Oregon Health Authority

2018 External Quality Review Technical Report

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HSAG HEALTH SERVICES ADVISORY GROUP

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Abbreviations and Acronyms Used in This Report

BC/DR	business continuity/disaster recovery
CAHPS®[1]	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
HEDIS®[2]	Healthcare Effectiveness Data and Information Systems
HERC	Health Evidence Review Commission
HSAG	Health Services Advisory Group, Inc.
ISCA	Information Systems Capabilities Assessment
MAT	medication-assisted treatment
MCE	managed care entity
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
QAPI	quality assessment and performance improvement
QHOC	Quality and Health Outcomes Committee
QI	quality improvement
SHCN	special health care needs

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

1. Executive Summary

Overview

Coordinated care organizations (CCOs) were formed as part of Oregon's health care system transformation. With state legislation and approval of Oregon's 1115 Medicaid Demonstration Waiver by the Centers for Medicare & Medicaid Services (CMS), Oregon implemented the CCOs as the delivery system for Medicaid. In 2012, the CCOs became responsible for managing physical and mental health services for Oregon Health Plan (OHP) members, and for managing dental health of OHP members in 2014. The current 15 CCOs manage health services (including non-emergent medical transportation [NEMT] services) for OHP members statewide. The Oregon Health Authority (OHA) also contracts with Greater Oregon Behavioral Health, Inc. (GOBHI), a managed health organization (MHO), and six dental care organizations (DCOs) to provide behavioral health and dental services to OHP members not enrolled with the CCOs. In this report, CCOs and the MHO are collectively referred to as "managed care entities (MCEs)."

According to 42 CFR §438.358, which describes external quality review (EQR) activities, the state Medicaid agency, an external quality review organization (EQRO), or the state's agent that is not a Medicaid managed care organization (MCO), prepaid ambulatory health plan (PAHP), or prepaid inpatient health plan (PIHP) may perform the mandatory and optional EQR-related activities to obtain data to support production of the annual EQR in 42 CFR §438.350. In 2018, OHA was contracted with HealthInsight Assure (HIA) as an EQRO and then transitioned to Health Services Advisory Group (HSAG) as a new EQRO in July 2018. Activities conducted by the two EQROs in 2018 include:

- Compliance Monitoring Reviews to determine the MCEs' compliance with federal (42 CFR §438) and state standards which address requirements related to access, structure and operations, and quality measurement and improvement.[1-1] Follow up on the status of MCEs' 2017 compliance review findings and related improvement plans.[1-2]
- An information systems capabilities assessment (ISCA) to review the MCEs' information systems, data processing and reporting procedures to determine the extent to which they maintain the capacity to manage the health care of its members and support the collection, management, and use of valid and reliable data.
- An evaluation of the CCOs' performance improvement projects (PIPs) and focus studies. Each quarter, the CCOs submit information on the status and outcome of three ongoing PIPs and one focus study. This information is reviewed and evaluated by HSAG staff, and used to provide general feedback to OHA regarding potential areas for improvement.

[1-1] HSAG was contracted by OHA to complete seven compliance reviews beginning July 2018; HealthInsight Assure (HIA) conducted EQR activities (compliance review, performance improvement project validation and review, and information systems capabilities assessments (ISCA) for the other eight CCOs and the MHO prior to July 2018. Final reports were completed and submitted to OHA and HSAG in September 2018.
[1-2] The 2017 review standards included: enrollee rights, grievance systems, and certifications and program integrity.

- Performance Measure Validation (PMV) of six specific measures to evaluate the accuracy and validity of OHA's calculation of the performance measure rates for the State's 15 CCOs.
- An evaluation of the delivery system network (DSN) for CCOs through the comprehensive review of CCO DSN Provider Capacity and Narrative Reports regarding provider capacity compliance in accordance with the State's standards for access to care, network adequacy to provide covered services to all enrollees, and strengths and gaps regarding the delivery system network.

For 2018, the two EQROs followed protocols, review tools, scoring, and other processes originally developed by HIA, which were adapted from the Centers for Medicare & Medicaid Services (CMS) guidelines. HSAG's use of these protocols, tools, and scoring for its 2018 reviews provided consistency with the 2018 MCE reviews conducted prior to HSAG's contract start date in July 2018.

This technical report is a compilation of the results from HSAG and HIA 2018 EQR activities to the extent the two EQROs conducted each of the activities. Below are high-level summaries of results from those activities with more complete summaries included in the following report sections. Information by MCE is further provided in *Appendix A. MCE Profiles*.

Compliance Review

MCE compliance was review by the two EQROs based on the 2018 QAPI Protocol document, a compilation of standards previously prepared by HIA. The review consisted of one-half of the full set of standards in 2018 to complete the compliance cycle within a three-year period. Specific standards evaluated in 2018 included the following:

- Availability and Accessibility of Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Provider Selection
- Subcontractural Relationships and Delegation
- Practice Guidelines
- Quality Assessment and Performance Improvement (QAPI)

Findings for the 2018 compliance review were determined from:

- Desk reviews of MCE documents submitted prior to, during, and after the onsite portion of the reviews.
- Onsite activities that included reviewing additional documents and records, interviewing key administrative and program staff members, system demonstrations, and file reviews.

Overall Strengths

During the compliance reviews, MCEs demonstrated levels of care coordination through concerted efforts by care coordinators to work with members and their families to help navigate their care. Many MCEs had robust tracking systems to track care coordination notes considering needed care across physical, behavioral, and oral health. This care coordination also sought to address family needs and socioeconomic conditions, such as homeless individuals needing cell phones to ensure follow up and new appointment setting can be achieved.

Compliance reviews also brought to light MCE efforts to move toward better quality of care and engaging community members and partners to address specific quality of care issues, integrated care, and diversity. The Transformation Quality Strategy (TQS) framework OHA requires is a useful factor for CCOs in identifying the focus on this work and prioritization cross the continuum of care for Oregon OHP members. While quality oversight structure varied across the MCE, each had structures that engaged various community partners and some members. The CCOs identified countless examples of collaboration on quality initiatives that included the adoption of behavioral health practice guidelines, Native American community health, and diversity awareness among other things. Other demonstrated strengths included:

- MCE policies generally supporting appropriate and timely service authorizations.
- Formalized agreements between MCEs and their partners that described delegated activities and addressed unsatisfactory performance.
- Appropriate credentialing and recredentialing policies, with delegated credentialing activities being regularly monitored.
- MCEs utilizing Health Evidence Review Commission (HERC) guidelines and the guidances contained within the OHA's Prioritized List, with many of them developing ad hoc guidelines for the treatment of specific conditions.
- Quality plans across each MCE and CCOs TQSs that incorporated quality plans with at least some quality committee structure in place and the ability to obtain and incorporate stakeholder feedback.

Major Areas for Improvement and Recommendations

Recommendations were provided for the individual MCEs and for OHA to help address improvement needs. General recommendations appear below.

- **Documentation:** Documentation (e.g., policies and procedures, contracts, etc.) should be developed and maintained to clearly and effectively define MCE operational and delegated activities, ensuring compliance with regulations and contractual provisions related to Medicaid members.
- **Care Coordination and Treatment Plans:** OHA should work with MCEs to provide guidance on care planning and effective care coordination system functionality. It is additionally necessary for MCEs to be able to properly identify and track individuals with SHCNs to proactively ensure they are receiving the services they need.

- **Ensuring Coverage:** MCEs should ensure their documentation is clear regarding members' liability for payment of covered services and monitor payment denials for covered services to ensure they are occurring appropriately.
- **Provider Selection:** Efforts should be made to directly ensure policies are in place at the MCE level, rather than relying on delegate policies, and that issues of discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment are mitigated.
- **Practice Guidelines:** MCEs should be aware the HERC guidelines and the guidances contained in the OHA's Prioritized List do not comprehensively address all conditions and should not be the only source of guidelines used to provide care for their members. MCEs should also have a mechanism to appropriately disseminate adopted practice guidelines to providers, and to members upon request.
- **Delegation Accountability:** MCEs are ultimately accountable for all activity subcontracted or delegated to other organizations or providers and identifying clear expectations for oversight activities is needed to ensure accountability.

Organizational Information Systems Capability Assessment (ISCA)

The ISCA was conducted to assess MCE information systems, security policies and procedures, and data collection and reporting capabilities. To accomplish its objective, HIA in collaboration with OHA, developed a standardized data collection tool and processes used by the two EQROs to assess and document each organization's compliance with 11 ISCA sections. Each section assessed a component of the MCE's information systems. The 11 ISCA sections included:

1. Staffing
2. Meaningful Use of Electronic Records
3. Configuration Management
4. Member Enrollment Systems
5. Information Systems
6. Security
7. Provider Directory
8. Data Integration
9. Report Production
10. Vendor Management
11. Administrative Data

Findings for the 2018 ISCA reviews were determined from:

- Desk reviews of MCE documents submitted prior to, during, and after the onsite portion of the review.

- Onsite activities that included reviewing additional documents and records, interviewing key administrative and program staff members, and system demonstrations.
- Provider network telephonic interviews targeting claims/encounter data processing, data integrity, electronic and physical security, and business continuity and disaster recovery planning.

Overall Strengths

Most of the MCEs provided documentation on the flow of all internal and external information systems and evidence of processes for daily maintenance, configuration, and operation of all systems essential to process Medicaid encounter data. They also had processes in place related to processing, handling, and verifying of Medicaid member eligibility and enrollment records. This included adequate mechanisms for handling and maintaining Medicaid member enrollment restrictions, disenrollment, and breaks in enrollment. Most of the MCEs demonstrated adequate staffing levels and training to support administrative and information technology (IT) services related to staff duties.

The MCEs additionally had practices used to manage, process, and integrate claims and operational data sources to produce valid and reliable reporting. In cases where work involving Medicaid data was delegated to another entitiy, MCEs generally had documented expectations for delegate reporting, monitoring, and corrective actions. A majority of the MCEs demonstrated practices related to the timeliness, accuracy, and completeness of claims and encounter data, and maintenance and operation of their respective systems.

Major Areas for Improvement and Recommendations

Recommendations were provided for the individual MCEs and for OHA to help address improvement needs. General recommendations appear below.

- **Documentation:** HSAG recommends that MCEs document policies and procedures to the extent possible. The availability of documentation (e.g., policies and procedures, plans, practices, contracts, etc.) is critical to ensuring operational procedures and guidelines are available to guide health care operations as well as training and monitoring of staff performance.
- **Providing Security Guidance:** MCEs business continuity and disaster recovery (BC/DR) and Incident Response (IR) had mostly not been tested and several of them could not demonstrate evidence of a current System Security (SS) plan that covers all IT functions, systems, and equipment. OHA should work with CCOs to provide guidance in the area of IT security applicable to OHA contract and Health Insurance Portability and Accountability Act requirements.
- **Ensuring Vendor Management:** Many of the MCEs' delegation agreements and subcontracts did not always support and define organizational operations and management of outsourced data processing. Additionally, some MCEs could not demonstrate ongoing monitoring and trending of data and calculations related to performance measures provided by delegates. Efforts should be made to directly ensure that MCEs clearly define expectations and accountability for oversight of contracted vendors responsible for ISCA related activities.

- **Streamlining the ISCA:** HSAG recommends the ISCA review activity and materials be streamlined for clarity and alignment with State and federal requirements to ensure submission represents a more focused review the MCEs' information systems and data processing and reporting procedures to determine the extent to which the MCE maintains the capacity to manage the health care of its members and support the collection, management, and use of valid and reliable data.

Performance Measure Validation (PMV)

The purpose of PMV is to assess the accuracy of performance measures reported and determine the extent to which the reported rates follow the measure specifications and reporting requirements. HSAG evaluated the accuracy and validity of OHA's calculation of the performance measure rates for the 15 CCOs according to CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.[1-3] OHA identified a set of six incentive performance measures for validation in 2018, in which the rate calculations were based on administrative data only (i.e., enrollment and claims/encounters) for the calendar year 2017 measurement period. These measures represented HEDIS-like measures and measures developed by OHA and are listed in Table 1-1 below.

Table 1-1—List of Performance Measure Indicators for Oregon Health Authority

Performance Measure
Adolescent Well Care Visits
Ambulatory Care: Emergency Department (ED) Utilization
Dental Sealants
Developmental Screening in the First There Years of Life
Effective Contraceptive Use
Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up

PMV Results

HSAG validated the rates for the six performance measures selected by OHA for validation. In summary, all six performance measure indicators in the scope of HSAG's PMV activities for calendar year 2018 were compliant with the measure specifications and the rates can be reported. For the measure selected for PMV,

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 30, 2018.

HSAG did not identify any issues or concerns with the accuracy or validity of OHA's calculation of the performance measure rates.

CCO Performance Improvement Projects (PIPs)

During 2018, the CCO's were required to conduct three PIPs and one focus study in alignment with the CCO's Transformation Plan and OHA quality and incentive requirements. One of the required PIPs is being conducted statewide and focuses on opioid management. OHA contracted with HIA to conduct a review of the statewide PIP topic from inception through 2018 first quarter PIP activities, which included progress through March 2018. HSAG reviewed the CCOs second and third quarter 2018 PIP progress reports for activities completed from April 2018 through September 2018. For the 2018 activities as part of the PIP assessment process, HSAG identified areas in need of improvement or technical assistance within each CCO's progress on the statewide PIP and the CCO-specific PIP topics.

Statewide PIP

The selected statewide PIP, initiated in 2015, focused on improving opioid safety by reducing the prescription of high morphine milligram equivalent (MME/day). After reviewing literature and receiving feedback from the Quality and Health Outcomes Committee (QHOC) discussions and OHA's quality committee comprised of CCO clinical leadership, OHA elected to focus on members age 12 years of age and older with opioid prescriptions for ≥ 90 MME/day and ≥ 50 MME/day morphine equivalent dosage per day and for 30 consecutive days.

Individual CCOs have the option of measuring one or both dosage thresholds. Within the quarterly PIP report submissions, each CCO documented the outcome measures selected for the dosage threshold. In addition, the CCOs are responsible for developing their own interventions and documenting their progress in quarterly reports submitted to OHA.

The aggregated statewide results for the statewide PIP were reviewed and conveyed by HIA for the baseline measurement period, and the first and second remeasurement periods, in a report generated by HIA in March 2018. HIA reported a chi-square test yielded a statistically significant difference for both outcome measures at the baseline and current remeasurement periods, and between the first and second remeasurement periods.

HIA provided each CCO with an evaluation (met, partially met, or not met) for the degree of completeness, clarity and consistency in addressing each of the evaluation criteria. HSAG provided OHA with areas in need of improvement or technical assistance within each CCO's quarterly progress report submission for quarters two and three.

The CCO profiles in *Appendix A. MCE Profiles* report each CCO's interventions, barriers and areas in need of improvement for the Statewide PIP, as well as the topics of additional PIPs and focus projects the CCO conducted in 2018.

CCO-Specific PIP and Focus Projects Review Results

The CCOs provided quarterly reports on their selected PIPs and focus studies. The OHA contract required the CCO-specific PIPs and focus study topics to address care within seven 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.

HSAG's PIP team reviewed the second and third quarter 2018 progress reports and documented observations and findings for each CCO in the PIP Progress Review tool. The CCO-specific PIPs and focus studies addressed a wide range of topics. While the CCOs reported extensive updates on improvement strategies and activities from the second quarter to the third quarter, HSAG identified similar areas of strengths and areas for improvement during the progress review for each quarter.

