oregon-specific issues.[16]

Topic selection and prioritization

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

HealthInsight encouraged, but did not require, CCOs to solicit stakeholder input. It is not clear what, if any, influence enrollees had in prioritizing the topic. The

[16] Oregon Opioid Prescribing Guidelines: Recommendations for the Safe Use of Opioid Medications. https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf. Accessed on February 28, 2018.

overwhelming majority of CCOs selected the topic of opioid management as their first preference. The selection of opioid management as a topic for the second Statewide PIP received final approval by the OHA Quality Council in June 2015.

Standard 2: Study Question

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

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

Two primary and secondary study questions were developed after finalization of the study metric in 2015. For the first and second remeasurement periods (calendar years 2016–2017), the study questions were:

> Study question #1: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥120 MME on at least one day within the measurement year?*
>
> Study question #1a: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥120 MME for thirty consecutive days or more within the measurement year?*
>
> Study question #2: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥90 MME on at least one day within the measurement year?*
>
> Study question #2a: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥90 MME for thirty consecutive days or more within the measurement year?*

In spring 2017, CCO medical directors and QI leaders elected to continue implementing the statewide PIP for another measurement period with revised study metrics. The study questions for the third remeasurement year (calendar year 2018) were:

> Study question #1: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥90 MME on at least one day within the measurement year?*

Study question #1a: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥90 MME for thirty consecutive days or more within the measurement year?*

Study question #2: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥50 MME on at least one day within the measurement year?*

Study question #2a: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥50 MME for thirty consecutive days or more within the measurement year?*

Standard 3: Study Population

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

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

Study population (denominator) inclusion criteria and definitions

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

Denominator exclusion criteria

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

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

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

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

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

Standard 4: Study Indicator

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

[17] Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain. 3rd Edition, June 2015. http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf. Accessed February 28, 2018

First remeasurement and second remeasurement periods study indicators:

Percentage of OHP enrollees age 12 years and older who filled prescriptions for opioid pain relievers of ≥120 MME, and percentage of enrollees with at least ≥90 MME on at least one day and for thirty consecutive days or more within the measurement year.

Third remeasurement period study indicators:

Percentage of OHP enrollees age 12 years and older who filled prescriptions for opioid pain relievers of ≥90 MME, and percentage of enrollees with at least ≥50 MME on at least one day and for thirty consecutive days or more within the measurement year.

Metric selection for first and second remeasurement periods

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

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

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

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

a survey asking each of the 16 CCOs to submit a single vote for one of the three metrics. These are the survey results:

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

This information, along with feedback from the PHD and the CCO Pharmacy Directors workgroup, was presented to OHA leadership. At OHA's request, the Office of Health Analytics conducted data analyses of each CCO's Medicaid populations using the Minnesota metric eligibility criteria to determine the metric's feasibility. The analyses demonstrated that four CCOs had numerators of less than 40, and another two CCOs had numerators less than 50. Although OHA leadership was interested in the Minnesota metric, the small study populations presented a barrier to implementation, as was demonstrated in the first Statewide PIP on diabetes monitoring in the SPMI population. Instead, OHA leadership selected the ≥120 mg MME metric as the Statewide PIP metric and decided to investigate other avenues for a metric focused on naïve to chronic users, such as review by the OHA Scoring and Metrics Committee.

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

Data provided by the Office of Health Analytics revealed that CCOs that had worked on opioid prescribing issues for several years had significantly lower percentages of members on ≥120 MME per day than did organizations just beginning work in this area. Experienced CCOs expressed concern that given the lower percentages, it would be

[19] See note 17 above.
[20] Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med.* 2010.
[21] Fulton-Kehoe D, Garg RK, Turner JA, et al. Opioid poisonings and opioid adverse effects in workers in Washington State. *Am J Ind Med*. 2013.
[22] See note 15 above.

difficult to demonstrate improvement over a short period of time. After discussion of additional pros and cons of different dosage levels at the November QHOC meeting, HealthInsight surveyed CCOs as to their study metric dosage threshold preference. Each of the 16 CCOs was asked to select only one option. The results of the survey are as follows (PacificSource–Central Oregon and PacificSource–Columbia Gorge voted as a single CCO):

- ≥ 90 MME/day – 7
- ≥100 MME/day – 1
- ≥120 MME/day – 7

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

After examining the initial data pull, some CCOs expressed concerns that their metrics were artificially elevated due to overlapping or early refills, and did not accurately reflect the extent of an opioid safety issue for their organization. A literature review revealed that different organizations selected opioid use at 30- or 60- or 90-days as predictors for long-term use. The Office of Health Analytics agreed to pull data for one additional metric. OHA and HealthInsight selected a days' supply metric of 30 days because, evidence showed the majority of people on 30 days' supply would go on to using opioids for 60 and 90 days. The Washington Guideline on Prescribing Opioids stated that "with the exception of severe injuries, such as multiple trauma, opioid use beyond the acute phase (longer than 6 weeks) is rarely indicated," and a 30-day threshold would result in a reasonable size population for all CCOs.

The OHA Office of Health Analytics conducted additional analyses examining the number and percentage of members who had opioid prescriptions for 30 days or more at both thresholds. The percentage of those members with at least one day of opioid prescriptions at 120 MME who had prescriptions for 30 or more consecutive days ranged from 5.0 to 37.7% among the CCOs.

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

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

Metric selection for third remeasurement period

In early 2017, HealthInsight facilitated discussions at QHOC regarding the next steps for the statewide PIP. Medical directors and QI staff were unanimous in their decision to continue the Statewide PIP on Opioid Safety for a third remeasurement period (January 1–December 31, 2018). QHOC stakeholders agreed to drop the ≥120 MME/day metric and replace it with a ≥ 50 MME/day metric. As noted by several participants, dosage limits of ≤ 50 MME/day and ≤ 90 MME/day align with current recommendations from the CDC[23] and the Oregon Opioid Prescribing Guidelines Task Force.[24]

Study numerators for the first and second remeasurement periods

Numerator inclusion criteria and definitions:

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

Any enrollee in the denominator who filled prescriptions for opioid pain relievers of at least ≥120 or at least ≥90 MME for one day during the measurement year was included in the numerators.

Study numerators for the third remeasurement period

- Study eligible (meet the denominator definitions)
- *50 and 90 MME per day:* Daily MME is calculated as drug strength multiplied by quantity divided by days' supply, multiplied by the conversion factor identified by CDC (the table of morphine equivalent conversion factors is available as a separate document from the Office of Health Analytics). MME/day will be calculated per filled prescription, applied to the date range according to the fill

[23] See Note 8 above.
[24] See Note 16 above.

date and days' supply and then summed for patient total. Any overlapping prescriptions should be summed on each day of overlap.

Any enrollee in the denominator who filled prescriptions for opioid pain relievers of at least ≥90 or at least ≥50 MME for one day during the measurement year was included in the numerators.

Standard 5: Data Collection and Data Analysis Plan

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

Data collection

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

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

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

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

Data verification and validation

At the end of the remeasurement period, OHA allows for a 90-day period to receive all CCO claims (a 90-day period to collect and process claims is routine practice). OHA then calculates the study data and posts member-level data on each CCO's secure FTP

site. CCOs are asked to review the information and send any revisions/questions to the designated OHA contact, who works with the Office of Health Analytics to evaluate the CCO queries.

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

Study Time Periods

- **Baseline measurement:** January 1–December 31, 2014
- **First remeasurement:** January 1–December 31, 2016
- **Second remeasurement:** January 1–December 31, 2017
- **Third remeasurement:** January 1-December 31, 2018

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

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

Standard 6: Study Results

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

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

- Aggregated statewide numerator, denominator and calculated indicator for baseline and first measurement periods
- Results of statistical tests
- Table of aggregated statewide numerator by age

- Graph of the aggregated statewide numerators, denominators and rates from 2014 (baseline) to first remeasurement period
- Graph of the individual CCO rates from 2014 to the first remeasurement period

≥120 mg MME/day metric results

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

Table 1. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥120 MME on at least one day during the measurement year.

Study indicator	**Baseline** January 1–December 31, 2014	**1st remeasurement** January 1–December 31, 2016
Numerator	11,945	9,394
Denominator	112,768	100,586
Calculated indicator	10.6%	9.3%

The chi-square test yielded a statistically significant difference (p<0.001) between the percentage of enrollees age 12 years and older who filled opioid prescriptions for at least ≥120 MME/day at baseline and first remeasurement.

Table 1a shows the 120 MME/day study metric data according to age group

Table 1a. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥120 MME on at least one day during the measurement year according to age group.

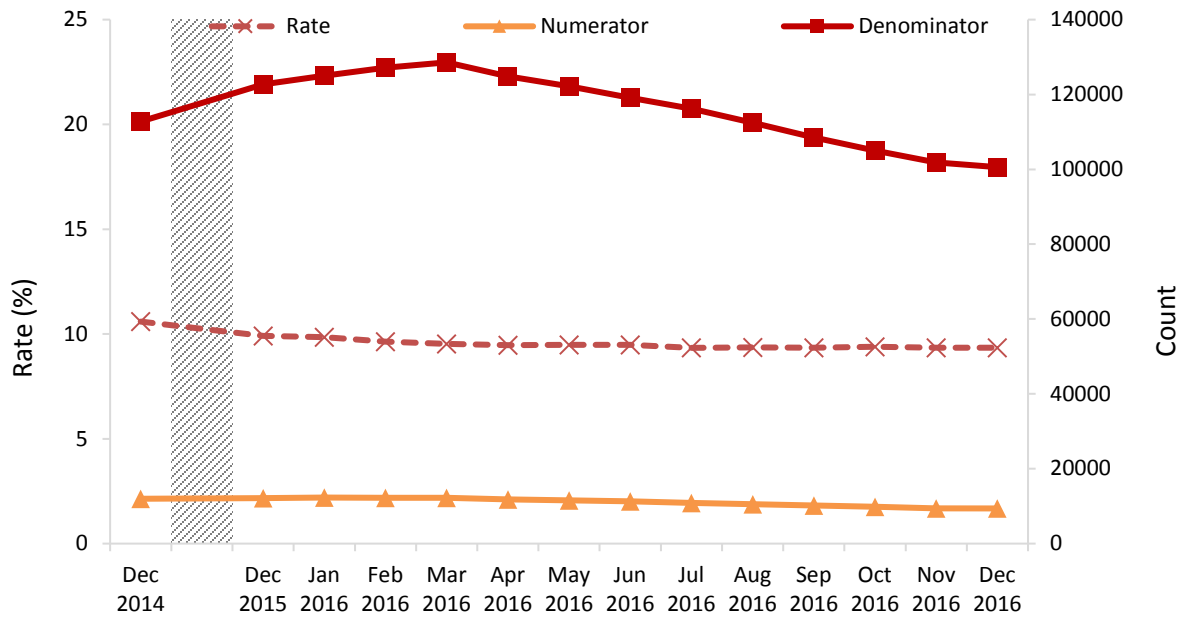
Age group	**Baseline** January 1–December 31, 2014			**1st remeasurement** January 1–December 31, 2016		
	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage
12–17 years	142	6,453	2.2%	77	4,623	1.7%
18+ years	11,803	106,315	11.1%	9,317	95,963	9.7%

The number of enrollees age 12–17 who filled an opioid prescription ≥120mg MME on at least one day during the measurement period decreased by approximately 46% from baseline to first remeasurement, compared to the 18+ age group, which decreased by approximately 21% in the same period.

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

Figure 1 shows the aggregated statewide results for the 120 MME/day metric over time.

Figure 1. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥120 MME on at least one day during the measurement year over time.