HSAG identified some common areas of strength and areas for improvement across the CCO-specific PIP and focus study progress reports. The CCOs demonstrated strength in clearly stating the problem addressed by each PIP or focus study, deploying interventions that were logically linked to study outcomes, and addressing identified barriers to intervention implementation. Common areas for improvement among the CCOs included incomplete documentation of measurement and data collection plans, lack of a clearly documented causal/barrier analysis process, and insufficient use of intervention effectiveness evaluation to guide next steps.

Delivery System Network Evaluation

Pursuant to 42 CFR §438.206 "Availability of Services" and 42 CFR §438.207 "Assurances of Adequate Capacity and Services," and based on the requirements outlined in the state regulations and in the OHA 2018 CCO Health Plan Services Contract Exhibit G (1)(a)(b), CCOs are required to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract.[1-4] To assess this, HSAG conducted a comprehensive evaluation of the OHP Delivery

[1-4] See 42 CFR §438.206 and §438.207; OAR 410-141-3220.

System Network (DSN) by reviewing 2018 CCO DSN Narrative and Capacity Reports and documenting findings across five narrative categories:

1. Description of the delivery network and adequacy
2. Description of enrollees
3. Provider network to meet enrollee needs
4. Coordination of care
5. Performance on metrics

While the evaluation findings had not yet been finalized at the time this report was developed, the preliminary findings suggest that the overall aggregate performance across CCOs was fair while variation in scores across the CCOs indicated several areas for improvement. Of note, many CCO DSN Provider Capacity Reports did not follow OHA's required template. HSAG provided recommendations to OHA regarding the standardization of reporting and technical assistance to CCOs in collecting and reporting on network adequacy.

2. Introduction

Overview

As required by 42 CFR §438.364,[2-1] OHA was contracted with HIA as an EQRO and then transitioned to a HSAG as a new EQRO in July 2018. The EQROs were contracted to perform the mandatory external quality review activities. HSAG used the results from these activities to support the production of an annual technical report. This annual technical report summarizes EQR activities conducted in 2018 by both EQROs and provides:

- An overview of Oregon's Medicaid program, referred to as the OHP.
- A description of the scope of EQR activities conducted in 2018.
- A description of OHA's quality strategy for the OHP and its annual assessment.
- Information on the assessment and summarized findings for each of the EQR activities conducted in 2018. Recommendations to OHA for each of the EQR activities related to access, timeliness, and quality of care related to the health care services provided to Medicaid members in Oregon.

With state legislation and approval of Oregon's 1115 Medicaid Demonstration Waiver by CMS, Oregon implemented CCOs in 2012 as the managed care entities responsible for the Medicaid delivery system referred to as the OHP. The now 15 CCOs responsible for managing physical and mental health services for OHP members (including NEMT), and for managing the dental health of members. OHA also contracts with GOBHI, a MHO, and six DCOs to provide behavioral health and dental services, respectively, to OHP members not enrolled with the CCOs. Each CCO and 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.

Note: *Unless citing Title 42 CFR, this report will refer to OHA's CCOs and the MHO as MCEs.*

While quality, access, and timeliness are distinct aspects of care, most MCE activities and services cut across more than one area. Collectively, all MCE activities and services affect the quality, access, and timeliness of care delivered to Members. As required by the CFR, this independent technical report summarizes conclusions drawn by the EQROs related to MCE strengths and areas for improvement with respect to the quality and timeliness of, and access to the health care services furnished to OHP Members (referred to as "members" in this report) and includes:

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431, 433, §438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Nov 14, 2017.

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the MCE.
- For each EQR activity conducted in accordance with 42 CFR §438.358:
  - Objectives
  - Technical methods of data collection and analysis
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR §438.358(b)(1)(i) and (ii)
  - Conclusions drawn from the data
- An assessment of each MCE's strengths and areas for improvement for the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of health care services furnished by each MCE, including how the State can target goals and objectives in the quality strategy, under 42 CFR §438.340, to better support improvement in the quality and timeliness of, and access to health care services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCEs, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR §438.352(e).
- An assessment of the degree to which each MCE has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Review Activities

According to 42 CFR §438.358, which describes EQR activities, the state Medicaid agency, an EQRO, or the state's agent that is not a Medicaid MCO, PAHP, or PIHP may perform the mandatory and optional EQR-related activities to obtain data to support production of the annual EQR in 42 CFR §438.350. In 2018, OHA was contracted with HIA as an EQRO and then transitioned to HSAG as a new EQRO in July 2018 to carry out these activities which include conducting:

- A review to determine MCE compliance with federal (42 CFR §438) and state requirements which address requirements related to access, structure and operations, and quality measurement and improvement.[2-2] The review consisted of one-half of the full set of standards in 2018 to complete the compliance cycle within the required three-year period. Specific standards evaluated in 2018 included the following:
  - Availability and Accessibility of Services
  - Coordination and Continuity of Care

[2-2] HSAG was contracted by OHA to complete seven compliance reviews beginning July 2018; HealthInsight Assure (HIA) conducted EQR activities (compliance review, performance improvement project validation and review, and information systems capabilities assessments (ISCA) for the other eight CCOs and the MHO prior to July 2018. Final reports were completed and submitted to OHA and HSAG in September 2018.

  - Coverage and Authorization of Services
  - Provider Selection
  - Subcontractural Relationships and Delegation
  - Practice Guidelines
  - Quality Assessment and Performance Improvement (QAPI)
- Follow up on the status of CCOs' 2017 compliance review findings and related improvement plans.[2-3]
- An information systems capabilities assessment (ISCA) to review the CCOs' information systems, data processing and reporting procedures to determine the extent to which they maintain the capacity to manage the health care of its members and support the collection, management, and use of valid and reliable data.
- A review of the CCOs' performance improvement projects (PIPs) and focus studies. Each quarter, the CCOs submit information on the status and outcome of three ongoing PIPs and one focus study. This information is reviewed and evaluated by HSAG staff and used to generate feedback to OHA regarding potential areas for improvement.
- Performance measure validation (PMV) to assess the accuracy of a set of six incentive performance measures reported and determine the extent to which the reported rates follow the measure specifications and reporting requirements.
- An evaluation of the delivery system network (DSN) for CCOs through the comprehensive review of CCO DSN Provider Capacity and Narrative Reports regarding provider capacity compliance in accordance with the State's standards for access to care, network adequacy to provide covered services to all enrollees, and strengths and gaps regarding the delivery system network.

For 2018 compliance review and ISCA activities, the two EQROs followed protocols and review tools originally developed and used by HIA, which were adapted from CMS guidelines. Use of these protocols and tools by both EQROs for the 2018 reviews provided consistency with the MCE reviews. Overall, the EQR review activities described above and summarized in this technical report assessed whether the MCEs:

- Met CMS regulatory requirements in selected standard areas.
- Complied with the related OHA contract requirements.
- Monitored and oversaw delegated entities in their performance of any delegated activities to ensure regulatory and contractual compliance.
- Followed up on its improvement plans related to 2017 compliance review findings.
- Conducted its PIPs properly and achieved improvement in PIP outcomes.
- Had information systems, data processing, and reporting procedures that supported the capacity to manage the health care of its enrollees and produced of valid and reliable performance metrics.

[2-3] The 2017 review standards included: enrollee rights, grievance systems, and certifications and program integrity.

Oregon Managed Care

The OHP is the source of health coverage for nearly 850,000 Oregonians. Care for OHP members is provided through CCOs, and MHO, and DCOs that interact in varying ways. Below is a summary of each type of organization in Oregon.

Coordinated Care Organizations

CCOs are the primary agents of Health System Transformation in Oregon. The state's innovative CCO model has made progress on the triple aim of better health, better care and lower costs, and Oregon continues to improve the model to meet these goals. During the current cycle of CCO contracting, all fifteen CCOs across the state improved access to primary care, reduced costly Emergency Department (ED) visits, and saved the state an estimated $2.2 billion dollars in avoided health care costs.[2-4] Future plans for CCOs in the contracting period of 2020-2014 (known as "CCO 2.0") will build upon this success as well as address the gaps and challenges that persist in Oregon's health care system.

Table 2-1 displays the CCOs and their enrollment totals as of November 2018.

Table 2-1—OHP Enrollment by CCO—November 2018[2-5]

Coordinated Care Organization (CCO)	Total Enrollees
Advanced Health	19,264
AllCare Health Plan	48,176
Cascade Health Alliance (CHA)	16,981
Columbia Pacific CCO (CPCCO)	23,454
Eastern Oregon CCO (EOCCO)	47,796
Health Share of Oregon (HSO)	304,568
Intercommunity Health Network (IHN)	52,241
Jackson Care Connect (JCC)	29,973
PacificSource Community Solutions–Central Oregon (PSCS-CO)	11,665
PacificSource Community Solutions–Columbia Gorge (PSCS-CG)	48,048
PrimaryHealth of Josephine County (PHJC)	9,644

[2-4] OHSU Center for Health Systems Effectiveness. Evaluation of Oregon's 2012-2017 Medicaid Waiver. Accessed on January 21, 2019. Available at: https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf

[2-5] Oregon Health Authority. Oregon Health Plan: Coordinated Care, Managed Care and Fee for Service Enrollment for November 15, 201. Available at: https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/November%202018%20Total%20CCO-Managed%20Care%20and%20FFS%20Enrollment.pdf

Coordinated Care Organization (CCO)	Total Enrollees
Trillium Community Health Plan (TCHP)	85,500
Umpqua Health Alliance (UHA)	26,377
Willamette Valley Community Health (WVCH)	97,437
Yamhill Community Care Organization (YCCO)	23,080
Total	**844,204**

Mental Health Organization

OHA contracts with Greater Oregon Behavioral Health, Inc. (GOBHI) as a Mental Health Organization (MHO) to manage mental health services for FFS Medicaid members. GOBHI has approximately 4,000 members throughout the State and has contracts with CCOs to manage mental health benefits for Medicaid managed care members in 16 counties, maintaining key partnerships with community mental health programs (CMHPs), private nonprofit agencies, individual providers, and hospitals to deliver treatment and services. Like the CCOs, GOBHI is responsible for ensuring that mental health services are delivered in a manner that supports the triple aim and complies with legal, contractual and regulatory obligations to provide effective care. Results from EQR activities conducted with GOHBI are included in this report.

Dental Care Organizations

Several DCOs contract with OHA to provide managed dental care services to Medicaid fee-for-service members and like GOBHI, they also contract with the CCOs to manage dental health benefits for Medicaid managed care members across the State. DCOs will undergo a compliance review in 2019.

Managed Care Quality Strategy

OHA's current quality strategy was included as part of Oregon's §1115(a) Waiver and approved by CMS in June 2018.[2-6] The quality strategy provides a framework to accomplish OHA's mission to improve the lifelong health of Oregonians, increase the quality, reliability, and availability of care for all Oregonians, and lower or contain cost of care so it is affordable to everyone. This framework for quality includes eight focus areas identified in the *Section 4. Quality Strategy*. CCOs are required to submit their own TQS incorporating all components of the QAPI program to ensure a robust quality program that supports the strategic goals of OHA. These strategies, ongoing accountability and compliance reviews, and PIP activities are assessed and monitored by OHA for continuous improvement and incorporated in

[2-6] Oregon's 2017 Section 1115(a) Medicaid Demonstration Waiver. Accessed January 13, 2019. Available at: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Oregon%20Health%20Plan%20STCs_2017-2022.pdf

quality strategy updates. OHA engages several stakeholder groups and provides public comment opportunities in the process.

3. Overall Results

Overview

CMS requires states to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by MCEs. The data come from activities conducted in accordance with 42 CFR §438.358. From the data collected, HSAG summarized each performance with attention toward each plan's strengths and weaknesses providing an overall assessment and evaluation of the quality, timeliness of, and access to, care and services provided. The evaluation was based on the following definitions of quality, access, and timeliness:

- **Quality**—The CFR indicates that quality, as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP increases the likelihood of desired outcomes of its enrollees through:
  - Its structural and operational characteristics.
  - The provision of services that are consistent with current professional, evidence-based knowledge.
  - Interventions for performance improvement.
- **Access**—The CFR indicates that 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 under 42 CFR §438.68 (Network adequacy standards) and 42 CFR §438.206 (Availability of services).
- **Timeliness**—National Committee for Quality Assurance (NCQA) defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3-1] NCQA further discusses the intent of this standard as being to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require timely response by the MCE (e.g., processing expedited appeals and providing timely follow-up care). The Agency for Healthcare Research and Quality indicates that "timeliness is the health care system's capacity to provide health care quickly after a need is recognized."[3-2] Timeliness includes the interval between identifying a need for specific tests and treatments and receiving those services.[3-3]

[3-1] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.
[3-2] Agency for Healthcare Research and Quality. *National Healthcare Quality Report* 2007. AHRQ Publication No. 08-0040. February 2008.
[3-3] Ibid.

Overall Assessment of Access, Timeliness, and Quality

The following paragraphs provide a high-level overview of examples of the MCEs' performance related to the quality and timeliness of, and access to care furnished to members. The information is intended to be representative and should not be considered an all-inclusive list. Overarching recommendations by EQR activity are provided in *Section 10. Recommendations*. While quality, access, and timeliness are distinct aspects of care, most MCE activities and services cut across more than one area. Collectively, all MCE activities and services affect the quality, access, and timeliness of care delivered to beneficiaries.

Quality

The CCOs all participate in the Oregon Statewide PIP on Opioid Safety and continue to implement their interventions. They also submitted 45 CCO-PIPs and focus study projects for the 2018 validation cycle with several of them related to ED utilization, reducing hospital readmission, oral health during pregnancy, screening for specific conditions (e.g., colorectal cancer, Hepatitis C, and depression), tobacco cessation, and contraceptive care. The project topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of, and access to care and services. Across the CCO-specific PIP and focus studies, problem statements were clearly defined and barriers were addressed. CCOs and OHA should develop the Statewide PIP study design based on analyses of historical study indicator data and ensure measurement for the projects is fully documented.

OHA works closely with its MCEs, partners, and stakeholders on quality for OHP members. This is primarily done through the engagement of internal and external committees to support quality and access monitoring, the requirement for MCEs to annually maintain a Transformation and Quality Strategy (TQS) to ensure robust and streamlined quality programs, and statewide and MCE-specific PIPs and focus studies.

MCEs generally make coverage and practice decisions consistent with the State's HERC guidelines and Prioritized List treatment guidances in a manner that ensures care is both clinically sound and cost-effective. In the MCEs that have adopted external practice guidelines separate from the HERC guidelines or Prioritized List treatment guidances, all were based on valid and reliable clinical evidence. Most of the MCEs still need to adopt and maintain comprehensive practice guidelines and ensure the dissemination of the guidelines to providers and to members upon request.

All of the MCEs are coordinating care at some level and most of them have dedicated care managers that work with members identified as needing intensive care coordination. Care coordination is generally tracked in care management systems that are sometimes linked to claims data. However, many MCEs were lacking formal care plans, and in most cases, care plans that were available did not comprehensively cover the continuum of care. While there have certainly been improved efforts to integrate care in the past several years, full integration sometimes appeared to be an afterthought. As care becomes more fully integrated, MCEs will likely achieve exceptional levels of quality health care.

Access

Most of the MCEs provided evidence of a sufficient network of appropriate providers, including preventive and specialty care, supported by written agreements. The MCEs prioritized member assignment to PCPCHs to support the objective of delivering of coordinated and integrated care. To address the inherent challenges associated with availability of services and rural networks, many MCEs utilized innovative strategies to ensure access to care, including contracting with mobile and telehealth providers, as well as enlisting the services of community health workers to accompany members to appointments. Most MCEs were able to demonstrate how out-of-network data was monitored and used to inform network adequacy. Many of the MCEs used single-case agreements to ensure access to out-of-network providers. While all MCEs are monitoring access to care issues, the monitoring is largely reactive, focused on the review of access related grievances and complaints.

MCEs are addressing cultural competency through interpretation and translation services, but there is an opportunity to broaden cultural competency and look beyond race and ethnicity for cultural considerations. Many of the MCEs acknowledge the need to provide culturally-sensitive care to the lesbian gay, bisexual, transgender, queer, and intersex community; those living in poverty; and the homeless population. Community partnerships and the inclusion of the member's voice are paramount to providing culturally competent care. Staff training and community outreach is being done across the MCEs with one CCO facilitating listening sessions that highlighted the voices and perspectives of members of diverse cultural and ethnic groups (e.g., Native American and Persistently Mentally Ill (SPMI) populations) and others participate in community partnerships and committees that offer forums for member perspectives to be heard.

Timeliness

The MCEs generally met the requirements specified in 42 CFR §438 and established standards for timely access to care and services, taking into account the urgency of members' need for services. Overall, the MCE reviews revealed that they had policies, procedures, and programs that described their coverage and authorization of service activities and supported timely access to care and services. While most MCEs were proficient at defining timeliness standards for delegates and providers, monitoring efforts for many them were deficient or poorly documented. The MCEs should create a culture of accountability by enforcing state requirements and taking corrective action whenever requirements are not met.

Most MCEs demonstrated evidence of robust policies and procedures that addressed the process for handling requests for initial and continuing authorization of services and ensured consistency in the prior authorization decision making process. Policies and procedures addressed the timeframes for standard and expedited service authorizations with processes to ensure that authorization decisions and notices to members for both types of decisions were provided in a timely manner. However, MCEs do not consistently conduct routine monitoring to ensure staff and delegates are meeting timeliness standards for authorization decisions.

All CCOs are now using the Emergency Department Information Exchange (EDIE) system to alerting CCO staff to enrollee ED visits. This enables the CCOs to timely coordination care and discharge planning.

4. Quality Strategy Assessment

Overview

Federal regulations under 42 CFR §438.340 require each state Medicaid agency contracting with managed care organizations to develop and implement a written quality strategy to assess and improve the quality of managed care services. The quality strategy should serve as a blueprint or road map for states and their contracted managed care organizations in assessing the quality of care Medicaid beneficiaries receive and set forth measurable goals and targets for improvement. Specifically, the quality strategy must include goals, objectives, metrics, and performance targets for the organizations. OHA's current quality strategy was included as part of Oregon's §1115(a) Waiver and approved by CMS in June 2018.[4-1]

Quality Strategy Focus Areas

OHA's quality strategy provides a framework to accomplish OHA's mission to improve the lifelong health of Oregonians, increase the quality, reliability, and availability of care for all Oregonians, and lower or contain cost of care so it is affordable to everyone. The framework for quality includes the following eight focus areas:

- Reduce preventable re-hospitalizations
- Address population health issues (i.e., diabetes, hypertension and asthma) within a specific geographic area
- Deploy care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers
- Integration of health: physical health, oral health, and/or behavioral health
- Ensure appropriate care is delivered in appropriate settings
- Improve perinatal and maternity care
- Improve primary care for all populations through increased adoption of the patient-centered primary care home (PCPCH) model of care
- Social Determinants of Health

OHA recognizes that to achieve the Triple Aim goals of better health, better care, and decreasing costs, all health delivery systems (i.e. Medicare, Medicaid and federal improvement programs) must be

[4-1] Oregon's 2017 Section 1115(a) Medicaid Demonstration Waiver. Accessed January 13, 2019. Available at: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Oregon%20Health%20Plan%20STCs_2017-2022.pdf

aligned. There are plans to develop strategic alignment for quality programs to increase organizations' efficiencies, decrease burden on health systems for reporting, and communicate common-thread goals.

OHA Monitoring of Quality

OHA utilizes subject matter experts across all spectrums of the delivery of health care to assist with monitoring quality programs through continuous quality improvement practices and robust data systems and to assess CCO adherence to quality metric standards and contract compliance. The agency's key leadership is directly involved with and contributes to efforts to drive innovation, improve health outcomes, and maintain compliance. Internal and external committees are also utilized to support quality and access monitoring including the Oregon Health Policy Board, OHA Quality Council, Managed Care and CCO Collaborative, Quality Management Program & Contract Compliance, Quality and Health Outcomes Committee, and the Health Evidence Review Committee.

In addition, OHA requires CCOs to maintain a TQS, to document structures and processes in place that assure quality performance in accordance with 42 CFR §438.330. The TQS incorporates all components of the Quality Assessment and Performance Improvement (QAPI) program to ensure a robust quality program with a streamlined approach. CCOs submitted their first annual TQS on March 16, 2018, and submitted their six-month progress report on September 30, 2018. The 2019 TQS will be due March 15, 2019. Each CCO's annual TQS and progress report is available on OHA's website.[4-2]

OHA also conducts ongoing accountability and compliance reviews. These include reviews of:

- Operations and ongoing quality focus areas
- Appointment and availability studies
- Marketing materials
- Quarterly and annual financial statements
- Network adequacy
- Credentialing
- Complaints and grievances

Updates to the Quality Strategy

HSAG understands that OHA must update its quality strategy as necessary but no less than once every three years, based on CCO performance; stakeholder input and feedback; achievement of goals; changes

[4-2] Oregon's Transformation Quality Strategy website. Accessed on January 13, 2019. Available at: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx

resulting from legislative, state, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Medicaid program.

OHA's most recent update to the quality strategy was completed and approved by CMS in June 2018 and is included as part of Oregon's §1115 Waiver. This update reflects a focused and comprehensive plan to assess all aspects of the CCOs' activities for quality improvement and contract compliance and addresses how specific performance improvement projects (PIPs) from the 2012-2017 demonstration waiver period have impacted care delivery. OHA has committed to continuing and expanding all elements of the 2012 waiver related to the integration of behavioral, physical and oral health, with a new focus on social determinants of health, population health and quality of care. Future goals also include maintaining gains made in health transformation while increasing the alignment of quality activities to decrease the administrative burden of reporting. One example of such administrative efficiencies is OHA's use of the TQSs that include elements of the QAPI, Transformation Plan, and Annual Work Plan instead of a Transformation Plan and a QAPI.

OHA's current quality strategy states the quality strategy will be reviewed and updated, if needed, by December of each year. Updates are to be based on health plan performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and significant changes to the programmatic structure of the Medicaid program. Significant changes must be submitted in the State's subsequent quarterly report update to CMS. OHA's Quality Council is responsible for guiding the annual review and update of the quality strategy that includes both internal and external stakeholder engagement. Such stakeholders include:

- Addictions and Mental Health Planning and Advisory Council*
- Medicaid Advisory Committee*
- Health Systems Division Executive Team
- Health Policy and Analytics Management Team
- OHA Executive Team
- CCO Medical Directors
- FFS Contractors
- CCO Quality Management Coordinators
- Local Government Advisory Committee*
- DHS Internal Stakeholders
- OHA Internal Stakeholders
- Health Equity Policy Committee*

* *Committees including consumer representatives.*

Assessment of the Quality Strategy

HSAG stays abreast of CMS requirements for states' Quality Strategy. As a result of the CMS Medicaid Managed Care Final Rule (CMS final rule), effective no later than July 1, 2018, new quality strategy elements must include:

- A plan for improving quality of care and services
- Standards for network adequacy and availability of services
- A plan to identify and reduce health disparities
- Transition of care policy
- A plan to identify persons needing long-term service and support (LTSS) or with special health care needs

OHA combines a number of different quality programs to align with its quality strategy. This approach allows OHA mechanisms to address quality comprehensively, combining the strategies of its Medicaid managed care organizations via their own quality plans and by ensuring stakeholder and public input in continuous improvement. However, while OHA has identified eight quality focus areas, it is unclear how these areas and the federally required elements are addressed comprehensively through these mechanisms. OHA was working with stakeholders at the end of 2018 to review and assess the current quality strategy.

5. Compliance Review

Overview

According to 42 CFR §438.358, which describes EQR activities, the state Medicaid agency, an EQRO, or the state's agent that is not an MCO, PAHP, or PIHP must conduct a review within each three-year period to determine the MCOs', PAHPs' and PIHPs' compliance with state standards. In accordance with 42 CFR §438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438, which address requirements related to access, structure and operations, and quality measurement and improvement. Results from 2018 compliance reviews were compiled and reported to each MCE and the State.

Review Activities

The 2018 compliance reviews followed previously approved protocols and review tools[5-1] developed by HIA. These materials included an evaluation tool listing the standards and elements for review, preliminary questions, and documentation requirements to guide the MCE's submission of compliance documentation and onsite interviews. MCEs were able to submit additional or clarifying documentation identified during the onsite review up to two weeks following the onsite visit.

The primary objective of the compliance reviews was to provide meaningful information to OHA and the MCEs regarding its compliance with requirements in seven select areas. To accomplish its objective, HIA in collaboration with OHA, developed a standardized data collection tool and processes to assess and document each organization's compliance with certain federal Medicaid managed care regulations, OHA's contract with the MCEs, Oregon Administrative Rules (OARs), and other state regulations where applicable. The review tool included requirements that addressed the following seven compliance areas:

- Standard I—Availability of Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Selection
- Standard VI—Subcontractual Relationships and Delegation
- Standard XI—Practice Guidelines
- Standard XII—Quality Assessment and Performance Improvement (QAPI)

[5-1] The compliance review protocols and review tools were consistent with the CMS *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

During the on-site portion of the review, a sample of files were reviewed to evaluate how each MCE implemented the requirements for each of the following functions:

- Initial credentialing and recredentialing of individual and organization providers
- Care coordination
- Service authorizations

Observations and findings for each MCE were documented in the compliance review data collection tool and then analyzed to determine the MCE's performance for each of the individual elements and sub-elements in the standards. For each of the individual sub-elements (i.e., requirements) within each standard, it was determined whether the sub-element was *Met* or *Not Met* based on the information collected during the review. When all the sub-elements were evaluated, MCE's were assigned a score of *Fully Met (4), Substantially Met (3), Partially Met (2),* or *Not Met (1)* for each element based on the scoring criteria contained in the 2018 QAPI Protocol prepared by HIA. A designation of *NA* was used if an individual element did not apply during the period covered by the review. A total weighted score was then derived for each of the seven standards and an overall average compliance score across the standards. After the scoring was completed, overall strengths and areas for improvement were documented based on the findings.

Table 5-1 provides a description of the scoring criteria applied to each standard.

Table 5-1—Scoring Scheme for Elements in the Compliance Review

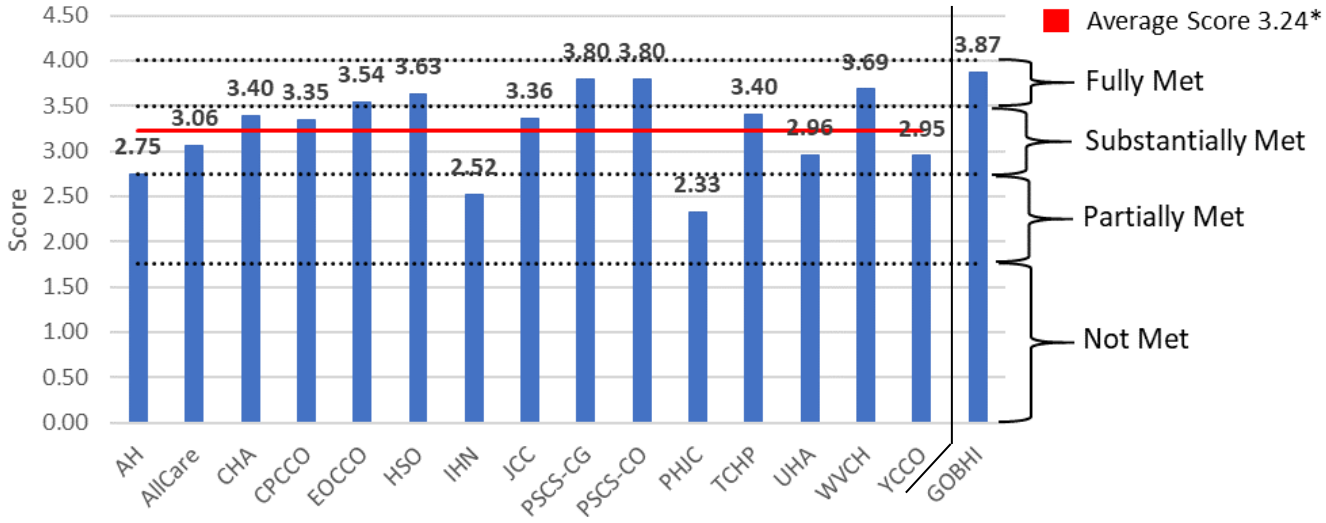
Rating	Element Score	Weighted Score
Fully Met	4	3.50 to 4.00
Substantially Met	3	2.75 to 3.49
Partially Met	2	1.75 to 2.74
Not Met	1	<1.75

Summary of Review Results

To assess overall compliance, HSAG combined the scores and ratings identified across the CCO's to develop an average score and rating using the same 2018 QAPI Protocol prepared by HIA. The MHO's scores and ratings were not included in the overall averaged score ratings due to the entity being considered a PIHP with a slightly different scope than the CCOs. Each standard was averaged and then rolled up to provide the overall OHA compliance score. The overall compliance rating achieved was *Substantially Met* (i.e., 3.24) across CCOs for the standards included in the 2018 review of compliance.

Figure 5-1displays the overall average scores and ratings for each CCO across all standards.

Figure 5-1—Overall OHA Compliance Scores and Ratings



**Averages do not include the MHO's performance as a PIHP.*

Of the 15 CCOs, six of them (i.e., EOCCO, HSO, PSCS-CG, PSCS-CO, and WVCH) achieved a *Fully Met* rating and eight CCOs (i.e., AH, AllCare, CHA, CPCCO, JCC, TCHP, UHA, and YCCO) achieved a rating of *Substantially Met*. The remaining two CCOs (i.e., IHN and PHJC) achieved a rating of *Partially Met*. GOBHI achieved a *Fully Met* rating.

Table 5-2 displays the overall scores and ratings across each standard.

Table 5-2—Overall OHA Compliance Scores and Ratings

Standard	Review Section	Score	Rating
42 CFR §438, Subpart D (MCO, PIHP, and PAHP Standards)			
I	Availability of Services	3.53	Fully Met
III	Coordination and Continuity of Care	2.85	Substantially Met
IV	Coverage and Authorization of Services	2.98	Substantially Met
V	Provider Selection	3.28	Substantially Met
VI	Subcontractual Relationships and Delegation	3.53	Fully Met
XI	Practice Guidelines	2.80	Substantially Met
42 CFR §438.330 Quality Assessment and Performance Improvement (QAPI) Requirements			
XII	Quality Assessment and Performance Improvement	3.65	Fully Met

Overall Score and Rating	3.24	Substantially Met

To provide review results by standards, HSAG has outlined MCE performance by standard below. Each standard includes depiction of overall performance in the standard and strengths and area for improvement by each of the main elements within the standards. Recommendations for OHA based on the overall performance of MCEs are identified in *Section 10. Recommendations* of this report.