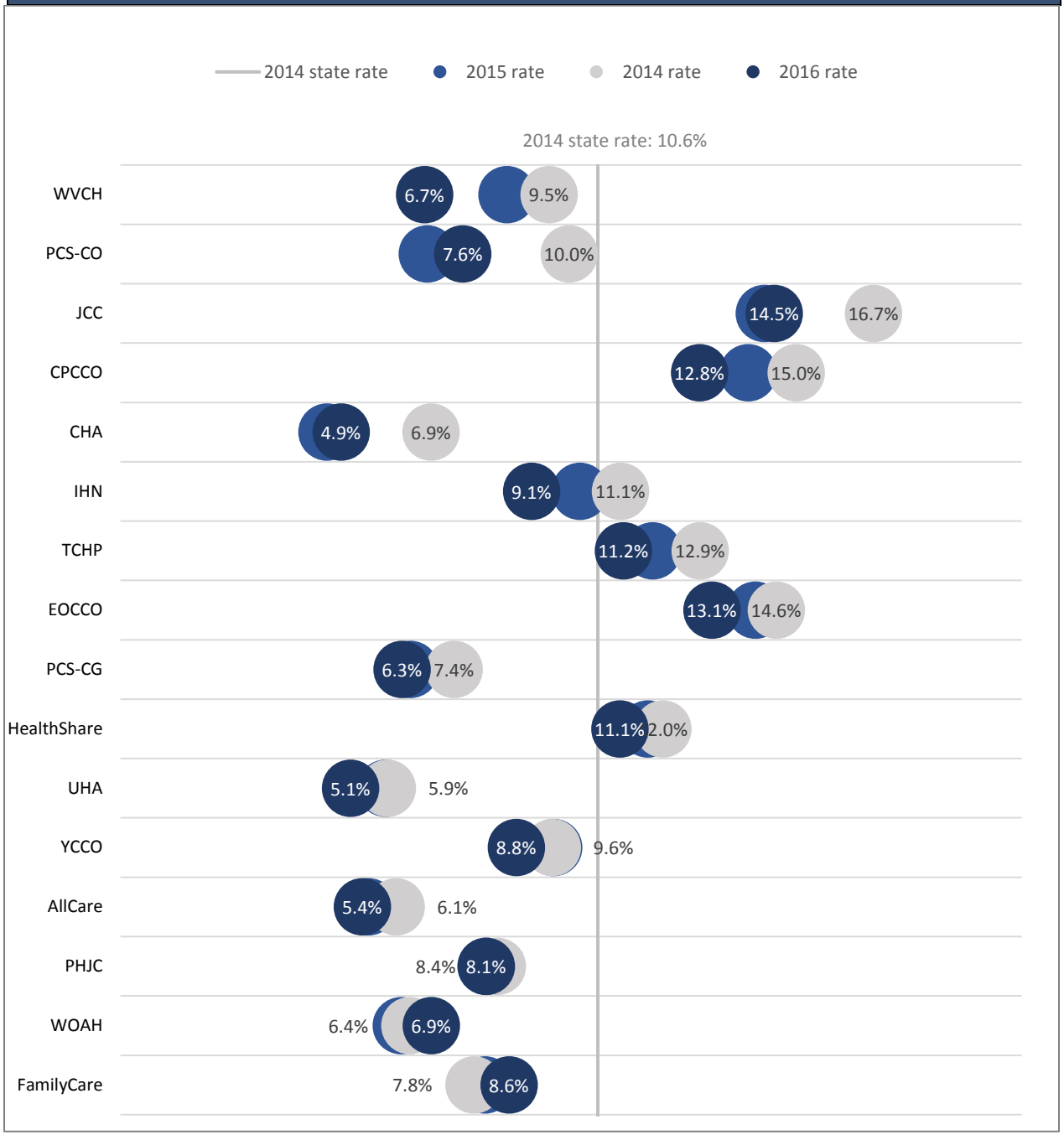


The study denominator increased over time until March 2016, when it dropped steadily until the first measurement. Although difficult to discern because of the scale of the graph, the study numerator also increased from 2014 to 2015, then decreased slightly and steadily over time. The statewide rate showed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

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

Figure 2 shows CCO progress on the 120 MME/day metric over time. CCOs are ordered from top to bottom according to the amount of progress from baseline to current measurement. Note: 2015 rate data labels are not displayed in figure.

Figure 2. CCO progress on ≥120 MME/day study metric from baseline to first remeasurement period by CCO.



≥90 MME/day metric results

Table 2 shows the baseline and first remeasurement results for the ≥90 MME/day metric.

Table 2. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME on at least one day during the measurement year.		
Study indicator	**Baseline** January 1–December 31, 2014	**1st remeasurement** January 1–December 31, 2016
Numerator	20,235	16,778
Denominator	112,768	100,586
Calculated indicator	17.9%	16.7%

The chi-square test yielded a statistically significant difference ($p<0.01$) between the percentage of enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME/day at baseline and first remeasurement

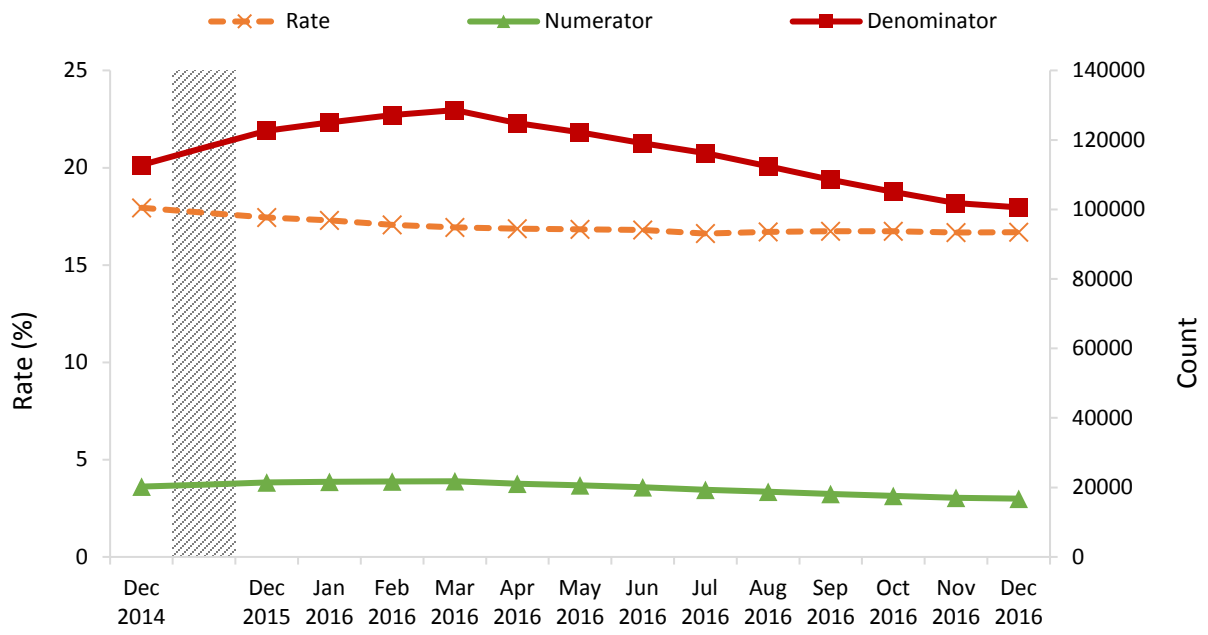
Table 2a shows the 90 MME/day study metric data according to age group

Table 2a. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME on at least one day during the measurement year according to age group.						
Age group	**Baseline** January 1–December 31, 2014			**1st remeasurement** January 1–December 31, 2016		
	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage
12–17 years	354	6,453	5.5%	230	4,623	5.0%
18+ years	19,881	106,315	18.7%	16,548	95,963	17.2%

As with the 120 MME/day metric, the 12–17 year old group showed a greater percentage decrease from baseline to first remeasurement than the older group. Compared to the 120 MME/day metric results, the decreases were not as large (approximately 35% for the 12–17 year old group; approximately 17% for the 18+ year old group).

Figure 3 shows the aggregated statewide results for the 90 MME/day metric over time.

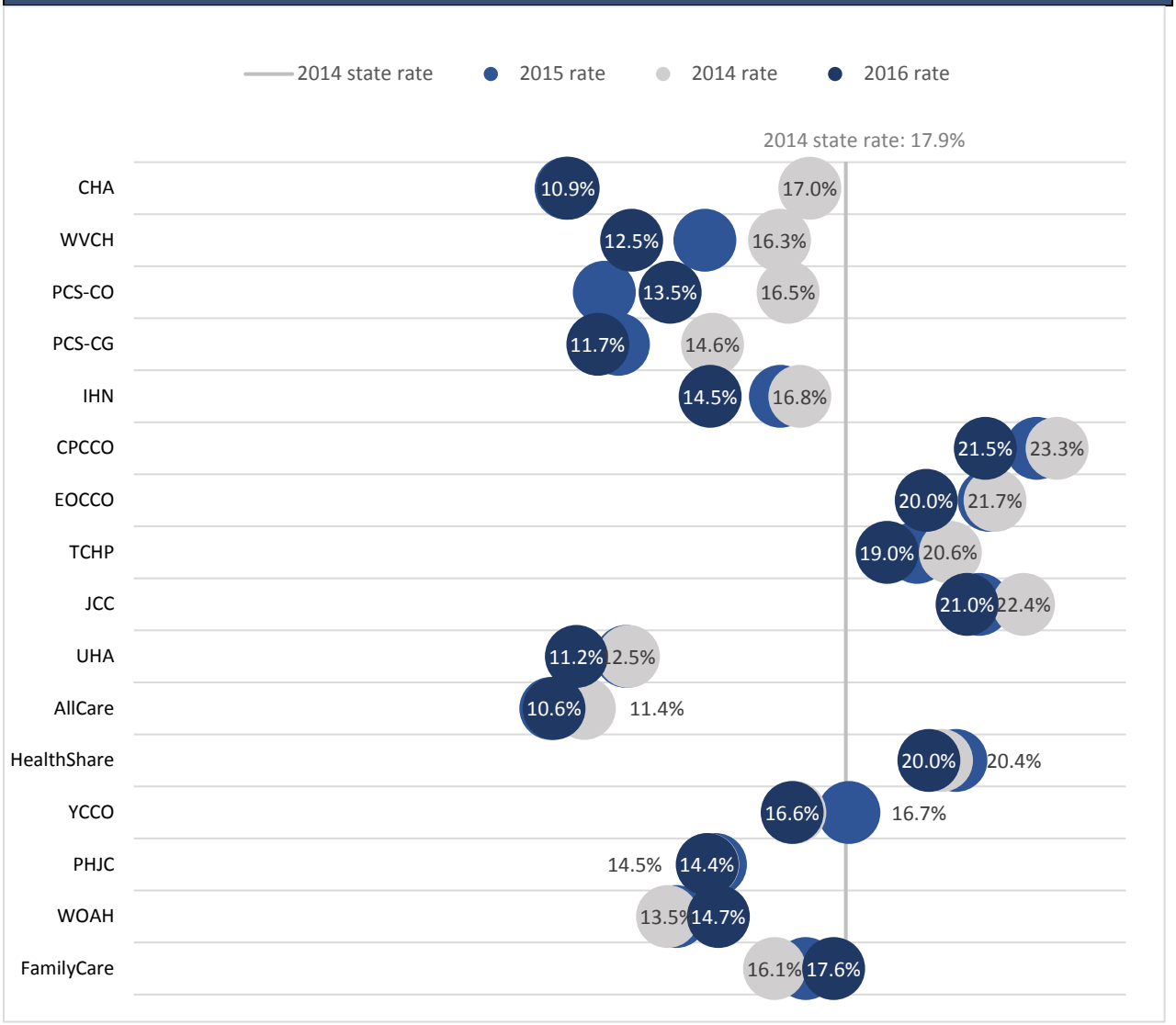
Figure 3. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME on at least one day during the measurement year.



As with the 120 MME/day metric results, the study numerator and rate decreased slightly from baseline to current measurement.

Figure 4 shows CCO progress on the 90 MME/day metric over time. CCOs are ordered from top to bottom according to the amount of progress from baseline to current measurement. Note: 2015 rate data labels are not displayed in figure.

Figure 4. CCO progress on ≥90 MME/day study metric from baseline to first remeasurement period by CCO.



Additional Analyses

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

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

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

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

Study indicator	Baseline January 1–December 31, 2014	1st remeasurement January 1–December 31, 2016
Numerator	3,129	1967
Denominator	112,768	100,586
Calculated indicator	2.8%	2.0%

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

Study indicator	Baseline January 1–December 31, 2014	1st remeasurement January 1–December 31, 2016
Numerator	4,448	3,201
Denominator	112,768	100,586
Calculated indicator	3.9%	3.2%

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

Figures 5 and 6 show CCO progress over time on the supplemental measures. Note: 2015 rate data labels are not displayed in figure.

Figure 5. CCO progress on ≥120 MME/day for 30 consecutive days study metric from baseline to first remeasurement period by CCO.

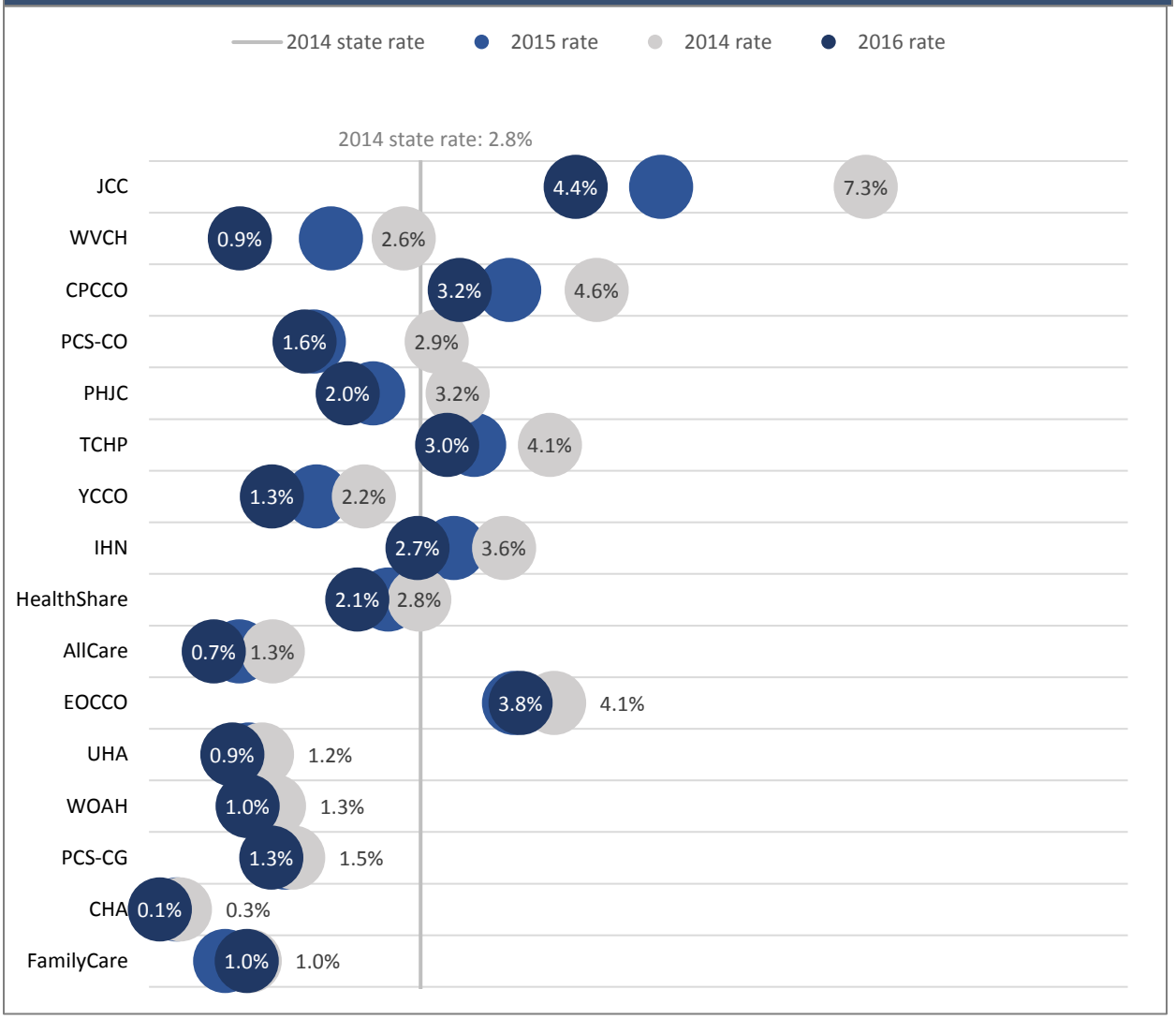
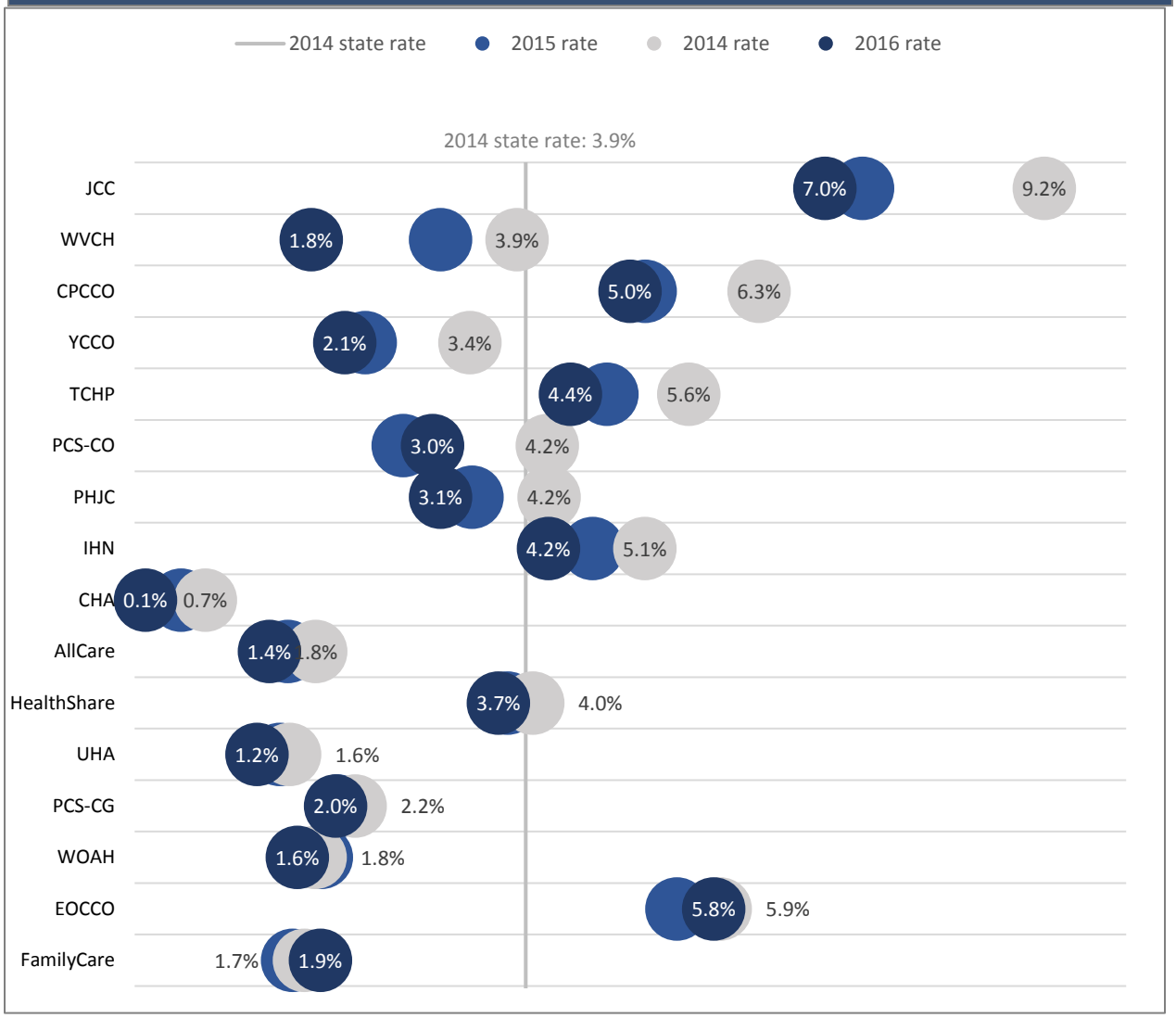


Figure 6. CCO progress on ≥90 MME/day for 30 consecutive days study metric from baseline to first remeasurement period by CCO.



Standard 7: Interpretation of Results

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

No changes were made to the study design during the first remeasurement year.

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

Data validity and limitations

- The baseline (calendar year 2014) and first remeasurement period (calendar year 2016) are not contiguous, leaving calendar year 2015 unaccounted for. However, this project is not a strictly before-after comparison, as at least four CCOs had implemented prior authorization and quantity limits for opioids and provider education for several years prior to the study baseline. Collection and analyses of an additional data point (calendar year 2015) will better demonstrate any trends and help rule out statistical regression as a threat to validity.
- The study data are aggregated across 16 CCOs, but as noted above, a number of CCOs had implemented interventions aimed at improving the opioid problem in their communities, resulting in significantly lower than average study metrics at baseline. To gain a better understanding of the actual progress on this measure, it will be necessary to analyze the individual CCO study results alongside the aggregated study indicators.
- Although patients with a diagnosis for palliative care, hospice or end-of-life care are excluded from the denominator, patients with a diagnosis of cancer are not. It is likely that a small number of members with active malignancy who had not yet received an exclusion diagnosis will be included in the numerator, but no reason to expect that proportion would change from one measurement period to another.
- The single end-of-measurement period data do not reflect ongoing improvement efforts. Members originally on very high dosages of opioids, who had significantly decreased their dosages, but are still on ≥120 MME/day and ≥90 MME/day are included in numerators. Improvement in outcomes other than the study indicators is discussed under "lessons learned."

- Members might be included in the numerator for administrative reasons (one-day overlap in prescriptions) that do not reflect the member's ongoing opioid use. However, this PIP is focused on opioid safety, and even one day at 120 MME or 90 MME puts members at risk. Their inclusion in the numerator, therefore, is appropriate.
- CCO Medicaid claims do not capture cash payments by members for prescription opioids. It is not clear to what extent the exclusion of cash purchases of opioids affect the study numerators and denominator.
- The topic of opioid safety is complex, and the study metrics address only one safety aspect (high dosages and chronic high use). CCO efforts around other and equally important opioid safety issues, such as co-prescribing and the transition from naïve to chronic use, are not reflected in the study metrics.

Possible confounding factors

- Other local and state organizations (see Standard 1) have implemented interventions as part of their own strategies to address opioid misuse and abuse, independent of the CCO-initiated interventions, which could have contributed to a decrease in the remeasurement study indicator results. Nationally, CDC released its final Guideline for Prescribing Opioids for Chronic Pain in March 2016. These guidelines and the media attention surrounding their release could have influenced provider prescribing practices, separate from any local CCO-initiated interventions.
- The delay in the implementation of OHA's back and spine policy guidelines (originally scheduled to begin January 1, 2016, but implemented July 1, 2016) disrupted CCOs' plans to develop and fund non-opioid therapies, and could have had a negative impact on improvement in the study indicators in the first remeasurement period. However, the restrictions on opioid treatment for enrollees with newly diagnosed back and spine conditions (seven days' medication at a time, no medication coverage after 90 days), might have had an effect on the number of opioids in circulation (study denominator).

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

Analysis of performance by percentage without taking frequencies into account provides an incomplete picture. As shown in the Standard 6 graphs and tables, the number of enrollees in the statewide and CCO study denominators decreased at a more rapid rate than the study numerators (see Attachment D for CCO-level data). Even though their numbers decreased, some CCOs saw little change or even an increase in

their study metric rates over time. The amount of opioids in circulation would be expected to decrease more quickly than the number of members being tapered off chronic doses of high opioids. A number of CCOs implemented taper plans of several months' duration that did not begin until late 2016. It is not clear whether or not the decrease in opioids in circulation is appropriate. CCOs have reported that they plan to monitor provider refusals to prescribe opioids. No quantitative or qualitative results regarding this topic were documented in quarterly progress reports.

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

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

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

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

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

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

Standard 8: Improvement Strategies

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

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

OHA required that CCOs submit quarterly reports documenting their progress on the Statewide PIP, beginning with the January 2016 quarterly report. At the end of the first remeasurement period (12/31/16), each CCO received an evaluation (met/partially met/not met) for the degree of completeness, clarity and consistency in addressing each of the Standard 8 criteria. See Attachment F for an explanation of the Standard 8 criteria, and Attachment G for the final overall 2016 Standard 8 criteria evaluations for each CCO. HealthInsight revised the evaluation process for the second remeasurement period (ending December 31, 2017). See Standard 10 for more details of the 2017 CCO evaluation process.