Standard I: Availability of Services

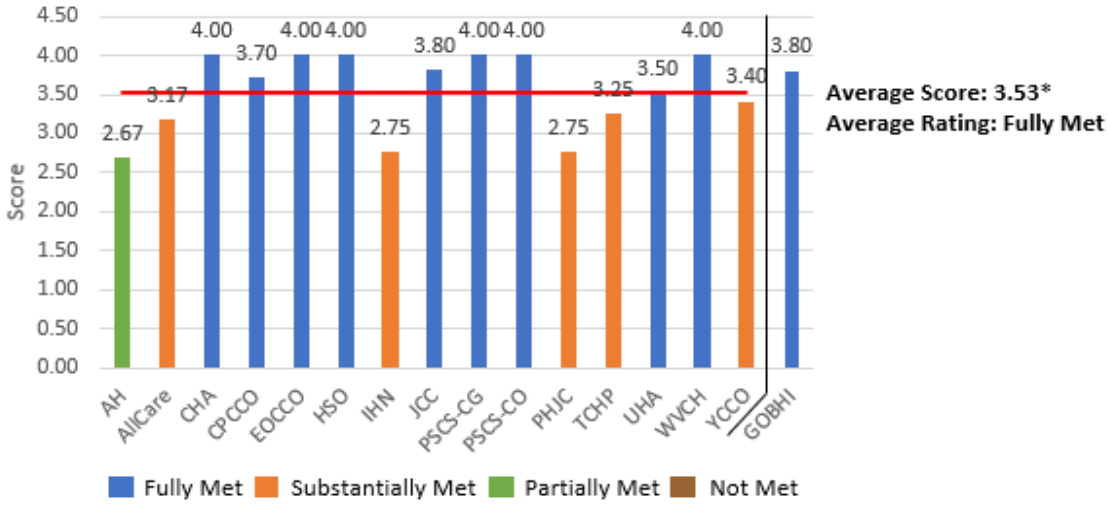
Availability of Services was evaluated by examining the MCE's compliance with delivery network requirements, its furnishing of services, and cultural consideration. Pursuant to 42 CFR §438.206 (b) and (c), MCEs must:

- Maintain and monitor a network of appropriate providers to provide adequate access to all covered services;
- Provide for a second opinion from a qualified health care professional within the network or outside the network, at no cost to the enrollee;
- Provide adequate and timely coverage of services out-of-network if the network is unable to provide necessary services;
- Require out-of-network providers to coordinate with the MCE for payment and ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network;
- Provide timely access to care and services; and
- Participate in the State's effort to promote the delivery of culturally competent services.

Overall, the CCOs scored a *Fully Met* (i.e., 3.53) across the Availability of Services standard with nine CCOs achieving a *Fully Met* rating, five CCOs achieving a *Substantially Met* rating, and one CCO achieving a *Partially Met*. None of the CCOs received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 5-2 displays the average CCO scores and rating across the Availability of Services standard.

Figure 5-2—Compliance Scores: Availability of Services



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Delivery Network, General Standards

Most of the MCEs provided evidence of a sufficient network of appropriate providers, including preventive and specialty care, supported by written agreements. The MCEs additionally prioritized member assignment to PCPCHs to support the objective of delivering of coordinated and integrated care. The majority of MCEs demonstrated consideration of the following factors in establishing and maintaining their respective networks:

- Adequate physical access to facilities for disabled members
- Expected service utilization, considering the oral, behavioral and physical health care needs of the members
- Number and types of providers required to provide services to CCO members
- Geographic distribution of providers being reasonably accessible to members

To address the inherent challenges associated with availability of services and rural networks, many MCEs utilized innovative strategies to ensure access to care, including contracting with mobile and telehealth providers, as well as enlisting the services of community health workers to accompany members to appointments. One MCE focused on the impact of adverse childhood experiences (ACEs) on young members to anticipate the appropriate needs of the community in future years. This data was used to inform network decision making.

Delivery Network, Second Opinion

MCEs had a keen awareness of their members' right to a second opinion. The majority of MCEs demonstrated their ability to provide for a second opinion from a qualified health care professional within the network or outside the network, at no cost to the member.

Delivery Network, Provide Necessary Care

Most MCEs were able to demonstrate how out-of-network data was monitored and used to inform network adequacy. Many of the MCEs used single-case agreements to ensure access to out-of-network providers.

Delivery Network, Out-of-Network Coordination

MCEs were able to identify select strategies for monitoring out-of-network encounters to ensure adequate and timely access. Some MCEs gave examples such as review of complaints and consideration of data trends in the category of denied referrals and second opinions.

Timely Access

MCEs were proficient in explicitly identifying state standards on timely access to care and services within provider contracts or handbooks. Monitoring mechanisms included secret shopper calls and surveying of providers and members.

Cultural Considerations

The MCEs demonstrated a strong commitment to ensuring the delivery of culturally competent care and services, partnering with tribal organizations and other community partners to meet the needs of their members. Many of the MCEs looked beyond race and ethnicity, acknowledging the need to provide culturally-sensitive care to the lesbian gay, bisexual, transgender, queer, and intersex community; those living in poverty; and the homeless population. The MCEs also overwhelmingly displayed dedication to addressing health disparities within their membership.

One CCO produced evidence of training for staff and providers in topics ranging from health equity, health literacy, and cultural humility. This included facilitating listening sessions that highlighted the voices and perspectives of members of diverse cultural and ethnic groups, including Native American and Persistently Mentally Ill (SPMI) populations. Data and insight collected from these groups informed the CCO's planning and implementation of performance improvement projects and annual quality priorities, including the design of the 2018 Transformation and Quality Strategy.

Another CCO reported community outreach and cultural inclusiveness through its community partnerships. Members were encouraged to offer their perspectives through their unique lenses of homelessness, youth, gender or sexual identity, rural residency, and racial diversity. In addition, the CCO displayed a strong commitment to cultural competency through the establishment of its Diversity and Health Equity Committee and facilitated a lunch and learn series focused on addressing health disparities.

Major Areas for Improvement

Delivery Network, General Standards

Inadequate numbers of providers throughout Oregon creates ongoing barriers to access. Because of this, most MCEs struggled with providing timely access to services, expressing challenges with recruiting primary care physicians and specialists to rural areas. MCEs should provide for more effective utilization planning to ensure accessibility of needed services of for members and could benefit from prioritizing the anticipation of the enrollment of Medicaid and dual eligible members.

Delivery Network, Second Opinion

Most of the MCEs need to address communication deficits regarding the process for members obtaining a second opinion. While MCEs were knowledgeable about members' right to a second opinion and had written documentation on the ability of obtaining a second opinion, greater effort should be made to

explicitly communicate that the second opinion is available at no cost. Furthermore, MCEs should communicate the member's ability to access a second opinion directly from the MCE rather than only through the member's primary care provider or specialist. Additionally, monitoring of second opinions appear to be largely reactive, with review of complaints and grievances rather requests and payment. MCEs should apply more proactive strategies in the monitoring of second opinions.

Delivery Network, Provide Necessary Care

Many MCEs failed to demonstrate proactive monitoring strategies for out-of-network encounters. And, while most MCEs had policies in place to ensure coverage of needed out-of-network services, several of them failed to integrate behavioral and oral health into those policies. While there have certainly been improved efforts to integrate care in the past several years, full integration sometimes appeared to be an afterthought. As care becomes more fully integrated, MCEs will likely achieve exceptional levels of quality health care.

Delivery Network, Out-of-Network Coordination

For some MCEs, the requirement for out-of-network providers to coordinate with the MCE with respect to payment was poorly monitored and reinforced. Outside of requesting that members alert the MCE if they receive a bill from an out-of-network provider, there was little evidence of monitoring member payment requests after receiving services.

Timely Access

Although most MCEs were proficient at defining timeliness standards for providers, monitoring efforts for many of them were deficient or poorly documented. Those MCEs that did not achieve a score of *Fully Met* could enhance quality of care by improving its monitoring of timeliness standards. Furthermore, the MCEs should create a culture of accountability by enforcing state requirements and taking corrective action whenever the requirements are not met.

Cultural Considerations

Although many MCEs succeeded at cultural and linguistic competency efforts, some MCEs have an opportunity to broaden cultural sensitivity and provide more robust training. Some MCEs failed to look beyond race and ethnicity for cultural considerations, while others failed to address cultural competency beyond interpretation and translation services. Community partnerships and the inclusion of the member's voice are paramount to providing culturally competent care.

Standard III: Coordination and Continuity of Care

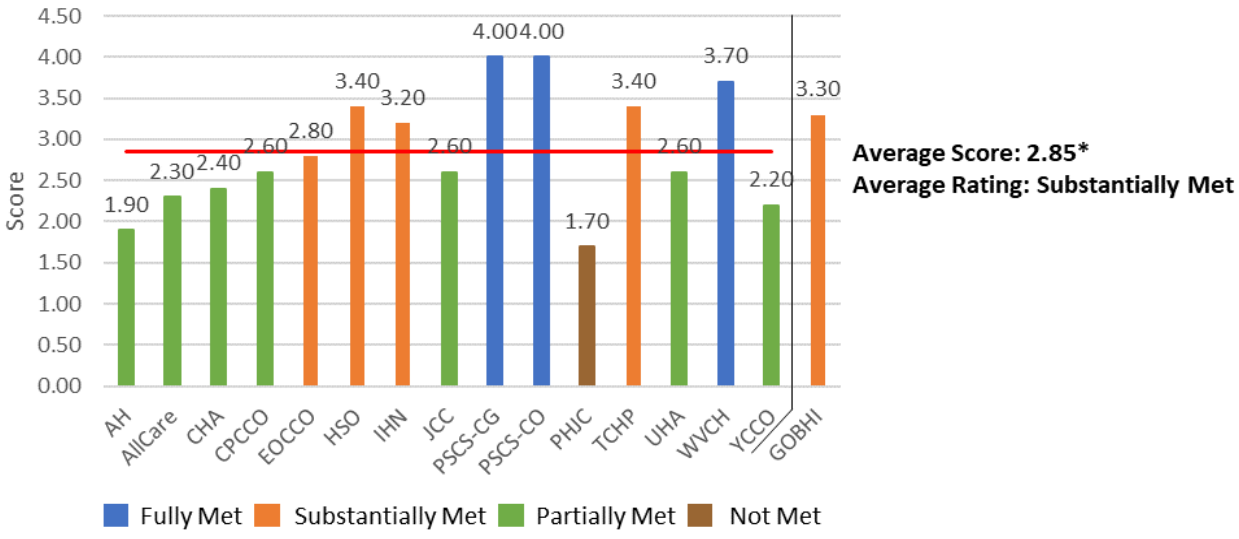
Coordination and Continuity of Care was evaluated in the areas of care and coordination of services for all enrollees and additional services for enrollees needing long-term services and supports (LTSS) and those with special health care needs. Pursuant to 42 CFR §438.208(c), MCEs must:

- Make a best effort to conduct an initial screening of each enrollee's needs,
- Implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State as needing LTSS and those with special healthcare needs,
- Provide a treatment/service plan for enrollees needing LTSS or those with special health care needs,
- Provide direct access to specialists as determined through an assessment, and
- Participate in the State's effort to promote the delivery of culturally competent services.

Overall, the CCOs scored a *Substantially Met* (i.e., 2.85) across the Coordination and Continuity of Care standard with three CCOs achieving a *Fully Met* rating, four CCOs achieving a *Substantially Met* rating, and seven CCOs achieving a *Partially Met,* indicating several opportunities for improvement. One CCO received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 5-3 displays the average CCO scores and rating across the Coordination and Continuity of Care standard.

Figure 5-3—Compliance Scores: Coordination and Continuity of Care



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Coordination and Continuity of Care, General Standards

Many MCEs, generally those with well-developed electronic health records, provided evidence of communication (e.g., secure email, phone, fax, and direct access to electronic provider records) with and collaboration between providers, members and family members with the goal of ensuring that the members' health care needs were met. Several CCOs displayed efforts to coordinate services and MCEs had processes in place to coordinate care with provider partners through a variety of methods, including:

- Internal and external interdisciplinary teams.
- Provider training on case management requirements.
- Regular monitoring of monthly trend reports.

Most MCEs and their subcontractors also had policies and procedures in place to address transitions of care settings from the hospital setting.

Identification and Assessment of Special Health Care Needs

Some MCEs' policies detailed procedures used to coordinate intensive case management services for SHCN members between physical, dental and behavioral health. For MCEs that delegate care coordination activities, there was in some cases evidence that implementation of these policies had been monitored annually, which included a review of member risk assessments, care plans, and case management notes.

Treatment Plans for Special Health Care Needs

During the onsite review of care coordination records, most MCEs had a process to screen members to determine whether they needed care coordination and treatment plans. In one CCO, health risk assessments were segmented by adults and youth, which demonstrates awareness to the differing needs of the populations. For members needing care coordination, MCEs incorporated member input in their care planning and provided specific care managers to work with, but there was a lack of formal treatment plans with many MCEs relying on care manager notes to track coordination.

Direct Access to Specialist for Special Health Care Needs

Some MCEs incorporated the necessary resources and policies to ensure direct access to specialists without being hindered by prior authorization requirements for SHCN members. Direct access to specialists for SHCN members was assessed in many cases through the grievance system and Consumer Assessment of Healthcare Providers and Systems survey measures as proxies for timeliness and appropriateness.

Major Areas for Improvement

Coordination and Continuity of Care, General Standards

In general, many of the MCEs' care coordination policies, procedures, and/or practices were lacking several key aspects of the care coordination requirements including:

- Coordinating and communicating care with other health plans to prevent duplication of efforts and services.
- Coordinating and communicating care for SHCN members at the MCE level rather than relying on delegated to subcontractors for mental health and PCPCHs.
- Coordinating all care and services, specifically formal methods to coordinate care with DCOs.
- A defined process and up-to-date screening questionnaires to conduct initial screenings of member's needs within 90 days of enrollment.
- An effective system for capturing and retaining case-specific information for each member.

Identification and Assessment of Special Health Care Needs

Generally, across many MCEs, there was a lack of consistent application of the State's definition of SHCN members. While there was a common awareness of members with co-morbid conditions needing care coordination prioritized, there was limited evidence that SHCNs members were assessed or identified in a different manner than the general membership. MCEs, in many cases, did not have documented processes to ensure that SHCN members received periodic assessment, nor were there mechanisms in place to ensure periodic care monitoring.

Treatment Plans for Special Health Care Needs

After initial assessment, an individualized person-centered care plan that addressed each member's supportive, therapeutic, cultural and linguistic health needs is required. MCEs generally did not have formal care plans. They also did not always include evidence of a mechanism in policies and procedures regarding care coordination to ensure that treatment plans for SHCN members are reviewed at least every 12 months or when the member's circumstances change, or when the member requests it.