The following is a summary of high-level themes from the 16 CCOs' documentation of each of the Standard 8 criteria:

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

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

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

Member factors:

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

Provider factors:

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

Organizational factors:

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

In addition, several CCOs identified contributing factors specific to their situation. Four southern Oregon CCOs (AllCare, Jackson Care Connect, PrimaryHealth of Josephine County and Western Oregon Advanced Health), whose coverage areas and contracted providers overlap with each other, formed a regional collaborative (SW Oregon Collaborative) to address "CCO shopping" by members seeking desired benefits and frustration by providers over multiple different guidelines and processes. The proliferation of non-contracted pain clinics in one small area in southern Oregon resulted in a significant number of

members in both the covering and adjacent CCO receiving opioids from providers resistant to CCO policies and processes.

b. Brief description of the intervention(s)

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

Prior to the start of the first remeasurement period (January 1, 2016), almost all CCOs had implemented prior authorization (PA) processes and quantity limit (QL) guidelines to address the opioid problem in their communities. Following the CDC's recommendations (providers should carefully consider benefits and risks before increasing opioid dosages to ≥50 morphine milligram equivalents (MME)/day, and avoid increasing dosages to ≥90 MME[25]) and the adoption of those recommendations by the Oregon Opioid Prescribing Guidelines Task Force, most CCOs revised their PA and QL guidelines to align with the new thresholds.

Other common intervention themes included:

- Provider training/education: Education about opioid-related topics was provided at clinic site visits, hospital grand rounds, clinic continuing medical education and Pain/Opioid Summits. The topics covered CCO policy and guidelines, current literature on opioid risks, alternative non-opioid treatments, available resources, MAT services, how to use the PDMP and how to have difficult conversations with patients about opioids. CCOs also informed providers about PA processes, guideline changes and resources through individual letters, provider newsletters and provider toolkits.
  All CCOs developed interventions (dashboards or patient lists) to inform primary care providers about patients receiving high doses of opioids. In the second remeasurement period, some CCOs expanded this intervention to include dental providers and specialists.

[25] Centers for Disease Control and Prevention. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. *MMWR*, March 18, 2016. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm. Accessed February 28, 2018.

- Member education: Members were educated about the risks of opioids and CCO policies and guidelines through individual letters, newsletter articles, websites, videos in clinic and hospital waiting rooms and community forums.

  In 2017, the SW Oregon Collaborative launched a Community Media Campaign, which included a public education ad, an interview on a local news station and the Stay Safe Oregon website (a website that includes educational materials and resources).

- Targeted interventions with members and providers: Most CCOs analyzed data to identify top opioid prescribers and members receiving ≥120 MME/day or ≥90 MME/day. Top prescribers received a letter (with information about guidelines and resources) and often a visit by the medical director and/or pharmacist to determine how the provider could achieve compliance. CCOs sent letters to members on high doses of opioids about CCO policies and guidelines, the need to develop a taper plan with their provider and the availability of alternative non-opioid treatments and resources.

  In technical assistance meetings with HealthInsight staff, several CCOs reported that primary care providers appreciated getting information about their patients and were generally unaware about chronic high opioid users on their patient panels. Distribution of dashboards or member lists was most effective when coupled with or followed by non-judgmental offers of support (e.g., additional training, provision of resource materials, etc.)

- Taper plans: According to OHA's Guideline Note 60: Opioids for conditions of the back and spine, enrollees with back and spine pain diagnoses on long-term opioids were required to have a documented treatment plan by January 1, 2017 that included a taper plan to end opioid therapy by January 1, 2018. Most CCOs developed processes to inform applicable members and their providers about the policy and to track the receipt of taper plans.

- Alternative therapies: CCO strategies regarding alternative non-opioid treatments and services focused on alternative or complementary services, non-opioid pain medication and pain management programs.

  CCOs continued to recruit and contract with alternative treatment providers (acupuncture, chiropractic, massage). Information about alternative treatment resources was included in provider toolkits,

provider and member letters and websites. In their progress reports, many CCOs documents increased utilization of non-opioid treatments by members.

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

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

- Medication-assisted treatment (MAT): All CCOs implemented strategies to increase access to MAT, including provider education about the role of MAT, provider training needed to acquire the waiver necessary to prescribe buprenorphine, identifying MAT providers in the community, working with other organizations to implement opioid treatment programs and developing a hub-and-spoke MAT model.
- Collaboration with community organizations: Several CCOs reported working with local law enforcement or community organizations on initiatives to increase medication disposal sites and with local pharmacists to increase prescribing of naloxone. CCOs also collaborated with local community organizations and public health departments in sponsoring community education events.
- Collaboration with other CCOs: Four CCOs (AllCare, Jackson Care Connect, PrimaryHealth of Josephine County, and Western Oregon Advanced Health), formed a regional collaborative and created an umbrella advisory PIP group and multiple workgroups to address common concerns in an organized and consistent manner. The collaborative developed standardized member and provider letters (which included all four CCO logos in the header and signed by all four CCO medical directors), member and staff educational materials, a community media campaign and tapering forms and a staff/provider training video. Two other CCOs (Cascade Health Alliance and Umpqua Health Alliance) participated in the community media campaign, and Cascade Health Alliance also joined the Regional Collaborative's advisory workgroup.

In terms of the integration of physical, behavioral and oral health, almost all CCOs solicited the participation of substance use disorder organizations and staff in discussing strategies to increase access to MAT. Behavioral health staff were involved in training providers about substance use and how to have difficult conversations with members. An increasing number of CCOs began distributing opioid use dashboards or member lists to dental providers, identifying high dental prescribers and developing educational materials for dental providers.

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

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

d. Cultural and linguistic appropriateness of the intervention

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

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

e. Tracking and monitoring plans and results

In the first remeasurement year (January 1 –December 31, 2016), CCOs were given the option of reporting on either or both of the study indicators. Four CCOs chose to report on the 90 MME/day metric, six CCOs reported on the 120 MME/day metric and five CCOs reported data for both metrics. One CCO provided no data for either study metric. About half of the CCOs presented measurement plans that included internally derived study indicator data as well as other CCO-selected performance measures.

For the second remeasurement period evaluation (January 31, 2018), CCOs will report on the success of the PIP using the metric they have been using to measure performance. Most CCOs have been using one or both of the study metrics to measure improvement, but a few have developed their own internal metrics.

In terms of tracking the effective implementation of interventions, CCOs presented data on summit/grand rounds/training program attendance, number of mailings to providers and members, number of received taper plans, number of clinic/site visits, number of providers licensed to prescribe buprenorphine, number of opioid treatment programs and number of clinics receiving additional payments for meeting performance thresholds.

In terms of alternative therapies, approximately one-third of CCOs presented tables or graphs demonstrating increased utilization of acupuncture, chiropractic, massage and physical therapy services over the past year. A few CCOs also provided data on the number of members enrolled and graduated from pain management classes. Although several CCOs documented plans to evaluate the effectiveness of alternative therapies in decreasing opioid dosages at the individual member level, none had presented any results to date.

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

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

In the second remeasurement period, several barriers to intervention implementation continued to challenge CCOs, in particular staff turnover and data collection. A number of CCOs reported turnover of QI, pharmacy and data analytic staff, resulting in delayed development and implementation of intervention strategies and in lack of available study indicator or intervention effectiveness data. In addition to lack of staff, the difficulty of obtaining timely and accurate data was attributed to differences with the Pharmacy Benefit Manager or organizational partners.

Other reported barriers to implementation also included competing priorities, scheduling conflicts, and difficulty coordinating with different departments and community organizations.

Provider resistance or noncompliance was not reported as a barrier. Most CCOs anticipated provider concerns and mitigated risks by implementing multiple interventions focused on provider training and education.

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

CCOs had a well-established vision of the next steps for their intervention strategies. All CCOs were continuing with the interventions described in their intervention strategies table, sometimes with minor modifications in response to barriers. The CCOs in the regional collaborative are continuing to meet in different workgroups to develop shared tools, processes and strategies. A number of CCOs have expanded their efforts beyond working with chronic high opioid users to developing strategies around co-prescribing of opioids and benzodiazepines and acute prescribing of opioids.

Standard 9: Repeated Measurement of the Study Indicator

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

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

- Aggregated statewide numerator, denominator and percentage for baseline, first and current measurement for the 120 and 90 MME indicators
- Results of statistical tests
- Graphs of the aggregated statewide numerators, denominators and rates from 2014 (baseline) to the current measurement period
- Tables of the study metric results by CCO
- Tables of aggregated statewide numerators by age

Table 5 shows aggregated results for the ≥120 MME/day metric.

Table 5. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥120 MME on at least one day during the measurement year.

Study indicator	**Baseline** January 1–December 31, 2014	**1st remeasurement** January 1–December 31, 2016	**Current remeasurement** November 1, 2016-October, 2017
Numerator	11,945	9,394	7,173
Denominator	112,768	100,586	88,871
Calculated indicator	10.6%	9.3%	8.1%

The chi-square test yielded a statistically significant difference (p<0.001) between the percentage of enrollees age 12 years and older who filled opioid prescriptions for at least ≥120 MME/day at baseline and current remeasurement, and between first and current remeasurement (p< 0.001).

Figure 7 shows aggregated statewide results for the ≥120 MME/day metric over time.

Figure 7. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥120 MME/day on at least one day during the measurement year over time.

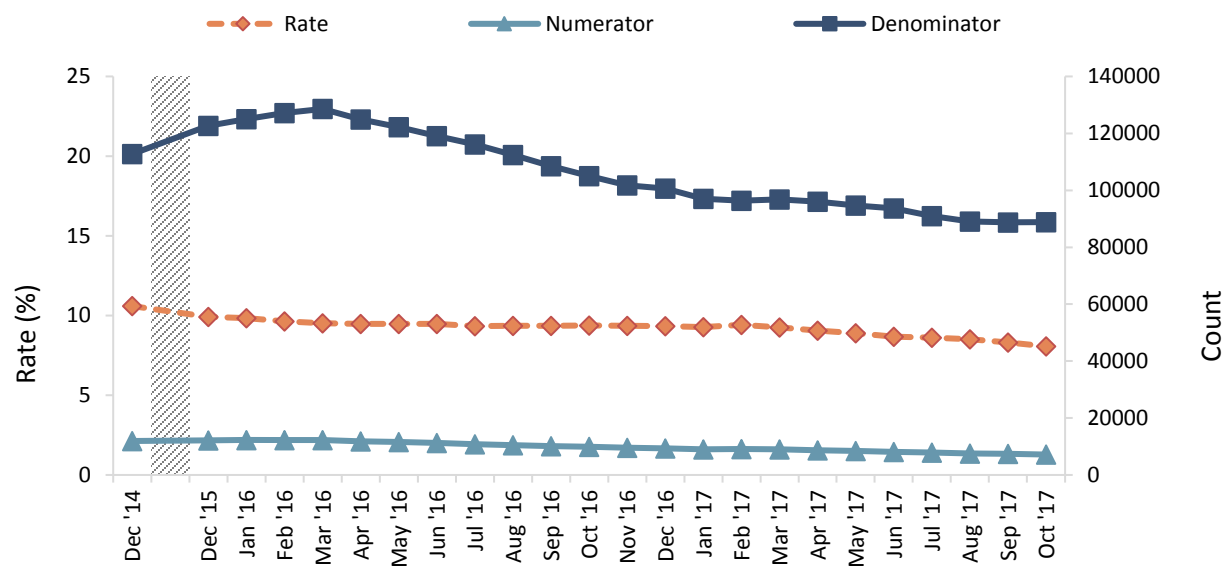


Table 6 shows the ≥120 MME/day metric results over time by CCO.

Table 6. Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥120 MME/day on at least one day during the measurement year.

CCO	January 1 – December 31, 2014	January 1 – December 31, 2016	November 1, 2016 – October 31, 2017
ALLCARE	6.1%	5.4%	4.4%
CHA	6.9%	4.0%	3.0%
CPCCO	15.0%	12.9%	10.8%
EOCCO	14.6%	13.1%	11.4%
FAMILYCARE	7.8%	8.6%	7.3%
Fee for Service	9.8%	8.1%	7.0%
HSO	12.0%	11.1%	9.7%
IHN	11.1%	9.1%	6.8%
JCC	16.7%	14.5%	12.7%
PSCS - CO	7.4%	6.3%	6.2%
PSCS - Gorge	10.0%	7.6%	6.8%
PHJC	8.4%	8.1%	5.7%
TRILLIUM	12.9%	11.2%	10.2%
UHA	5.9%	5.1%	3.4%
WOAH	6.4%	6.9%	5.6%
WVCH	9.5%	6.8%	6.3%
YCCO	9.6%	8.8%	6.7%
SUM OF CCOS	**10.6%**	**9.3%**	**8.1%**

All CCOs demonstrated improvement in the percentage of enrollees 12 years and older who filled opioid prescriptions for at least ≥120 MME/day on at least one day from baseline to the current remeasurement period.

Table 7 shows aggregated results for the ≥90 MME/day metric.

Table 7. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME/day on at least one day during the measurement year.

Study indicator	**Baseline** January 1–December 31, 2014	**1st remeasurement** January 1–December 31, 2016	**Current remeasurement** November 1, 2016-October, 2017
Numerator	20,235	16,778	13,569
Denominator	112,768	100,586	88,871
Calculated indicator	17.9%	16.7%	15.3%

The chi-square test yielded a statistically significant difference (p<0.001) between the percentage of enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME/day at baseline and current remeasurement, and between first and current remeasurement (p<0.001).

Figure 8 shows aggregated statewide results for the ≥90 MME/day metric over time.

Figure 8. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME/day on at least one day during the measurement year over time.

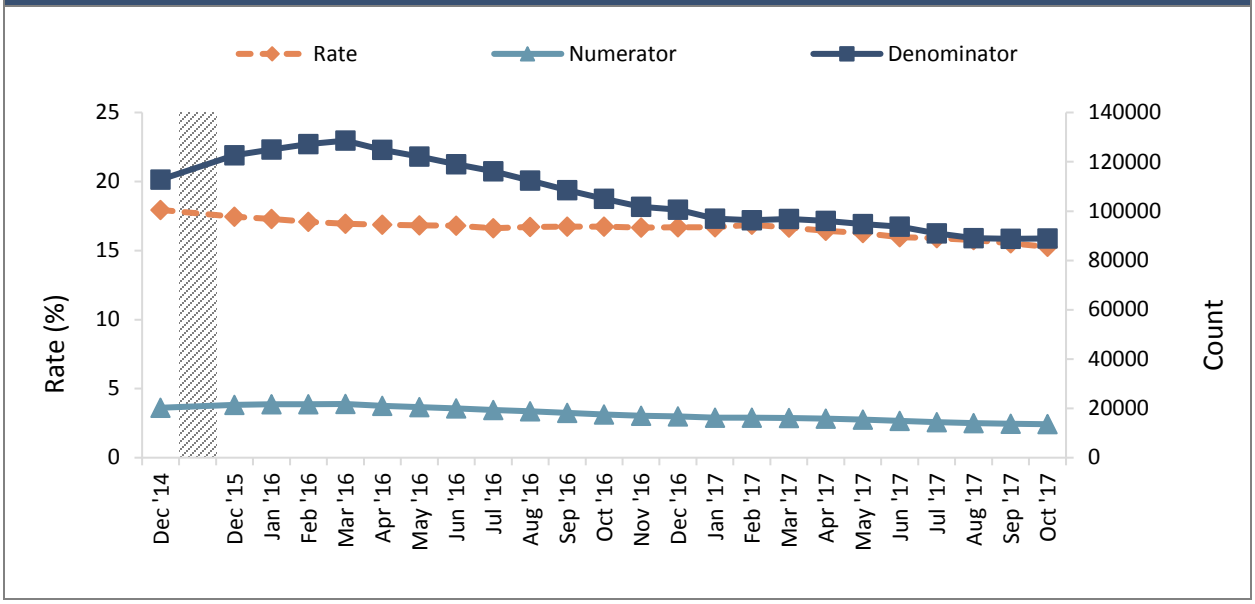


Table 8 shows the ≥90 MME/day metric results over time by CCO.

Table 8. Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME/day on at least one day during the measurement year.

CCO	January 1 - December 31, 2014	January 1 - December 31, 2016	November 1, 2016 – October 31, 2017
ALLCARE	11.4%	10.6%	11.2%
CHA	17.0%	11.0%	7.2%
CPCCO	23.3%	21.5%	20.7%
EOCCO	21.7%	20.0%	18.7%
FAMILYCARE	16.2%	17.6%	15.3%
Fee for Service	17.5%	15.4%	12.8%
HSO	20.4%	20.0%	18.3%
IHN	16.8%	14.5%	11.0%
JCC	22.4%	21.0%	20.6%
PSCS - CO	14.6%	11.7%	11.8%
PSCS - Gorge	16.5%	13.52	11.3%
PHJC	14.5%	14.5%	9.8%
TRILLIUM	20.6%	19.0%	17.8%
UHA	12.5%	11.2%	8.1%
WOAH	13.5%	14.7%	11.6%
WVCH	16.3%	12.6%	12.7%
YCCO	16.7%	16.6%	16.3%
SUM OF CCOS	**17.9%**	**16.7%**	**15.3%**

With the exception of two CCOs (AllCare and YCCO), CCOs showed observable improvement in the percentage of enrollees 12 years and older who filled opioid prescriptions for at least ≥90 MME/day on at least one day from baseline to the current remeasurement period. However, all CCOs demonstrated a decrease in both numerator and denominator counts over time.

In the second remeasurement period, OHA continued to provide CCOs with data on the percentage of OHP members on ≥120 MME/day and ≥90 MME/day for 30 or more consecutive days in order to help CCOs identify their chronic user populations.

Tables 9 and 10 compare baseline, first remeasurement and current remeasurement results for high chronic users. Figures 9 and 10 show aggregated results for those users over time.

Table 9. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥ 120 MME/day for consecutive 30 days or more within the measurement year.

Study indicator	Baseline January 1–December 31, 2014	1st remeasurement January 1–December 31, 2016	Current remeasurement November 1, 2016-October 31, 2017
Numerator	3,129	1,967	1,350
Denominator	112,768	100,586	88,871
Calculated indicator	2.8%	2.0%	1.5%

Statistical tests indicated a statistically significant difference between the percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least 120 MME/day for 30 consecutive days or more at baseline and at current remeasurement (p<0.001), and between first and current remeasurement (p<0.001).

Figure 9. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥120 MME /day for consecutive 30 days or more during the measurement year over time.

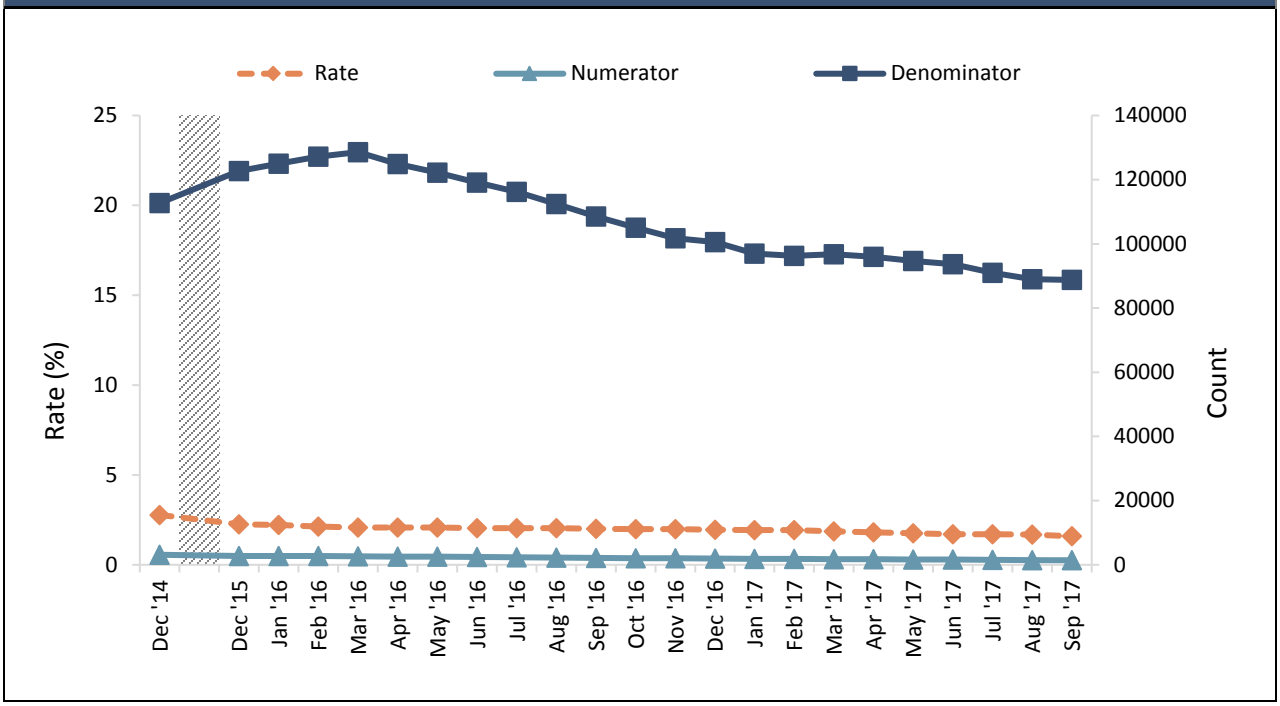
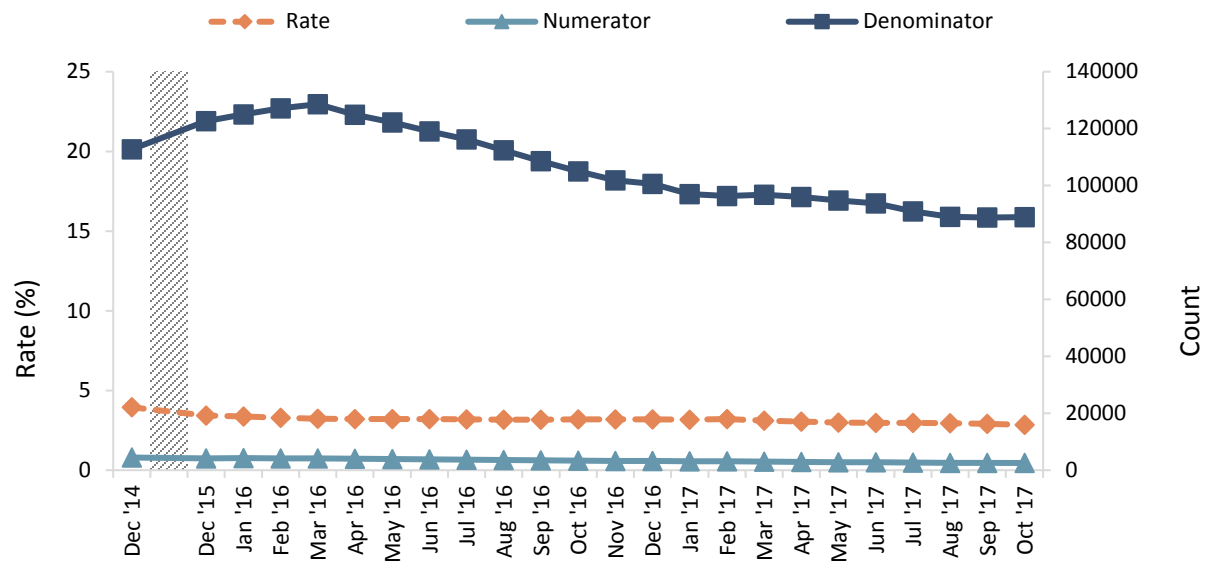


Table 10. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME for consecutive 30 days or more within the measurement year.

Study indicator	Baseline January 1–December 31, 2014	1st remeasurement January 1–December 31, 2016	Current remeasurement November 1, 2016-October 31, 2017
Numerator	4,448	3,201	2,527
Denominator	112,768	100,586	88,871
Calculated indicator	3.9%	3.2%	2.8%

Statistical tests indicated a statistically significant difference between the percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least 90 MME/day for 30 consecutive days or more at baseline and at first remeasurement (p<0.001), and between first and current remeasurement (p<0.001).

Figure 10. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME /day for consecutive 30 days or more during the measurement year over time.