Direct Access to Specialist for Special Health Care Needs

Some MCEs had policies that referenced specialist access for SHCN members, but there was limited documentation demonstrating that they provide that access in a timely manner. Documentation additionally did not always specifically address direct access to specialists for dental health and behavioral health needs.

Standard IV: Coverage and Authorization of Services

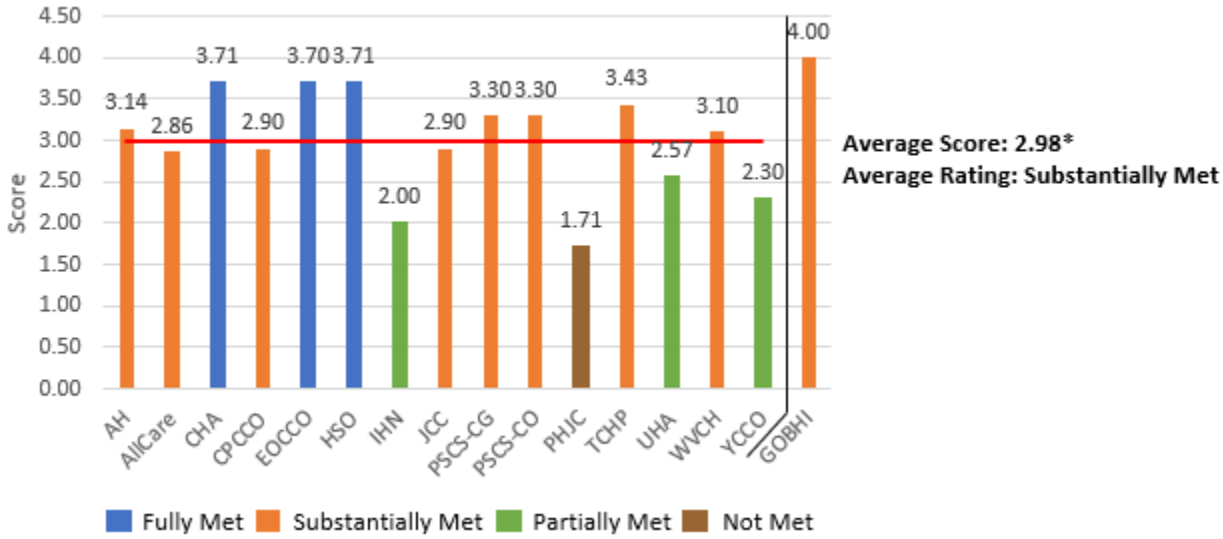
Coverage and Authorization of Services is measured throughout this Section in the areas of authorization of services and notice of adverse benefit determination, timeframe for decision, delivery network requirements, compensation for utilization management activities, and emergency and post-stabilization services. Pursuant to 42 CFR §438.210(b), (d)and (e), and also 42 CFR §438.114, MCEs must:

- Have written policies and procedures for the processing of requests for authorizations of services and provide notice of adverse benefit determination,
- Provide for decisions and notices for standard authorization and expedited authorization,
- Ensure compensation for utilization management does not provide incentives to deny, limit, or discontinue medically necessary services, and
- Cover and pay for emergency services and post-stabilization care services.

Overall, the CCOs scored a *Substantially Met* (i.e., 2.98) across the Coverage and Authorization of Services standard with four CCOs achieving a *Fully Met* rating, seven CCOs achieving a *Substantially Met* rating, and three CCOs achieving a *Partially Met*, indicating several opportunities for improvement. One CCO received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 5-4 displays the average CCO scores and rating across the Coverage and Authorization of Services standard.

Figure 5-4—Compliance Scores: Coverage and Authorization of Services



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Authorization of Services, Notice of Adverse Action

Most MCEs demonstrated evidence of robust policies and procedures that addressed the process for handling requests for initial and continuing authorization of services. These policies outlined how member eligibility, benefit coverage, medical necessity, and location and appropriateness of services are considered in making authorization decisions. MCEs ensured consistency in the prior authorization decision making process using the following methods:

- Development of interrater reliability processes and tools.
- Oversight mechanisms for delegated entities.
- Regular prior authorization team meetings.
- Appropriate reporting and staffing structures that allow for staff to review the work of peers and subordinates.

When appropriate, many MCEs consulted with requesting providers of services via phone, electronic means, and peer-to-peer reviews with the Medical Director. Lastly, decisions to deny a service authorization request, or approve requests at a lower level than requested are nearly unilaterally made by those with the appropriate expertise.

Timeframe for Decisions

MCEs generally provided policies and procedures addressing the timeframes for standard and expedited service authorizations. The MCEs also had processes to ensure that authorization decisions and notices to members for both types of decisions were provided in a timely manner. Most MCEs reported that they conduct routine monitoring to ensure staff and delegates were meeting timeliness standards for authorization decisions.

Compensation for UM Activities

The State's contracts with MCEs require that MCE policies may not be structured so as to provide incentives for its provider network, employees, or other utilization reviewers to inappropriately deny, limit, or discontinue medically appropriate services to any member. Most MCEs structure their provider contracts, even those that include alternative payment methodologies, to avoid those types of incentives.

Emergency and Post-Stabilization Services

Generally, the MCEs did not have any prior authorization requirements for emergency and post-stabilization services, as evidenced by review of written policies pertaining to payments and reimbursements. Additionally, most MCEs reported avoiding denials for emergency and post-stabilization services through claims system edits.

Major Areas for Improvement

Authorization of Services, Notice of Adverse Action

While most MCE policies identified a process for conducting prior authorizations for services, did do not include key elements such as:

- Procedures for standard and expedited authorizations,
- Appropriate timeframes for decisions, or
- How and when notices of those decisions are assigned internally and communicated externally.

Largely, MCEs provided evidence that appropriate timelines were maintained in the decision making process, but many were unable to display a mechanism for monitoring those decisions or ensuring consistent decision making on a broad scale.

Timeframe for Decisions

Collectively, MCE policies and procedures reflected an awareness of timeframes for both standard and expedited authorizations, although onsite records reviews reflected inconsistency with these standards, specifically those with expedited decisions. MCEs must ensure that expedited requests for service authorization are processed within 72 hours (and not three days), including weekends and holidays. There was also a general lack of documentation in the CCOs' authorization records and policies concerning behavioral health, NEMT, and dental care services related to the timeliness of member notices. MCEs do not consistently conduct routine monitoring to ensure staff and delegates are meeting timeliness standards for authorization decisions.

Compensation for UM Activities

In many cases, MCEs provided contract language for dental delegates requiring no incentives to inappropriately deny, limit, or discontinue medically necessary services for members, but not for behavioral health delegates. Many MCEs also did not provide evidence of monitoring providers to ensure that no denial, limitation or discontinuation of medically necessary services to members occurred.

Emergency and Post-Stabilization Services

Regarding the coverage of emergency services, most MCEs provided policies and procedures verifying they do not deny such services and that prior authorization is not required for ED evaluation. However, there was no indication of tracking and monitoring having occurred to ensure there are no instances of payment denials for emergency services. .

Standard V: Provider Selection

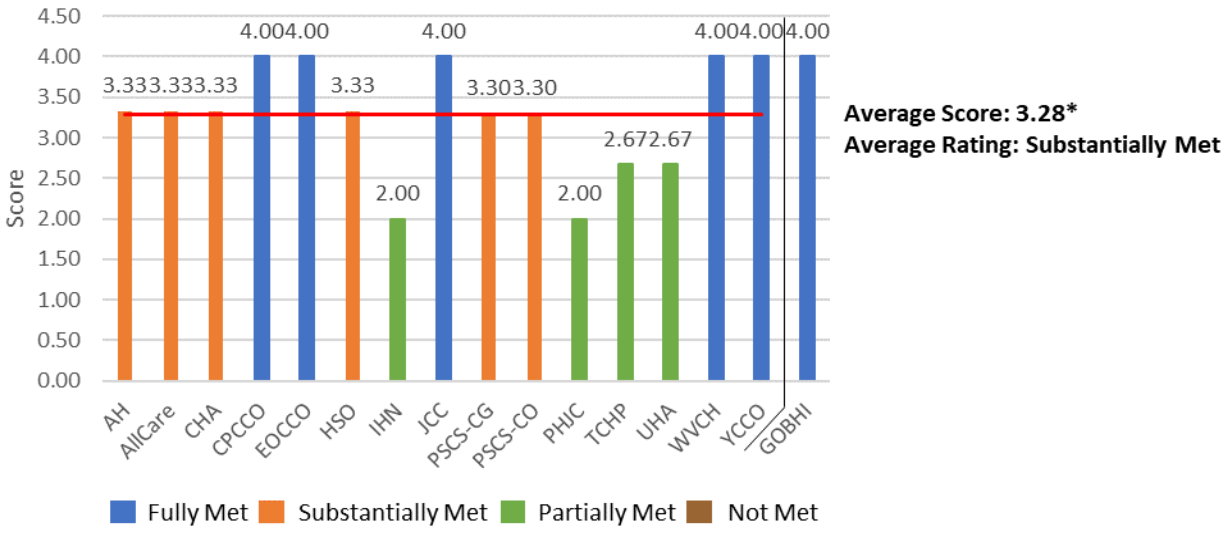
Provider Selection is measured throughout this section in the areas of credentialing and recredentialing requirements and ensuring nondiscrimination. Pursuant to 42 CFR §§438.214, 438.12, and 438.230 MCEs must:

- Have written policies and procedures for the selection and retention of network providers and
- Not discriminate against particular providers that serve high-risk populations, or specialize in conditions that require costly treatment.

Overall, the CCOs scored a *Substantially Met* (i.e., 3.28) across the Provider Selection standard with five CCOs achieving a *Fully Met* rating, six CCOs achieving a *Substantially Met* rating, and three CCOs achieving a *Partially Met*, indicating several opportunities for improvement. One CCO received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 5-5 displays the average CCO scores and rating across the Provider Selection standard.

Figure 5-5—Compliance Scores: Provider Selection



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

General Rules, Credentialing, and Recredentialing

Overwhelmingly, MCEs provided evidence of credentialing and recredentialing policies that clearly addressed the processes for the initial credentialing or recredentialing of participating providers. Policies were based on factors such as:

- Utilization Review Accreditation Commission guidelines, indicating that recredentialing activities are to be conducted every three years, and
- Council for Affordable Quality Healthcare standards, using National Committee for Quality Assurance accepted sources.

For organizational provider credentialing, some MCEs described their practice of accepting existing accrediting institutions and its site-visit process instead of creating independent institutional accreditation standards. Generally, MCEs maintained and followed a documented process for credentialing and recredentialing network providers. Many, especially those in rural areas, also reported an open and inclusive philosophy that strives to accept all willing providers in the geographic area that meet established criteria, including favorable Office of Inspector General List of Excluded Individuals/Entities, licensure, and Medicare Opt-out list screening reports.

Nondiscrimination

Most MCE policies and procedures indicated that credentialing and recredentialing decisions are not to be based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or patients in which the provider specializes.

Major Areas for Improvement

General Rules, Credentialing, and Recredentialing

While most MCEs adhered to its credentialing and recredentialing policy, some failed to ensure that their practices and policies included:

- The monitoring of delegated credentialing activities.
- The process for monitoring delegated credentialing activities is identified.
- A mechanism for the appropriate monitoring and oversight of MCE staff that serve concurrently in provider roles.
- Written notification to providers not selected to participate in the MCEs' network.

Nondiscrimination

Although most MCEs had non-discrimination policies, documentation in some cases did not include nondiscrimination language related to compensation practices for providers in their networks. MCE policy language of the credentialing and re-credentialing procedure in many cases did not offer precision on how reimbursement equity is ensured. MCE policies also did not include a nondiscriminatory process for selecting providers based on their treatment of high-risk populations or populations that require costly treatment.

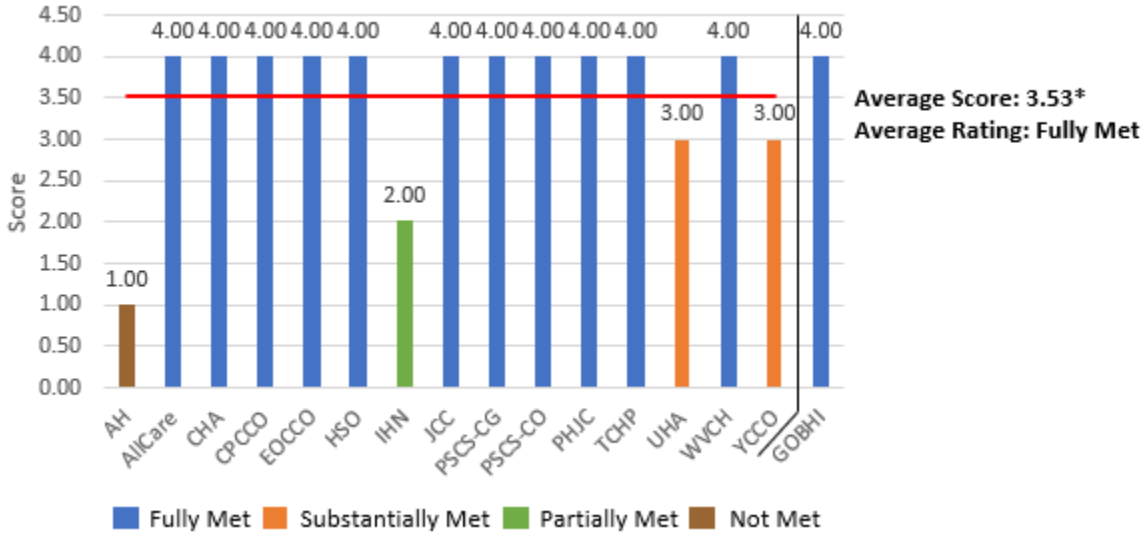
Standard VI: Subcontractual Relationships and Delegation

Subcontractual Relationships and Delegation is measured throughout this section. Pursuant to 42 CFR §438.230, MCEs must maintain ultimate responsibility for subcontractor activities and adhere to and otherwise fully comply with all terms and conditions of its contract with the State.

Overall, the CCOs scored a *Fully Met* (i.e., 3.53) across the Subcontractual Relationships and Delegation standard with eleven CCOs achieving a *Fully Met* rating, two CCOs achieving a *Substantially Met* rating, and one CCO achieving a *Partially Met.* One CCO received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 5-6 displays the average CCO scores and rating across the Subcontractual Relationships and Delegation standard.

Figure 5-6—Compliance Scores: Subcontractual Relationships and Delegation



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Subcontractual Relationships and Delegation, General Standards

MCEs had documented policies, processes, and procedures in place to monitor and evaluate subcontractors and the activities delegated to them. In most cases, MCEs presented evidence of written agreements that specified the activities and responsibilities delegated to each subcontractor for functions such as:

- Credentialing

- Pharmacy benefit management
- NEMT
- Utilization review

In many cases, MCEs submitted criteria and methodology used for subcontractor assessment. The scope for ongoing monitoring and oversight in at least one case takes into consideration NCQA-, CMS-, and OHA-specific requirements, and includes revocation or other remedies to address unsatisfactory performance. Some MCEs provided policies and schedules to define oversight practices that focus on high-volume, high-impact specialty care services and behavioral health services.

Major Areas for Improvement

Subcontractual Relationships and Delegation, General Standards

In a small number of MCEs, clear policies and processes that identify specific oversight and monitoring activities undertaken by MCE staff/committees and the frequency of those activities were not evident. Within documented procedures and in written agreements, MCEs did not universally specify corrective actions or sanctions for inadequate performance by delegates or subcontractors and some MCEs did not provide evidence of a robust process to review and monitor subcontractor performance on an annual basis.