Additional analyses

Table 11. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥120 MME on at least one day during the measurement year according to age group.

Age group	Baseline January 1–December 31, 2014			1st remeasurement January 1–December 31, 2016			Current remeasurement November 1, 2016-October 31, 2017		
	Numerator	Denominator	%	Numerator	Denominator	%	Numerator	Denominator	%
12–17 years	142	6,453	2.2%	77	4,623	1.7%	63	4,199	1.5%
18+ years	11,803	106,315	11.1%	9,317	95,963	9.7%	7,110	84,672	8.4%

The number of enrollees age 12–17 who filled an opioid prescription ≥120mg MME on at least one day during the measurement period decreased by about 46% from baseline to first remeasurement. The 18+ age group decreased by about 21% in the same period. From first to current remeasurement, the decreases were approximately 18% for the 12–17 age group and approximately 24% for the 18+ group.

Table 12. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 MME on at least one day during the measurement year according to age group.

Age group	Baseline January 1–December 31, 2014			1st remeasurement January 1–December 31, 2016			Current remeasurement November 1, 2016-October 31, 2017		
	Numerator	Denominator	%	Numerator	Denominator	%	Numerator	Denominator	%
12–17 years	354	6,453	5.5%	230	4,623	5.0%	193	4,199	4.6%
18+ years	19,881	106,315	18.7%	16,548	95,963	17.2%	13,376	84,672	15.8%

As with the 120 MME/day metric, the 12–17 age group showed a greater percentage decrease from baseline to first remeasurement than the older group. Compared to the 120 MME/day metric results, the decreases were not as large (about 35% for the 12–17 age group; about 17% for the 18+ group). From first to current remeasurement, the decreases were about 9% for the 12–17 group and about 19% for the 18+ group.

Factors affecting the validity of results

The factors affecting the validity of the results of the first remeasurement period (discussed under Standard 7) continue to be important considerations in interpreting the current measurement results. Those factors include cash payment; disproportionate changes in numerator and denominator; changes in CCO enrollment; inclusion of members with legitimate need for high doses of opioids; small CCO study populations; multiple treatment effects; staff turnover; statistical regression; and the limits of point-in-time measurement to detect improvement. As discussed in Standard 7, these factors should not have had a significant impact on the results or have altered conclusions about improvement in the study indicators. No new confounding factors or changes in mitigation of risks need to be taken into consideration in analyzing the current remeasurement period results.

At the time of this report, OHA was able to provide study data only through September 30, 2017, due to a 90-day claims lag. The current remeasurement period (October 1, 2016–September 30, 2017) overlaps the first remeasurement period and missing data for October, November and December 2017. OHA's back pain opioid guideline restrictions were to be implemented January 1, 2018. In technical assistance meetings, CCOs discussed their efforts to meet the OHA deadline, and it is likely that data for October through December 2017 will demonstrate a decrease in both study metric denominator and numerators.

Standard 10: Sustained Improvement

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

While the current measurement is not strictly comparable to the baseline and first remeasurement periods, tentative conclusions can be drawn. The baseline period (calendar year 2014) and first remeasurement period (calendar year 2016) are not contiguous, leaving calendar year 2015 unaccounted for. Calendar year 2015 data points have been included in the state-level graphs, helping to illustrate any trends.

The 2012 CMS PIP protocol states that "real improvement" is best determined by tests of statistical significance calculated between baseline and repeat measurement periods.[26] Statistical tests conducted by HealthInsight demonstrated that improvement

[26] Centers for Medicare & Medicaid Services. EQR Protocol 3: Validating Performance Improvement Projects (PIPs). https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed March 1, 2018.

in both the primary and secondary study indicators have been sustained over two measurement periods.

The extent of improvement in the study indicators can also be evaluated in comparison to federal or state Medicaid benchmarks or industry standards. Although the CDC has provided guidelines for opioid prescribing, provision of MAT and strategies to mitigate risk, the agency did not develop any national metrics or standards. Similarly, the State of Oregon developed opioid prescribing policies and guidelines but did not identify a statewide benchmark. In lieu of a statewide target, CCOs selected their own study targets and timeframes to evaluate their performance and the success of the PIP. At the end of the second remeasurement period (December 31, 2017), CCOs were asked to summarize their progress on this PIP, including achievement of study targets. At the time of this report, HealthInsight is reviewing the CCO reports. Each CCO will receive an evaluation (met/partially met/not met) for the degree of completeness, clarity and consistency in addressing each of the evaluation criteria. See Attachment F for an explanation of the criteria for interpretation of results. Upon completion, the final 2017 evaluations for each CCO will be included as an attachment.

Figures 9 and 10 visually represent the improvement of the study metrics over time. The study denominator (number of OHA enrollees 12 years and older who filled at least one opioid prescription in the measurement period) decreased significantly from March 2016 through February 2017; thereafter, the denominator decreased slightly through September 2017. It is possible that many CCOs' initial PIP intervention strategies—particularly the implementation of prior authorizations, benefit changes and more restrictive opioid guidelines—largely contributed to this decrease. CCOs' second remeasurement period evaluation reports, still pending at the time of this report, will confirm or negate this hypothesis. In October 2017 technical assistance meetings, CCO staff were asked their opinions on whether or not the decrease in the denominator (the number of people with at least one prescription for an opioid pain reliever filled within the measurement year) could be attributed to appropriate or inappropriate prescribing of opioids. Several CCOs acknowledged that while a small number of providers might have initially refused to treat enrollees on opioids, they had successfully addressed barriers and minimized the effect of that behavior. CCOs were unanimous in their opinion that the decrease in the number of members receiving an opioid prescription was "real," i.e., that fewer members were receiving opioids due to training and education to providers and members about appropriate use of opioids.

The graphs also show that both study numerators decreased at a much slower rate than the study denominator. The amount of opioids in circulation would be expected to decrease more quickly than the number of members being tapered off chronic doses of high opioids. Because of the disproportionate decrease in the denominator compared to

the numerators, it is important to examine counts as well as rates, especially at the CCO level. For example, according to Table 8, YCCO's ≥90 MME/day for any day study metric is unchanged from baseline to the current remeasurement period, suggesting no improvement in opioid management. However, further investigation shows that while the number of members who filled prescriptions for ≥90 MME/day for at least any day (numerator) decreased from 478 at baseline to 364 at current remeasurement, the number of members in the denominator decreased more rapidly, from 2,869 at baseline to 2,200 at current remeasurement, resulting in a calculated indicator that could be misleading.

Statistical tests conducted by HealthInsight also demonstrated improvement in both of the secondary study indicators (30 consecutive days or more at the relevant dosage limit) from baseline through current remeasurement. As shown in Table 13, CCOs varied greatly in the number and percentage of their members who could be considered high chronic opioid users.

Table 13. Among study members who filled at least one opioid prescription ≥90 MME/day in the measurement period , the number and percentage who filled presciptions for ≥90 MME/day for consecutive 30 days or more.

	2014			Current remeasurement		
CCO	≥90 MME/day for >30 days	≥90 MME any day	Rate	≥90 MME/day for >30 days	≥90 MME any day	Rate 9/30/16-10/1/17
ALLCARE	120	746	16.1%	55	588	9.4%
CHA	9	215	4.2%	2	107	1.9%
CPCCO	252	931	27.1%	113	609	18.6%
EOCCO	351	1290	27.2%	275	972	28.3%
FAMILYCARE	200	1886	10.6%	151	1501	10.1%
Fee for Service	412	1599	25.8%	126	544	23.2%
HSO	1114	5648	19.7%	719	3709	19.4%
IHN	427	1393	30.7%	222	669	33.2%
JCC	342	836	40.9%	197	639	30.8%
PSCS - CO	166	1089	15.2%	108	621	17.4%
PSCS - Gorge	51	202	25.2%	24	109	22.0%
PHJC	61	211	28.9%	32	102	31.4%
TRILLIUM	756	2783	27.2%	406	1892	21.5%
UHA	61	486	12.6%	24	258	9.3%
WOAH	57	421	13.5%	30	274	10.9%
WVCH	384	1620	23.7%	123	1154	10.7%
YCCO	97	478	20.3%	46	365	12.6%
SUM OF CCOS	**4448**	**20,235**	**22.0%**	**2527**	**13,569**	**18.6%**

Table 13 also confirms that for most CCOs, the ≥90 MME study numerator does not merely reflect overlapping prescriptions, but includes a significant percentage of members who are on high chronic dosages of opioids. All CCOs reported implementing interventions that targeted high chronic users, including sending member lists to providers, meeting with high prescriber providers one-on-one and conducting intensive case management. The rates of both the consecutive 30 day or more study numerators decreased at a slower rate than the at least one day study numerators.

As noted in Standards 7 and 9, a number of factors could affect the validity of the results. Of most concern to the CCOs is the inability to capture cash payments for opioids as part of the data. Hartung et al. analyzed PDMP data from 2012 to 2013.[27] The PDMP collects data on all schedule II, III and IV outpatient retail pharmacy fills dispensed, regardless of payor, in Oregon or to Oregonians. The authors stated that 13.5% of opioid fills by Medicaid beneficiaries could not be matched to a Medicaid claim, likely indicating an out-of-pocket payment. The research data were collected before the establishment of CCOs and the implementation of the Statewide PIP. It is unclear to what extent the percentage of fills lacking a Medicaid pharmacy claim have increased or decreased since 2013. More up-to-date data on PDMP opioid prescribing can be found on OHA's Opioid Data Dashboard. Graphs show that statewide prescribing of all opioids (prescription fills/1000 residents) decreased steadily from third quarter 2015 through third quarter 2017 (unlike the PIP study metric, the PDMP opioid category includes buprenorphine and buprenorphine/naloxone combinations as well as codeine antitussives).[28] A graph of the statewide ≥90 MED individuals/1000 residents from any fill showed a steep decline from fourth quarter 2015 through third quarter 2017. Although it is possible that there are differences between the different payors, it is likely that the significant decrease in the ≥90 MED rate could not have occurred without a decrease in the rates of all payors, including those due to out-of-pocket purchases. The PIP study metrics reflect changes in opioid Medicaid claims, but PDMP data indicate a similar decrease in the entire community.

Concerns about an increase in heroin use and overdose deaths as a result of implementing opioid guidelines do not seem to have been realized, according to limited available data. According to the OHA opioid dashboard, statewide heroin-related deaths, as identified by the medical examiner, decreased through mid-2017 after peaking in 2012, and heroin overdose deaths according to death certificates decreased from 2011 through 2016. However, deaths in the 18–44 age group increased in that period. Heroin overdose hospitalization data have only been collected through 2014,

[27] Hartung DM et al. Using prescription monitoring program data to characterize out-of-pocket payments for opioid prescriptions in a state Medicaid program. *Pharmacoepidemiol Drug Saf.* 2017 Sept; 26(9): 1053–1060.
[28] Oregon Health Authority. Opioid Data Dashboard. http://www.oregon.gov/oha/ph/PreventionWellness/SubstanceUse/Opioids/Pages/data.aspx. Accessed March 1, 2018.

and, similar to the death data, show an overall statewide decrease in rates, but an increase in the 18–44 age group.

In late 2017, CCOs participated in QHOC discussions to identify unanticipated positive and negative outcomes. Positive outcomes as a result of this PIP included better collaboration among CCOs, within CCOs and among local public health departments; development of a regional website; better access to data; accomplishment of more than expected; and increased interest in opioid management by dental care organizations. CCOs identified the following as unanticipated negative outcomes: increase in non-emergent medical transportation with the increase in MAT service demand; a strain on current detox programs, as members are finding it easier to obtain MAT through detox programs as access to and availability of other substance use disorder services is limited; and challenges in identifying and addressing unintended costs.

Additional lessons learned include:

- The importance of leadership support cannot be underestimated. In their review of QI methods, Powell et al. concluded that regardless of model or approach used, a number of conditions must be present for successful implementation and achievement of outcomes. These conditions include the provision of resources to enable quality improvement; "sustained managerial focus and attention"; coordination between different levels of health care; "substantial investment in training and development"; and the availability of timely data.[29] A project that challenges entrenched patient and provider attitudes and behaviors requires a long-term commitment. The willingness of leadership at the CCO and state levels to provide sustained human and financial resources to address the opioid problem has been key in achieving improved outcomes.
- Concurrent efforts at the national and state level helped to improve the efficacy of the local interventions and contributed to improvement in the study indicators: At the same time that CCOs were developing and implementing their interventions, state and national agencies, community-based organizations and local law enforcement agencies were funding and implementing projects to address the opioid epidemic, some in conjunction with CCOs and others independently. A partial list of the different projects and initiatives implemented in Oregon appears under Standard 1. In addition to these strategic efforts, the opioid epidemic has been regularly featured in newspaper/website articles and

[29] Powell AE, Rushmer RK, Davies HTO. A systematic narrative review of quality improvement models in health care (February 2009. http://www.healthcareimprovementscotland.org/previous_resources/hta_report/a_systematic_narrative_review.aspx. Accessed March 1, 2018.

television and radio programs. In Statewide PIP technical assistance meetings, CCOs agreed that the dissemination of similar messages about appropriate opioid prescribing from different sources validated efforts at the CCO level.

- It is challenging to identify and address unintended outcomes. Although CCOs knew that increased heroin usage and overdosing could occur as an unintended consequence of changing prescription opioid guidelines (i.e., decreasing the dosage threshold), most organizations have been unable to collect timely or accurate data to support or refute their assumptions. The OHA Opioid Data Dashboard allows access to data on drug overdose hospitalizations and deaths by drug type, but the data are calculated according to county, not CCO or insurance coverage. Also, the hospitalization data have been analyzed only through 2014, and the overdose deaths by death certificate through 2016. As a result, the data have limited value in evaluating improvement strategies. Some events were not anticipated, and the unintended consequences not identified, until the second remeasurement period. For example, non-emergent medical transportation costs increased significantly as MAT service demand increased because of provider and member education efforts.

- Best practices:
  - Involve behavioral health early on in planning and implementation of interventions.
  - Couple dissemination of member-level data to providers with non-judgmental provision of supportive services (training, toolkits, one-on-one education, etc.).

In their Standard 8 documentation, CCOs explained that their interventions, if successfully implemented, could be expected to improve the study indicators because they addressed identified barriers, were culturally and linguistically appropriate and incorporated evidence-based strategies or were consistent with successful interventions implemented by other CCOs. Quantitiative and qualitative tracking and monitoring data in the CCOs' quarterly progress reports demonstrated that the majority of interventions were implemented effectively. As noted above, factors that could have affected the validity of the results have been mitigated or shown not to have a significant impact on the interpretation of results. It is reasonable to attribute improvement in the study indicators to the implementation of CCO interventions. Because of concurrent activities by other community, state and national organizations, it is not possible to determine the degree to which improvement can be attributed solely to CCO efforts.

This PIP has been extended for a third and final remeasurement period. CCOs reported that they will continue to implement and modify their interventions and will begin incorporating these interventions into their standards of practice. It is expected that the study indicators will continue to demonstrate improvement. The degree of improvement might depend on OHA's enforcement of its back pain opioid usage guidelines. Many CCOs plan to expand the scope of this PIP into other areas of concern related to opioid usage, such as opioid use in co-prescribing of benzodiazepines and opioids and acute prescribing.

Statewide PIP, Attachment A: Denominator Exclusion Criteria: Diagnoses and CPT codes related to: Neoplasm-related pain, end-of-life care, palliative care or hospice care

ICD *	Title
ICD9 338.3	Neoplasm-related pain (acute) (chronic)
ICD10 G89.3	

***** CMS required the use of ICD10 codes for claims with a date of service on or after October 1, 2015.

Diagnoses and CPT codes related to: end-of-life care, palliative care, or hospice care		
DX		
V66	Convalescence and palliative care	
V667	Encounter for palliative care	
Z515	Encounter for palliative care	
CPT		
4350F	Cnslng Provided Symp Mngmnt	Counseling Provided On Symptom Management, End Of Life Decisions, And Palliation (Dem)
4553F	Pt Asst Re End Life Issues	Patient Offered Assistance In Planning For End Of Life Issues (Als)
99377	Hospice Care Supervision	Physician Supervision Of Patient Hospice Services, 15-29 Minutes Per Month
99378	Hospice Care Supervision	Physician Supervision Of Patient Hospice Services, 30 Minutes Or More Per Month
D9110	Tx Dental Pain Minor Proc	Palliative (Emergency) Treatment Of Dental Pain-Minor Procedures
G0065	Physician Supervision Of A Hospice Patient	Physician Supervision Of A Hospice Patient
G0151	Hhcp-Serv Of Pt,Ea 15 Min	Services Performed By A Qualified Physical Therapist In The Home Health Or Hospice Setting, Each 15 minutes

Diagnoses and CPT codes related to: end-of-life care, palliative care, or hospice care		
G0152	Hhcp-Serv Of Ot,Ea 15 Min	Services Performed By A Qualified Occupational Therapist In The Home Health Or Hospice Setting, Each
G0153	Hhcp-Svs Of S/L Path,Ea 15mn	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Or Hospice Setting,
G0154	Hhcp-Svs Of Rn,Ea 15 Min	Direct Skilled Nursing Services Of A Licensed Nurse (Lpn Or Rn) In The Home Health Or Hospice Setting
G0155	Hhcp-Svs Of Csw,Ea 15 Min	Services Of Clinical Social Worker In Home Health Or Hospice Settings, Each 15 Minutes
G0156	Hhcp-Svs Of Aide,Ea 15 Min	Services Of Home Health/Hospice Aide In Home Health Or Hospice Settings, Each 15 Minutes
G0157	Hhc Pt Assistant Ea 15	Services Performed By A Qualified Physical Therapist Assistant In The Home Health Or Hospice Setting
G0158	Hhc Ot Assistant Ea 15	Services Performed By A Qualified Occupational Therapist Assistant In The Home Health Or Hospice Set
G0182	Hospice Care Supervision	Physician Supervision Of A Patient Under A Medicare-Approved Hospice (Patient Not Present) Requiring
G0337	Hospice Evaluation Preelecti	Hospice Evaluation And Counseling Services, Pre-Election
G8768	Doc Med Reas No Lipid Profle	Documentation Of Medical Reason(S) For Not Performing Lipid Profile (E.G., Patients With Palliative
G8892	Doc Med Reas No Ldl-C Test	Documentation Of Medical Reason(S) For Not Performing Ldl-C Test (E.G. Patients With Palliative Goal
G9380	Off Assis Eol Iss	Patient Offered Assistance With End Of Life Issues During The Measurement Period
G9381	Doc Med Reas No Offer Eol	Documentation Of Medical Reason(S) For Not Offering Assistance With End Of Life Issues (Eg, Patient
G9382	No Off Assis Eol	Patient Not Offered Assistance With End Of Life Issues During The Measurement Period

Diagnoses and CPT codes related to: end-of-life care, palliative care, or hospice care		
G9433	Death, Nhres, Hospice	Death, Permanent Nursing Home Resident Or Receiving Hospice Or Palliative Care Any Time During The M
G9433	Death, Nhres, Hospice	Death, Permanent Nursing Home Resident Or Receiving Hospice Or Palliative Care Any Time During The M
HC100	Omap: Nf Hospice Care	Omap: Nf Hospice Care
Q5001	Hospice Or Home Hlth In Home	Hospice Or Home Health Care Provided In Patient'S Home/Residence
Q5002	Hospice/Home Hlth In Asst Lv	Hospice Or Home Health Care Provided In Assisted Living Facility
Q5003	Hospice In Lt/Non-Skilled Nf	Hospice Care Provided In Nursing Long Term Care Facility (Ltc) Or Non-Skilled Nursing Facility (Nf)
Q5004	Hospice In Snf	Hospice Care Provided In Skilled Nursing Facility (Snf)
Q5005	Hospice, Inpatient Hospital	Hospice Care Provided In Inpatient Hospital
Q5006	Hospice In Hospice Facility	Hospice Care Provided In Inpatient Hospice Facility
Q5007	Hospice In Ltch	Hospice Care Provided In Long Term Care Facility
Q5008	Hospice In Inpatient Psych	Hospice Care Provided In Inpatient Psychiatric Facility
Q5009	Hospice/Home Hlth, Place Nos	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (Nos)
Q5010	Hospice Home Care In Hospice	Hospice Home Care Provided In A Hospice Facility
S0255	Hospice Refer Visit Nonmd	Hospice Referral Visit (Advising Patient And Family Of Care Options) Performed By Nurse, Social Work
S0257	End Of Life Counseling	Counseling And Discussion Regarding Advance Directives Or End Of Life Care Planning And Decisions, W
S0271	Home Hospice Case 30 Days	Physician Management Of Patient Home Care, Hospice Monthly Case Rate (Per 30 Days)
S5150	Unskilled Respite Care /15m	Unskilled Respite Care, Not Hospice; Per 15 Minutes
S5151	Unskilled Respitecare /Diem	Unskilled Respite Care, Not Hospice; Per Diem
S9126	Hospice Care, In The Home, P	Hospice Care, In The Home, Per Diem

Diagnoses and CPT codes related to: end-of-life care, palliative care, or hospice care		
T2042	Hospice Routine Home Care	Hospice Routine Home Care; Per Diem
T2043	Hospice Continuous Home Care	Hospice Continuous Home Care; Per Hour
T2044	Hospice Respite Care	Hospice Inpatient Respite Care; Per Diem
T2045	Hospice General Care	Hospice General Inpatient Care; Per Diem
T2046	Hospice Long Term Care, R&B	Hospice Long Term Care, Room And Board Only; Per Diem

Statewide PIP, Attachment B: Buprenorphine Products

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

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

Among OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever within the measurement year.									
	12–17 years old			18+ years old			Both age groups (Total)		
CCO	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2014**	**CY 2015**	**CY 2016**
AllCare	331	309	269	6240	6428	5470	6571	6737	5739
CHA	95	77	84	1167	2062	1734	1262	2139	1818
CPCCO	209	171	131	3792	3850	3052	4001	4021	3183
EOCCO	431	369	300	5512	6176	5179	5943	6545	5479
FAMILYCARE	621	574	455	11058	13433	10653	11679	14007	11108
FFS	498	463	324	8638	5917	4973	9136	6380	5297
HEALTH SHARE	1538	1330	1033	26214	28850	22319	27752	30180	23352
IHN	480	396	330	7819	8305	6596	8299	8701	6926
JCC	240	195	149	3488	3837	3270	3728	4032	3419
PSCS-Central Oregon	475	399	303	6993	7462	6017	7468	7861	6320
PSCS-Columbia Gorge	82	74	62	1143	1292	1070	1225	1366	1132
PHJC	68	77	51	1391	1451	1181	1459	1528	1232
Trillium	665	614	474	12861	13538	11542	13526	14152	12016
UHA	189	152	152	3711	3676	3255	3900	3828	3407
WOAH	144	126	98	2986	3115	2583	3130	3241	2681
WVCH	643	633	577	9313	10781	9648	9956	11414	10225
YCCO	242	176	155	2627	2748	2394	2869	2924	2549
SUM OF CCOS	**6453**	**5672**	**4623**	**106315**	**117004**	**95963**	**112768**	**122676**	**100586**

For CY 2014: Data extraction date: 12/28/2015
For CY 2015: Data extraction date: 9/28/2016
For CY 2016: Data extraction date: 5/2/2017

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

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥120mg MED on at least one day												
CCO	**12–17 years**			**18+ years**			**Both groups (Total)**			**Rate for both groups**		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
AllCare	6	3	4	396	368	304	402	371	308	6.1%	5.5%	5.4%
CHA	7	2	1	80	96	88	87	98	89	6.9%	4.6%	4.9%
CPCCO	7	2	1	593	558	408	600	560	409	15.0%	13.9%	12.8%
EOCCO	10	6	6	855	916	713	865	922	719	14.6%	14.1%	13.1%
FAMILYCARE	10	9	8	906	1124	950	916	1133	958	7.8%	8.1%	8.6%
FFS	4	10	3	894	549	426	898	559	429	9.8%	8.8%	8.1%
HEALTH SHARE	40	28	22	3300	3504	2566	3340	3532	2588	12.0%	11.7%	11.1%
IHN	10	5	4	911	882	628	921	887	632	11.1%	10.2%	9.1%
JCC	7	1	3	616	575	493	623	576	496	16.7%	14.3%	14.5%
PSCS-CO	8	1	3	545	505	392	553	506	395	7.4%	6.4%	6.3%
PSCS-CG	1	0	1	121	93	85	122	93	86	10.0%	6.8%	7.6%
PHJC	0	0	0	122	124	100	122	124	100	8.4%	8.1%	8.1%
TRILLIUM	14	22	14	1726	1649	1327	1740	1671	1341	12.9%	11.8%	11.2%
UHA	3	5	2	228	220	172	231	225	174	5.9%	5.9%	5.1%
WOAH	3	3	1	198	199	184	201	202	185	6.4%	6.2%	6.9%
WVCH	10	8	1	937	971	689	947	979	690	9.5%	8.6%	6.7%
YCCO	6	6	6	269	275	218	275	281	224	9.6%	9.6%	8.8%
SUM OF CCOS	**142**	**101**	**77**	11803	**12059**	**9317**	**11945**	**12160**	**9394**	**10.6%**	**9.9%**	**9.3%**

For denominators and extraction dates, see Attachment C.