Standard XI: Practice Guidelines

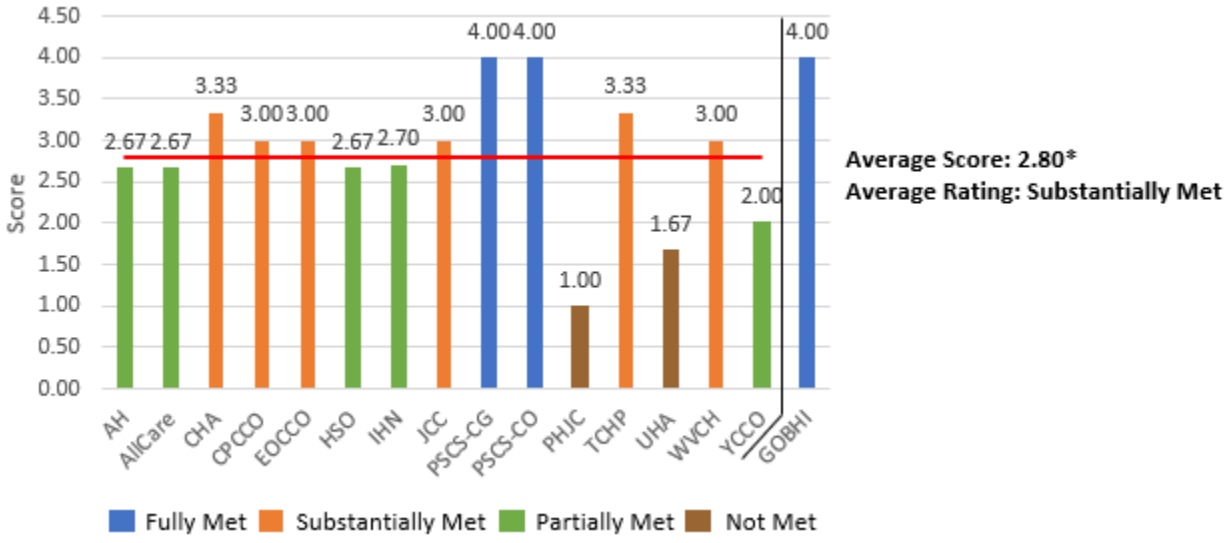
Practice Guidelines were measured in the areas of adoption of practice guidelines, dissemination of guidelines, and application of guidelines. Pursuant to 42 CFR §438.236(a) through (d), MCEs must:

- Adopt practice guidelines based on valid and reliable clinical evidence considering the needs of enrollees and ensure they are periodically updated;
- Disseminate guidelines to all affected providers and, upon request, to enrollees and potential enrollees;
- Ensure that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with guidelines.

Overall, the CCOs scored a *Substantially Met* (i.e., 2.80) across the Practice Guidelines standard with two CCOs achieving a *Fully Met* rating, six CCOs achieving a *Substantially Met* rating, five CCOs achieved a *Partially Met*, indicating several opportunities for improvement. Two CCOs received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 5-7 displays the average CCO scores and rating across the Provider Guidelines standard.

Figure 5-7—Compliance Scores: Practice Guidelines



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Basic Rule and Adoption of Practice Guidelines

MCEs generally make coverage and practice decisions consistent with the State's HERC guidelines and Prioritized List guidances in a manner that ensures care is both clinically sound and cost-effective. In the MCEs that have adopted external practice guidelines separate from the HERC guidelines or Prioritized List treatment guidances, all were based on valid and reliable clinical evidence. Most MCEs also discussed how their committee and clinical advisory panel structure ensured that the consensus of providers in their fields of expertise was considered in the adoption process. Many MCEs demonstrated that they seek clinical practice assurances and refine approaches through a variety of channels, including:

- The CCO's internal Pharmacy and Therapeutics committee.
- Prior authorization policies and practices.
- Pharmacy claims edits.
- Review of CCO claims and care management data.
- Consultation with contracted health care professionals.
- Focusing on high cost high risk conditions within the CCO membership.

Dissemination of Practice Guidelines

Some MCEs provided evidence of dissemination of their practice guidelines via a variety of methods including publishing adopted practice guidelines on provider portals, public websites, and in provider and member newsletters. Additionally, one CCO provided references to national resources outlining best practices and links to published clinical guidelines.

Application of Practice Guidelines

Some MCEs provided evidence that demonstrated service authorization and utilization management decisions were made consistent with the practice guidelines. There was also consistency in the integration of practice guidelines in the process of updating and developing the MCE's formulary and policies relating to step-therapy and prior authorization. CCOs also described monitoring of its providers' practice consistency with the guidelines through review of denials and appeals, quality of care case reviews, peer reviews, and claims data.

Major Areas for Improvement

Basic Rule and Adoption of Practice Guidelines

While most MCEs developed some clinical practice guidelines through advisory panels/committees, used HERC guidelines and guidances in the prioritized list, and require delegates to adopt practice guidelines relevant to their specialty scopes of services, there were several gaps, including:

- No evidence of adopting comprehensive clinical practice guidelines.
- Lack of a documented, specific process or schedule for periodic review and updating of practice guidelines.

- No evidence of a process for ensuring that delegates follow a review and updating schedule and maintenance process for their adopted guidelines.

Dissemination of Practice Guidelines

Dissemination of practice guidelines to providers and subcontractors for dental, NEMT and behavioral health or to members upon request was also not apparent in the documentation provided by most MCEs. MCEs often had no documented mechanisms and/or unclear written processes for informing providers or members of the availability of practice guideline information or how and where to access the guidelines or any revisions.

Application of Practice Guidelines

In many cases, MCEs did not have a mechanism or process for monitoring practice and coverage decisions of its providers and subcontractors responsible for utilization management, coverage of services, enrollee education, and care management to ensure consistency with the adopted guidelines.

Standard XII: Quality Assessment and Performance Improvement

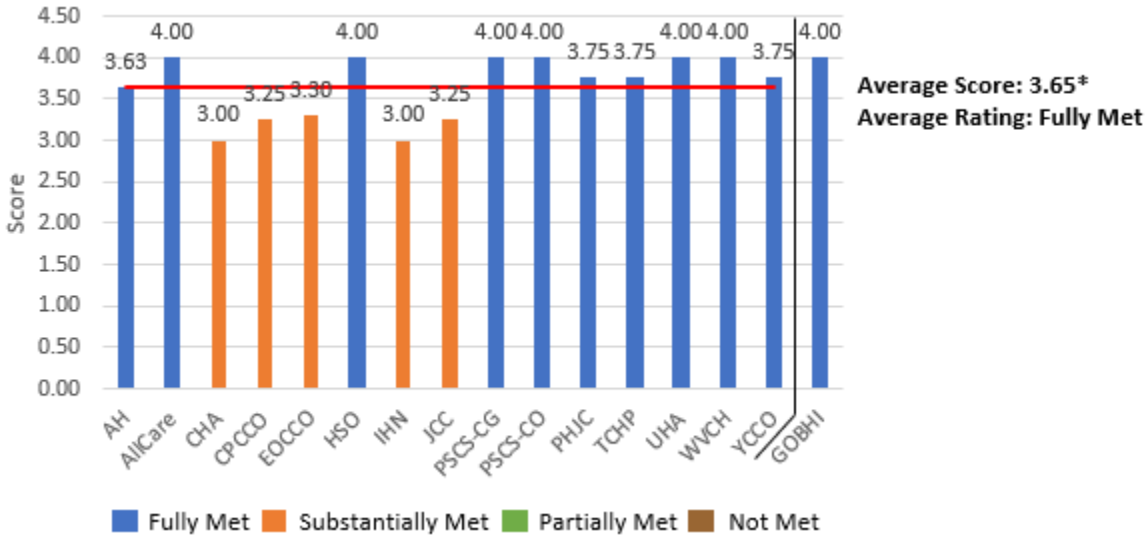
Quality Assessment and Performance Improvement (QAPI) is measured throughout this section in the areas of adoption of practice guidelines, dissemination of guidelines, and application of guidelines. Pursuant to 42 CFR §§438.330, 438.12, and 438.236(a) through (d), MCEs must:

- Establish and implement an ongoing comprehensive QAPI program for the services it furnishes to its enrollees
- Conduct performance improvement projects designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction
- Ensure that the comprehensive QAPI program includes mechanisms to detect both under-utilization and over utilization of services.

Overall, the CCOs scored a *Fully Met* (i.e., 3.65) across the Quality Assessment and Performance Improvement standard with eleven CCOs achieving a *Fully Met* rating, five CCOs achieving a *Substantially Met* rating, and zero CCOs achieving a *Partially Met*. None of the CCOs achieved a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 5-8 displays the average CCO scores and rating across the Quality Assessment and Performance Improvement standard.

Figure 5-8—Compliance Scores: Quality Assessment and Performance Improvement



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

QAPI: PIPs- General Rules, Basic Elements

All MCEs had substantial QAPI plans, with CCOs aligning them with a Transformation and Quality Strategy (TQS) that clearly evidenced quality improvement efforts supporting OHA goals. The majority of MCEs also had quality improvement committees that considered input from a variety of subcommittees, set priorities for performance improvement projects (as approved by OHA), and consisted of:

- Board members of the CCOs' governing body.
- Actively practicing physicians that served Medicaid members.
- Members of the CCOs' leadership teams.
- Subcontractors.
- Community partners.

QAPI: Performance Measurement

Overall, the MCEs demonstrated an ability and commitment to submit specified data elements to the State, allowing OHA to calculate standard performance measures in both an aggregated and individual manner, as outlined in their TQSs. Additionally, most MCEs leverage internal processes and data systems to measure performance against goals and benchmarks and to inform further quality improvement efforts.

Mechanisms to Detect Under- and Over-Utilization

The MCEs provided evidence of reviewing and analyzing data to identify actionable goals to further achievement of the Triple Aim, and to specifically address incidences of under- and over-utilization of health care services. This was readily apparent in the work done to reduce inappropriate ED utilization, as well as in the strides made to reduce health disparities with the goal of optimizing health outcomes in vulnerable populations.

Among the many remarkable and innovative quality improvement projects undertaken, notable examples include:

- Engagement and collaboration with a local nursing program to address the needs of members with uncontrolled diabetes.
- Targeted outreach to member populations with under-utilization for colorectal cancer screening.
- Monitoring and addressing the overuse of ED by Native American and SPMI populations.

- Interventions aimed at reducing the number of opioid deaths in Oregon by educating providers on safe prescribing practices and promoting harm reduction strategies such Narcan use and availability.
- Reallocation of case management resources to prevent admission and re-hospitalization of members with high-risk diagnoses such as chronic obstructive pulmonary disease and diabetes.
- Monitoring of claims data to develop "Hotspotter" reports to provide needed intervention and outreach to high-utilizing members.
- Tracking for missed opportunities for preventive care such as immunizations and well-care visits for children and young adults.
- Development of a Transitional Care program to provide needed care post-hospitalization and a palliative care program for members with life-limiting illnesses.

Mechanisms to Assess Quality and Appropriateness of Care

Approximately half of the MCEs were able to exhibit mechanisms to assess quality and appropriateness of care for SHCN members. Some of those MCEs demonstrated substantial success with the use of integrated data to target specific member populations with poor health outcomes and/or inappropriate use of the ED.

Major Areas for Improvement

QAPI: PIPs- General Rules, Basic Elements

Generally, MCEs performed very well in securing the basic elements and structures to support a successful QAPI program. A few MCEs demonstrated opportunity for improvement to include the following elements:

- Ensuring that the various committees meet regularly and integrate their quality improvement strategies to drive performance improvement projects.
- Ensuring that quality improvement committees report directly to MCE executive leadership.
- Increasing community stakeholder participation.
- Further developing documentation to specify quality improvement processes.

QAPI: Performance Measurement

Most MCEs demonstrated they met the requirements to conduct performance measurement activities and to submit the required data to OHA. Potential improvements to the performance measurement data collection process include:

- Ensuring MCE priorities align with that of subcontractors regarding data collection to confirm data quality.

- Verifying that standard integrated (dental, behavioral and physical health) data is available for use for analysis of performance measurement.

Mechanisms to Detect Under- and Over-Utilization

Some MCEs provided ample evidence of monitoring for over- and under-utilization, while others had difficulty demonstrating through policy, process and procedures describing how data is used to address these challenges. In many cases, minimal evidence addressing how over- and under-utilization is monitored, what reports are used, what criteria is used, and the frequency at which monitoring is conducted and reported was available.

Mechanisms to Assess Quality and Appropriateness of Care

. MCEs did not display evidence of defined criteria to identify SHCN members, which presented a gap in the monitoring of that specific member population. Nearly half of the MCEs did not meet requirements to assess the quality and appropriateness of care provided to SHCN members.

Review of 2017 Compliance Findings Follow Up

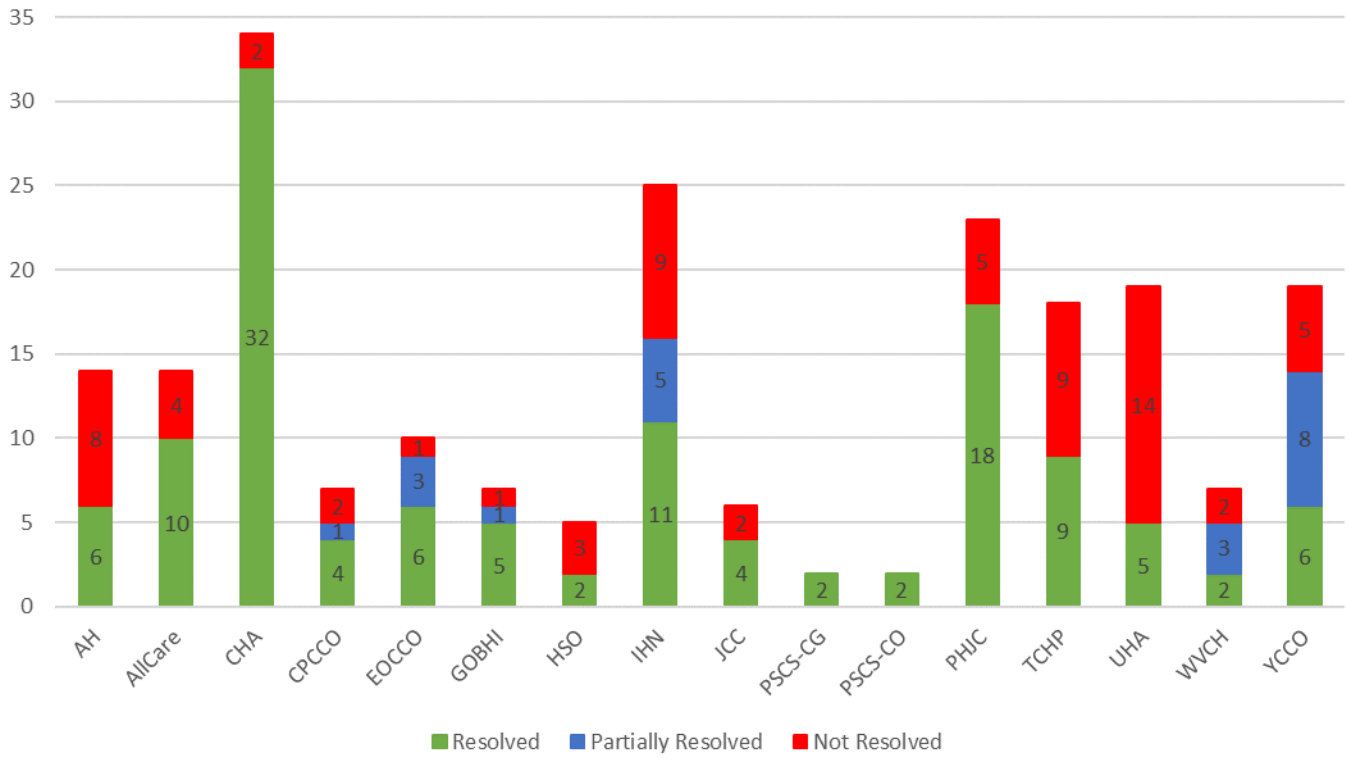
EQR Standards reviewed for compliance in 2017 included Standard VII Member Rights and Protections, X Grievance and Appeals, XV Member Information, and XIV Program Integrity. The MCEs implemented corrective action plans (CAPs) with targeted interventions focused on:

- Writing grievance and appeal communications in plain language.
- Implementing mechanisms to ensure members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliations.
- Clearly identifying services available through OHP, but not provided by the MCE.