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥90mg MED on at least one day											
CCO	**12–17 years**			**18+ years**			**Both groups (Total)**			**Rate for both groups**		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
AllCare	7	10	6	739	698	602	746	708	608	11.4%	10.5%	10.6%
CHA	13	5	5	202	228	194	215	233	199	17.0%	10.9%	10.9%
CPCCO	16	5	2	915	910	681	931	915	683	23.3%	22.8%	21.5%
EOCCO	32	21	11	1258	1390	1083	1290	1411	1094	21.7%	21.6%	20.0%
FAMILYCARE	40	35	26	1846	2337	1933	1886	2372	1959	16.1%	16.9%	17.6%
FFS	25	29	12	1574	1000	804	1599	1029	816	17.5%	16.1%	15.4%
HEALTH SHARE	89	82	60	5559	6171	4619	5648	6253	4679	20.4%	20.7%	20.0%
IHN	21	18	14	1372	1400	992	1393	1418	1006	16.8%	16.3%	14.5%
JCC	12	4	5	824	855	713	836	859	718	22.4%	21.3%	21.0%
PSCS-CO	26	18	12	1063	942	727	1089	960	739	14.6%	12.2%	11.7%
PSCS-CG	2	2	3	200	160	150	202	162	153	16.5%	11.9%	13.5%
PHJC	1	3	2	210	221	176	211	224	178	14.5%	14.7%	14.4%
TRILLIUM	39	53	43	2744	2741	2238	2783	2794	2281	20.6%	19.7%	19.0%
UHA	6	8	9	480	467	371	486	475	380	12.5%	12.4%	11.2%
WOAH	7	8	14	414	435	381	421	443	395	13.5%	13.7%	14.7%
WVCH	27	18	6	1593	1625	1277	1620	1643	1283	16.3%	14.4%	12.5%
YCCO	16	14	12	462	513	411	478	527	423	16.7%	18.0%	16.6%
SUM OF CCOS	**354**	**304**	**230**	**19881**	**21093**	**16548**	**20235**	**21397**	**16778**	**17.9%**	**17.4%**	**16.7%**

For denominators and extraction dates- see Attachment C.

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥120mg MED consecutive 30 days or more												
CCO	**12–17 years**			**18+ years**			**Both groups (Total)**			**Rate for both groups**		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
AllCare	0	1	0	83	61	38	83	62	38	1.3%	0.9%	0.7%
CHA	0	0	0	4	6	2	4	6	2	0.3%	0.3%	0.1%
CPCCO	0	0	0	183	148	101	183	148	101	4.6%	3.7%	3.2%
EOCCO	1	0	0	245	244	208	246	244	208	4.1%	3.7%	3.8%
FAMILYCARE	0	0	0	120	109	111	120	109	111	1.0%	0.8%	1.0%
FFS	0	0	0	258	154	94	258	154	94	2.8%	2.4%	1.8%
HEALTH SHARE	0	0	0	766	737	497	766	737	497	2.8%	2.4%	2.1%
IHN	0	0	0	301	271	190	301	271	190	3.6%	3.1%	2.7%
JCC	0	0	0	273	211	149	273	211	149	7.3%	5.2%	4.4%
PSCS-CO	0	0	0	110	109	79	110	109	79	1.5%	1.4%	1.3%
PSCS-CG	0	0	0	36	23	18	36	23	18	2.9%	1.7%	1.6%
PHJC	0	0	0	46	35	25	46	35	25	3.2%	2.3%	2.0%
TRILLIUM	0	0	0	554	470	366	554	470	366	4.1%	3.3%	3.0%
UHA	0	0	0	45	39	29	45	39	29	1.2%	1.0%	0.9%
WOAH	0	0	0	40	36	27	40	36	27	1.3%	1.1%	1.0%
WVCH	0	0	0	259	212	95	259	212	95	2.6%	1.9%	0.9%
YCCO	0	0	0	63	50	32	63	50	32	2.2%	1.7%	1.3%
SUM OF CCOS	**1**	**1**	**0**	**3128**	**2761**	**1967**	**3129**	**2762**	**1967**	**2.8%**	**2.3%**	**2.0%**

For denominators and extraction dates- see Attachment C.

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥90mg MED consecutive 30 days or more												
CCO	**12–17 years**			**18+ years**			**Both groups (Total)**			**Rate for both groups**		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
AllCare	0	1	0	120	103	78	120	104	78	1.8%	1.5%	1.4%
CHA	0	0	0	9	10	2	9	10	2	0.7%	0.5%	0.1%
CPCCO	0	0	0	252	207	159	252	207	159	6.3%	5.1%	5.0%
EOCCO	1	0	0	350	358	320	351	358	320	5.9%	5.5%	5.8%
FAMILYCARE	0	0	0	200	223	208	200	223	208	1.7%	1.6%	1.9%
FFS	0	0	0	412	245	177	412	245	177	4.5%	3.8%	3.3%
HEALTH SHARE	0	0	0	1114	1135	857	1114	1135	857	4.0%	3.8%	3.7%
IHN	0	0	0	427	402	289	427	402	289	5.1%	4.6%	4.2%
JCC	0	0	0	342	296	238	342	296	238	9.2%	7.3%	7.0%
PSCS-CO	0	0	0	166	161	128	166	161	128	2.2%	2.0%	2.0%
PSCS-CG	0	0	0	51	37	34	51	37	34	4.2%	2.7%	3.0%
PHJC	0	0	0	61	52	38	61	52	38	4.2%	3.4%	3.1%
TRILLIUM	0	0	0	756	674	528	756	674	528	5.6%	4.8%	4.4%
UHA	0	0	0	61	56	42	61	56	42	1.6%	1.5%	1.2%
WOAH	0	0	0	57	61	44	57	61	44	1.8%	1.9%	1.6%
WVCH	0	0	0	384	352	182	384	352	182	3.9%	3.1%	1.8%
YCCO	0	0	0	97	68	54	97	68	54	3.4%	2.3%	2.1%
SUM OF CCOS	**1**	**1**	**0**	**4447**	**4195**	**3201**	**4448**	**4196**	**3201**	**3.9%**	**3.4%**	**3.2%**

For denominators and extraction dates- see Attachment C.

Statewide PIP, Attachment E: Study Demographics

Number of enrollees 12+ years and older who had least one prescription for an opioid pain reliever filled within the baseline measurement year by race and ethnicity.					
Denominator	**Hispanic/ Latino**	**Non-Hispanic/ Non-Latino**	**Unknown**	**Cross Ethnicity**	**% of denominator**
African American	162	4,589	46	4,797	4.25%
American Indian or Alaskan Native	122	1,414	24	1,560	1.38%
Asian	120	1,566	23	1,709	1.52%
Caucasian/White	4,943	80,800	1,326	87,069	77.21%
Native Hawaiian/Pacific Islander	27	248	0	275	0.24%
Hispanic	25	0	18	43	
Other Race or Ethnicity	874	1,826	37	2,737	2.43%
Unknown	4,611	9,827	140	14,578	12.93%
Total	**10,884**	**100,270**	**1,614**	**112,768**	

Percentage of denominator who are Hispanic = 9.65%.

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

Number of enrollees in the study baseline denominator with at least 30 consecutive days with ≥120 mg MED/day by race and ethnicity.					
Numerator: ≥120mg MED/day for 30 days or more	**Hispanic/ Latino**	**Non-Hispanic/ Non-Latino**	**Unknown**	**Cross Ethnicity**	**% of numerator**
African American	2	90	0	92	2.94%
American Indian or Alaskan Native	4	51	0	55	1.76%
Asian	0	10	0	10	0.32%
Caucasian/White	61	2,609	18	2,688	85.91%
Native Hawaiian/Pacific Islander	0	5	0	5	0.16%
Hispanic	0	0	0	0	0.0%
Other Race or Ethnicity	20	25	1	46	1.47%
Unknown	40	191	2	233	7.45%
Total	**127**	**2,981**	**21**	**3,129**	

Percentage of denominator who are Hispanic = 4.10%.
Data extraction date: 12/28/2015, Office of Health Analytics, OHA.

Statewide PIP, Attachment F: Standard 8 Scoring Criteria

8.1 Has the CCO described:

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

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

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

d. Cultural and linguistic appropriateness (CLA) of the interventions
    - Part 1 should include an explanation of how the interventions will address racial, ethnic and/or linguistic differences in the CCO study population.
    - Part 1 should include an explanation of how the interventions will address broader cultural considerations relevant to the CCO study population, such as socioeconomic status, geographic location (urban vs. rural living), literacy status, serious and persistent mental illness, etc.
    - Progress report with descriptions of new interventions should include an explanation of their cultural and linguistic appropriateness. This information should be included in the "additional information" section on page 3.
    - *Note: Cultural and linguistic appropriateness considerations should be consistent with the root cause, demographic and barrier analyses (e.g., if analyses indicate that rural environment is a contributing factor/barrier, the CLA discussion should include an explanation as to how that will be taken into account when developing and implementing interventions).*

e. Tracking and monitoring plans and results/intervention effectiveness
    - Part 1 should describe plans to collect study indicator and implementation effectiveness data.
    - Progress report should include study indicator data over time in the outcome table.
    - Progress report should include information on the # or % of study eligible enrollees reached by the interventions (when applicable*).*
    - Progress report (under the intervention effectiveness column) should include data (quantitative or qualitative) to demonstrate whether or not each intervention was implemented successfully
    - Graphs, run charts and tables can be used to further illustrate tracking and monitoring results.
    - *Note: CCOs should demonstrate that between all of the different interventions, they have covered the entire study population and not just "cherry-picked" sub-populations.*
    - *Note: Graphs and tables should be labelled and consistent with the narrative.*

f. Barriers:
   - Progress report should include information on factors/events/situations that negatively affected the development and implementation of the interventions, where applicable.
   - Progress report should include a description of how barriers were addressed (or could not be addressed).
   - *Note: The reported barriers should be consistent with next steps/intervention status (e.g., if an intervention is modified or abandoned, there should be a corresponding discussion of barriers in the barriers column*).

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

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

M = Met **P** = Partially met **N** = not met

CCO	Root cause			Description interventions			How improves the indicator			Cultural/linguistic appropriateness			Tracking and monitoring			Barriers			Next steps		
	M	P	N	M	P	N	M	P	N	M	P	N	M	P	N	M	P	N	M	P	N
AllCare	1				1			1		1				1		1			1		
CHA	1			1			1			1				1		1			1		
CPCCO	1			1			1			1				1		1			1		
EOCCO	1			1			1			1				1		1			1		
FamilyCare	1			1			1				1		1			1			1		
Health Share	1			1			1				1			1		1			1		
IHN	1			1				1			1		1			1			1		
JCC	1			1			1				1			1		1			1		
PSCS-CO	1				1		1				1			1		1			1		
PSCS-CG	1				1		1				1			1		1			1		
PHJC	1			1			1				1		1			1			1		
TCHP	1				1		1				1				1		1			1	
UHA		1		1					1		1			1				1		1	
WOAH	1			1			1				1		1			1			1		
WVCH		1		1				1			1		1			1			1		
YCCO	1			1			1			1			1			1			1		
Sum	**14**	**2**	**0**	**12**	**4**	**0**	**12**	**3**	**1**	**5**	**11**	**0**	**6**	**9**	**1**	**14**	**1**	**1**	**14**	**2**	**0**