Implementation of the CAPs was assessed during the 2018 compliance with standards review. Although some progress was made, the MCEs did not consistently implement the CAPs successfully. Several MCEs have unresolved findings from 2017 with continued plans for corrective action.

Figure 5-9 displays the resolution status of 2017 findings across all MCEs.

Figure 5-9—Results of 2018 Follow-up Review of 2017 Compliance Findings



6. Organizational Information Systems Capability Assessment

Overview

The 2018 Information Systems Capabilities Assessment (ISCA) represents a review the MCEs' information systems and data processing and reporting procedures to determine the extent to which the MCE maintains the capacity to manage the health care of its members and support the collection, management, and use of valid and reliable data. Although not a mandatory EQR activity, states are requirement to perform ISCAs as part of other mandatory EQR activity (e.g. Protocol 2-Validation of Performance Measures). Additionally, 42 CFR §438.242 requires that managed care entities maintain health information systems that collect, analyze, integrate, and report data for areas, including but not limited to, utilization, grievances and appeals, and disenrollment.[6-1] Specifically, federal regulations require that each MCO, PIHP and PAHP:

> (1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.
>
> (2) Ensure that data received from providers is accurate and complete by—
>
> > (i) Verifying the accuracy and timeliness of reported data;
> >
> > (ii) Screening the data for completeness, logic, and consistency; and
> >
> > (iii) Collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.
>
> (3) Make all collected data available to the State and upon request to CMS.

Although MCEs may subcontract activities to outside entities, the MCE is responsible for all duties and responsibilities included in its contract with OHA. The ISCA of the MCE's information systems is also important in supporting the OHA's validation of performance activity by evaluating the completeness and accuracy of data submitted to OHA for the purposes of monitoring and reporting. OHA last conducted an ISCA of the MCEs in 2016 and followed up on these results in 2017. This year, OHA again conducted a full ISCA of the MCEs.

[6-1] Centers for Medicare and Medicaid Services. Appendix V: Information System Capabilities Assessment – Activity Required for Multiple Protocols. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/app5-isassessment.pdf. Accessed on: Nov 06, 2018.

Review Activities

The 2018 ISCA reviews followed previously approved protocols and review tools[6-2] developed by HIA. These materials included an evaluation tool listing the requirements and elements for review, preliminary questions, and documentation requirements to guide the MCE's submission of documentation and onsite interviews. MCEs were able to submit additional or clarifying documentation identified during the onsite review up to two weeks following the onsite visit.

The primary objective of the ISCA was to provide meaningful information to the OHA and the MCEs regarding its information systems, security policies and procedures, and data collection and reporting capabilities. To accomplish its objective, HIA in collaboration with OHA, developed a standardized data collection tool and processes to assess and document each organization's compliance with certain federal Medicaid managed care regulations, OHA's contract with the MCEs, Oregon Administrative Rules (OARs), and other State requirements. The review tool was organized into 11 sections. Each section assessed a component of the MCE's information system. The 11 ISCA sections included:

1. Staffing
2. Meaningful Use of Electronic Records
3. Configuration Management
4. Member Enrollment Systems
5. Information Systems
6. Security
7. Provider Directory
8. Data Integration
9. Report Production
10. Vendor Management
11. Administrative Data

As part of the ISCA, supplemental interviews were conducted with a combination of delegates and providers. These supporting interviews consisted of a minimum of three providers and one delegate identified by OHA. The provider interviews consisted of standardized questions aimed at providing an overview of the provider's information systems.

Reviewers documented their observations and findings for each MCE in the ISCA review tool. Scoring criteria and supporting documentation listed in each section of the 2018 ISCA Scoring Protocol clearly identified the requirements needed to meet each element. The information was then analyzed to determine the MCE's performance for each of the elements and individual sub-elements within the section. For each of the sub-elements (i.e., requirements) within each section and element, it was

[6-2] The compliance review protocols and review tools were consistent with the CMS option protocol, *Appendix V: Information System Capabilities Assessment – Activity Required for Multiple Protocols.*

determined whether the sub-element was *Met* or *Not Met* based on the information collected during the review. When all the sub-elements were evaluated, a score of *Fully Met (4)*, *Substantially Met (3)*, *Partially Met (2)*, or *Not Met (1)* was assigned to the element based on the scoring criteria contained in the 2018 ISCA Scoring Protocol prepared by HIA. A designation of *NA* was used if an individual element or sub-element did not apply during the period covered by the review. A total score was then derived for each of the 11 sections and an overall ISCA score across all 11 sections.

Table 6-1 provides a description of the scoring criteria applied to each section.

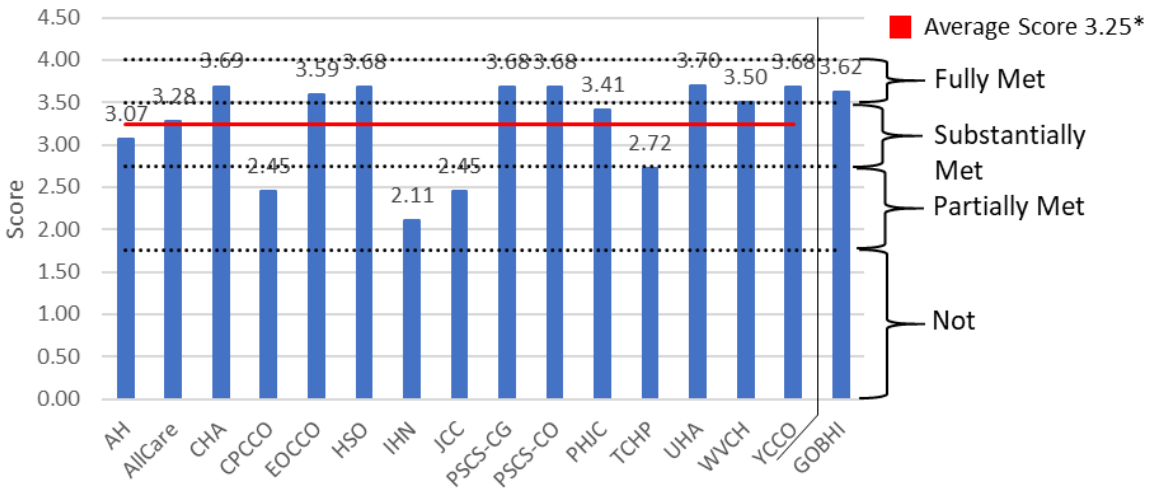
Table 6-1—Scoring Scheme for ISCA Elements

Rating	Definition	Element Score	Averaged Section Score
Fully Met	Meets or exceeds all requirements	4	3.50 to 4.00
Substantially Met	Meets essential requirements; has minor deficiencies	3	2.75 to 3.49
Partially Met	Meets essential requirements in most, but not all, areas	2	1.75 to 2.74
Not Met	Has not met the essential requirements in the element	1	<1.75

Summary of ISCA Review Results

To assess overall compliance, scores and ratings across the CCO's were combined to develop an average score and rating using the same 2018 QAPI Protocol prepared by HIA. The MHO's scores and ratings were not included in the overall averaged score ratings due to the entity being considered a PIHP with a slightly different scope than the CCOs. Each ISCA section was then averaged and rolled up to provide the overall OHA compliance score. The overall ISCA rating achieved was *Substantially Met* (i.e., 3.25) across the CCOs for the standards included in the 2018 review of compliance.

Figure 6-1—Weighted Average Scores for 2018 ISCA Review



**Averages do not include the MHO's performance as a PIHP.*

In 2018, HIA performed an ISCA of PH TECH, the third-party administrator that contracts with many CCOs, and also the four main Dental Plan Networks (DPNs). See *Appendix B. PH TECH 2018 ISCA Results* and *Appendix C. 2017 Dental Plan Network ISCA Findings* for a copy of this ISCA report.

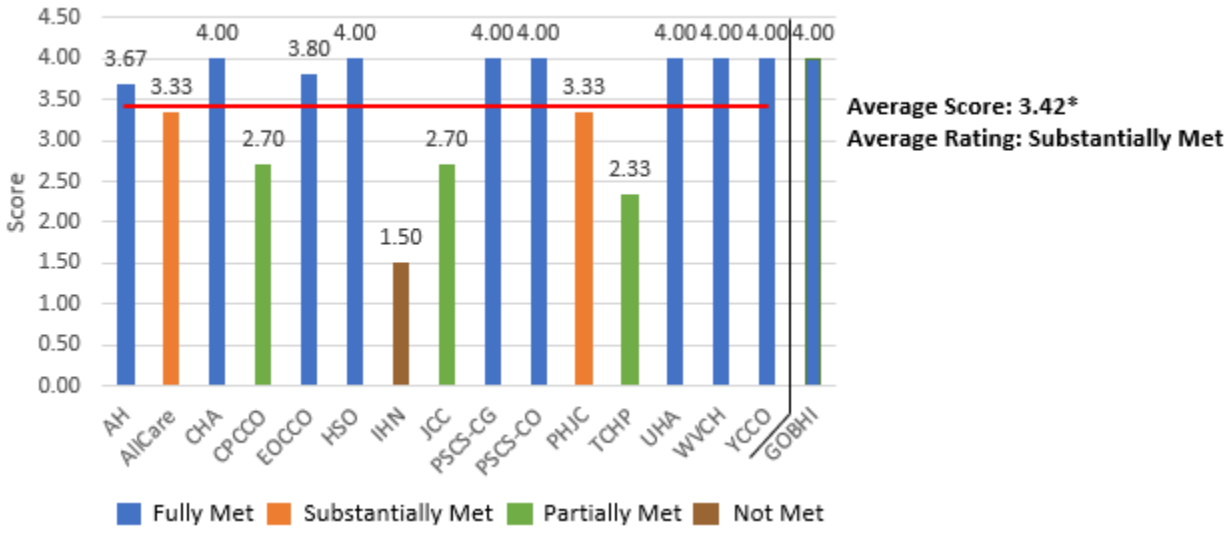
Section 1: Staffing

The *Staffing* section of the ISCA evaluated the MCEs' organizational structure as it relates to the processing of claims and encounters and general information systems programming (e.g., database and network management, analyses, and reporting). Specifically, the ISCA assessed the extent to which the MCE had the staff, policies and procedures (P&Ps), and training required to support critical information technology services.

Overall, the CCOs scored a Substantially Met (i.e., 3.42) across the Staffing section with nine CCOs achieving a Fully Met rating, two CCOs achieving a Substantially Met rating, and three CCOs achieving a Partially Met, indicating some opportunities for improvement. One CCO received a rating of Not Met. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-2 displays the average CCO scores and rating across the ISCA Staffing section.

Figure 6-2—ISCA Scores: Staffing



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Most of the MCEs had documented policies and procedures that defined productivity goals, staff performance evaluations, and training requirements for processors and programmers. The MCEs demonstrated adequate staffing levels, experience based on job requirements, and training to support administrative and information technology IT services related to staff duties. The majority of MCEs demonstrated consideration of the following factors related to the organizational structure of processors and programmers required to support critical information and network technology systems:

- New hire and ongoing training programs.
- Mechanisms to track for system maintenance work orders.
- Adequate performance evaluation of processor and programmers.

Major Areas for Improvement

Processor Productivity

One MCE provided no documentation or evidence that demonstrated how processor productivity goals were defined, communicated, or evaluated by the organization.

Staffing, Programmers

Two MCEa lacked documentation that demonstrated regular evaluation of the IT staff's programming, report development, data extraction, and data analytics.

Staffing, Programmer Training

Three MCEs that did not achieve a *Fully Met* rating could enhance their documented policies, procedures, and processes related to programmer training of IT staff. Furthermore, the MCEs should ensure that processes and procedures provide evidence of training programs and formal professional development of IT staff based on staff duties and functions.

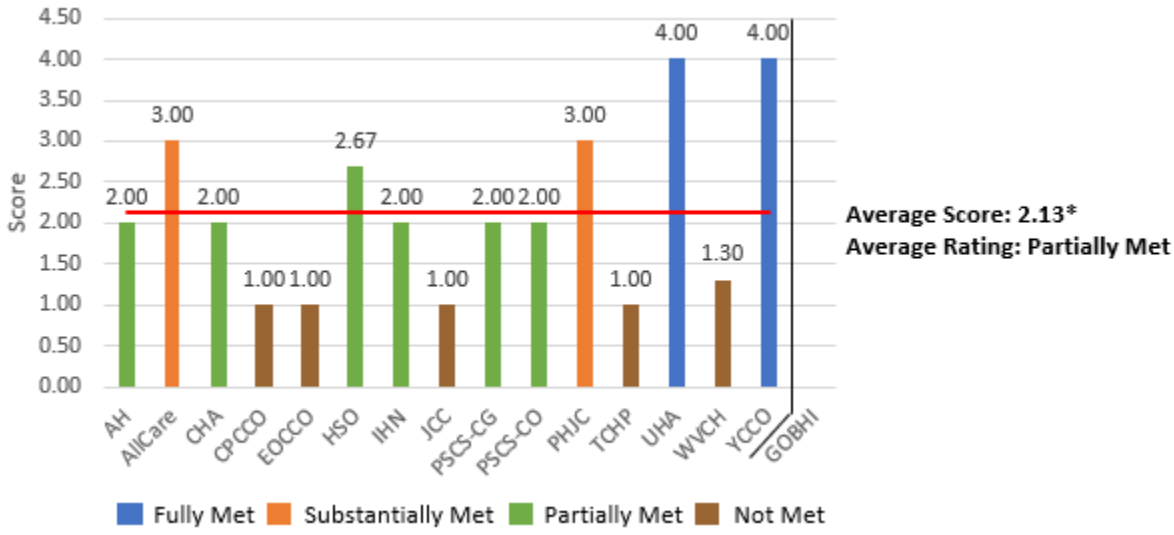
Section 2: Meaningful Use of Electronic Health Records (EHRs)

The *Meaningful Use of EHRs* section of the ISCA evaluated the MCE's processes for supporting the adoption and movement of its physical health providers to certified electronic health record technology (CEHRT), including provider education and outreach. Specifically, the ISCA assessed the extent to which the MCE had documented policies and procedures to support the adoption of CERHT by the MCE's provider network, the MCE's outreach efforts, and the use of EHR data in its quality improvement program.

Overall, the CCOs scored a *Partially Met* (i.e., 2.13) across the Staffing section with two CCOs achieving a *Fully Met* rating, two CCOs achieving a *Substantially Met* rating, and six CCOs achieving a *Partially Met*, indicating several opportunities for improvement. Five CCO received a rating of *Not Met and this section was not applicable for one CCO*. The MHO's scores and ratings were not included in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-3 displays the average CCO scores and rating across the ISCA Meaningful Use of EHRs section.

Figure 6-3—ISCA Scores: Meaningful Use of EHRs



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Most MCEs provided evidence supporting the adoption and movement of physical health providers to CEHRT, including provider education and outreach. Additionally, several MCEs demonstrated the use of electronic health records for performance measure monitoring and reporting related to PCPCH and

Alternative Payment Model incentive program methodologies. MCEs had processes in place relevant to the implementation of EHR meaningful use, including:

- Adequate outreach and education programs related to CEHRT adoption of contracted physical health providers.
- Mechanisms to track adoption of EHRs by contracted providers.
- Use of EHR data in quality improvement reporting and analytic programs

Major Areas for Improvement

Meaningful Use of Electronic Records, Provider Adoption

During onsite reviews, several MCEs described efforts to encourage contracted providers to either move to CEHRT, or gain certification of an existing EHR. However, many MCEs did not have these policies, procedures, or processes documented. Additionally, some of these MCEs specifically excluded efforts to encourage and track EHR utilization of dental health providers.

Meaningful Use of Electronic Records, Education Efforts

Six MCEs that did not achieve a *Fully Met* rating lacked documentation that demonstrated outreach, education efforts, and regular communication with contracted providers regarding meaningful use of CEHRT, or upgrading to a 2015 Edition of CEHRT. Additionally, three MCEs specifically excluded education efforts relevant to contracted dental health providers.

Section 3: Configuration Management

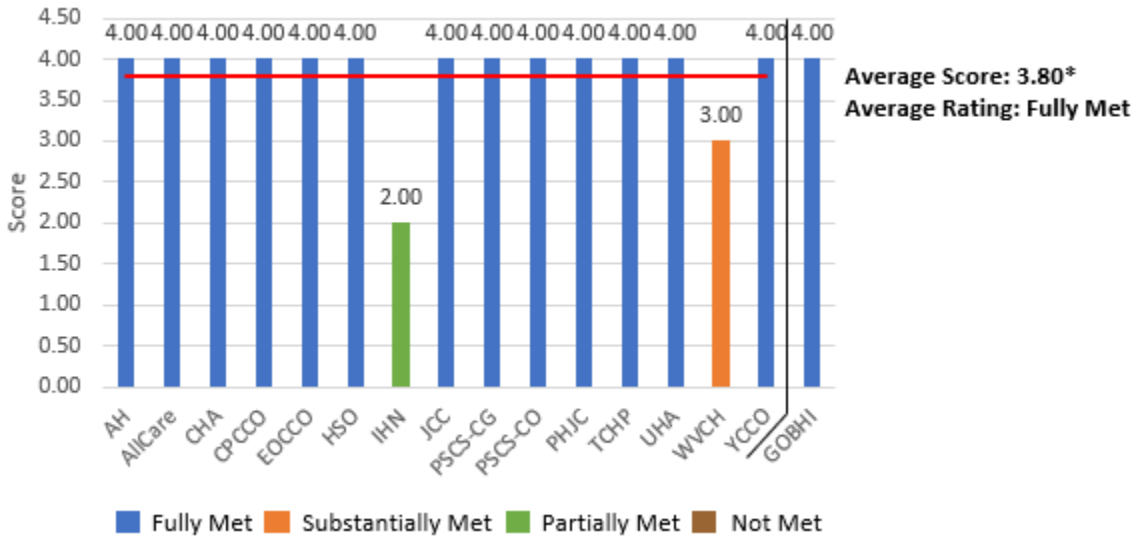
The *Configuration Management* section of the ISCA evaluated the MCE's ability to ensure its information systems and networks are configured and maintained appropriately to support its overall managed care operations. Specifically, the elements assessed whether the MCE established:

- Redundant network systems (including both hardware and software).
- Maintenance contracts, where applicable, to keep systems up-to-date. Policies, procedures, and processes that promoted the maintenance and use of Medicaid encounter data.

Overall, the CCOs scored a *Fully Met* (i.e., 3.80) across the Configuration Management section with thirteen CCOs achieving a Fully Met rating, one CCO achieving a Substantially Met rating, and one CCO achieving a *Partially Met.* None of the CCOs received a rating of *Not Met*. The MHO achieved a rating of *Fully Met.* The MHO's scores and ratings were not included in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-4 displays the average CCO scores and rating across the ISCA Configuration Management section.

Figure 6-4—ISCA Scores: Configuration Management



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

A majority of the MCEs provided evidence of sufficient policies, procedures, or processes related to daily maintenance, configuration, and operation of all systems essential to process Medicaid encounter data, including redundant hardware, software, and networking equipment used to minimize the risk of

loss of data. Most of them demonstrated a consideration of the following factors related to the configuration, maintenance, and operation of their respective networks:

- Adequate network systems for duplication of critical components
- Tracking mechanisms for system maintenance work orders
- Adequate maintenance and operation of wireless networks
- Appropriate agreements for vendors outsourced configuration management functions

Major Areas for Improvement

Configuration Maintenance

One MCE lacked documented policies, procedures, and processes regarding the oversight of its vendor subcontracted to configure, maintain, and operate the MCE's local area networks and desktop environment.

Maintenance Contracts

One MCE did not provide documentation of the agreement with the vendor contracted to support the configuration and maintenance of its information systems and networks.

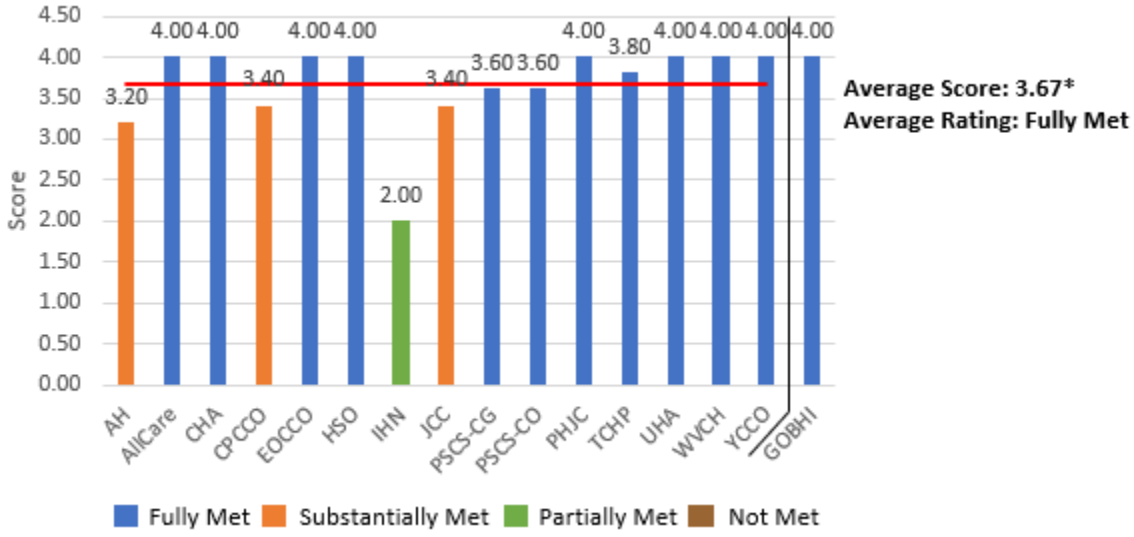
Section 4: Member Enrollment Systems

The *Member Enrollment Systems* section of the ISCA evaluated the MCE's policies and procedures for managing Medicaid enrollment systems and data. Specifically, the ISCA evaluated whether MCE member enrollment systems were clearly defined and set up to process member eligibility and enrollment data effectively and to ensure its accuracy. Additionally, ISCA elements assessed the extent to which the MCE had established policies and procedures that govern the enhancement and implementation of enrollment system changes.

Overall, the CCOs scored a *Fully Met* (i.e., 3.67) across the Member Enrollment Systems section with eleven CCOs achieving a *Fully Met* rating, three CCOs achieving a *Substantially Met* rating, and one CCOs achieving a *Partially Met*, indicating some opportunities for improvement. None of the CCOs received a rating of *Not Met*. The MHO achieved a rating of *Fully Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-5 displays the average CCO scores and rating across the ISCA Member Enrollment Systems section.

Figure 6-5—ISCA Scores: Member Enrollment Systems



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

A majority of the MCEs provided evidence of sufficient policies, procedures, and/or processes in place related to processing, handling, and verifying of Medicaid member eligibility and enrollment records. Several MCEs verified eligibility using a system that could access its provider network, online state systems, or telephone calls to its provider services or customer care departments. The MCEs also

provided evidence of detail planning, project implementation planning, and testing to address system- and product-based changes. The majority of them demonstrated a consideration of the following factors related to the configuration, maintenance, and operation of their respective member enrollment systems:

- Current and documented data flow diagrams illustrating every step of the member enrollment systems and the flow of Medicaid data.
- Adequate mechanisms for handling and maintaining Medicaid member enrollment restrictions, disenrollment, and breaks in enrollment.
- Provider training to verify enrollment at the time services are being rendered.

Major Areas for Improvement

Member Enrollment Systems – Data Integrity

A few of the MCEs' Medicaid member enrollment systems policies, procedures, and/or practices were lacking a few key aspects of the enrollment data integrity requirements including:

Mechanisms documenting changes to systems handling enrollment data.

Documenting and defining processes for conducting and tracking changes to systems handling enrollment data.

Documenting and defining processes for testing systems and the integrity of enrollment data.

Member Enrollment Systems – New Product Line or Enhancement to Existing System

A few of theMCEs' Medicaid member enrollment systems policies, procedures, and/or practices were lacking a few key aspects of the new product or enhancement to existing systems requirements including:

- Documentation for establishing a new product line on existing enrollment systems.
- Documentation for handling a new product line on an existing enrollment system.

Mechanisms that identify testing and data validation of records relating to the enhancement and implementation of enhancements on an existing enrollment system.

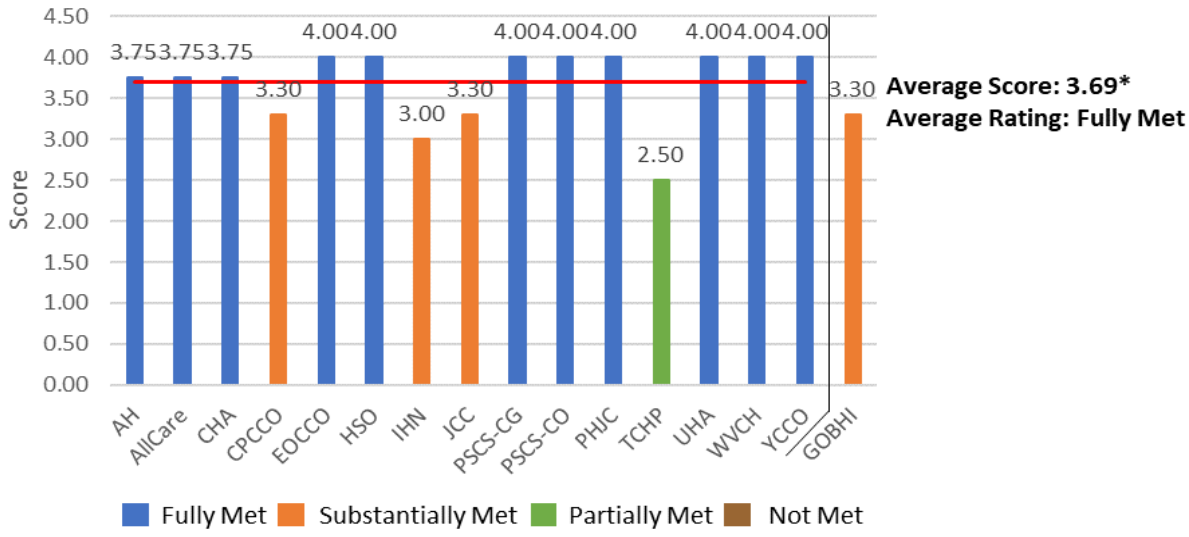
Section 5: Information Systems

The *Information Systems* section of the ISCA evaluated the MCE's documentation of its information systems infrastructure and the flow of Medicaid data through its integrated systems. The ISCA evaluated whether the MCE maintained documented policies and procedures to govern the administration of its information systems including the processing and storage of Medicaid data. The MCEs were also assessed on its policies and procedures for submitting complete and accurate encounter data to the OHA. Member enrollment systems were clearly defined and set up to process member eligibility and enrollment data effectively and to ensure its accuracy. Finally, several ISCA elements looked at the extent to which the MCE applied appropriate and programming languages when managing Medicaid data and subsequent reporting.

Overall, the CCOs scored a *Fully Met* (i.e., 3.69) across the Information Systems section with eleven CCOs achieving a *Fully Met* rating, three CCOs achieving a *Substantially Met* rating, and one CCO achieving a *Partially Met*. None of the CCOs received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-6 displays the average CCO scores and rating across the ISCA Information Systems section.

Figure 6-6—ISCA Scores: Information Systems



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Most of the MCEs provided evidence documenting the flow of all internal and external information systems used to process Medicaid claims/encounter data and repositories/databases used to manage data.

MCEs also provided evidence of sufficient policies, procedures, and/or processes in place for ensuring that state Medicaid reporting requirements are met, and changes required are implemented, tracking automated and manual processes interacting with Medicaid claims/encounter data, and tracking data merges, transfers and/or downloads and related scheduling of these functions. The majority of MCEs demonstrated a consideration of the following factors related to the configuration, maintenance and operation of their respective information systems:

- Adequate and clear documentation of data flow diagrams illustrating the management and flow of enrollment data between the computer systems of the MCEs and their external partners.
- Comprehensive lists of the programs and computer languages used by the CCO
- Trained staff to serve as a backup for primary programming staff.

Major Areas for Improvement

Information Systems – Data Reporting

Several MCEs had policies that documented processes to ensure state Medicaid reporting requirements were met and that required changes did not impact the completeness, accuracy, and timeliness of processing and reporting Medicaid data. However, the documentation lacked defining the attestation process and identifying the person responsible for attesting.

Information Systems - Software Development Life Cycle

While most MCEs had policies, procedures, and/or practices documenting key aspects of the software development life cycles, some of them lacked information and requirements including:

- Implementation and use of version control systems software to conduct testing within a non-production environment or manage changes deployed in a productive environment.
- A defined process related to the use of versions control programs.
- documentation specific to IT quality control programs/quality management systems.

Information Systems – Tools, Languages

A majority of MCEs had documented lists of the current industry programs and computer languages used by the MCE and supported by the manufacture and maintained by internal primary programming and backup staff. However, three MCEs did not have appropriate documentation that supported the daily maintenance and support for its proprietary software and/or in-house developed products.

Section 6: Security

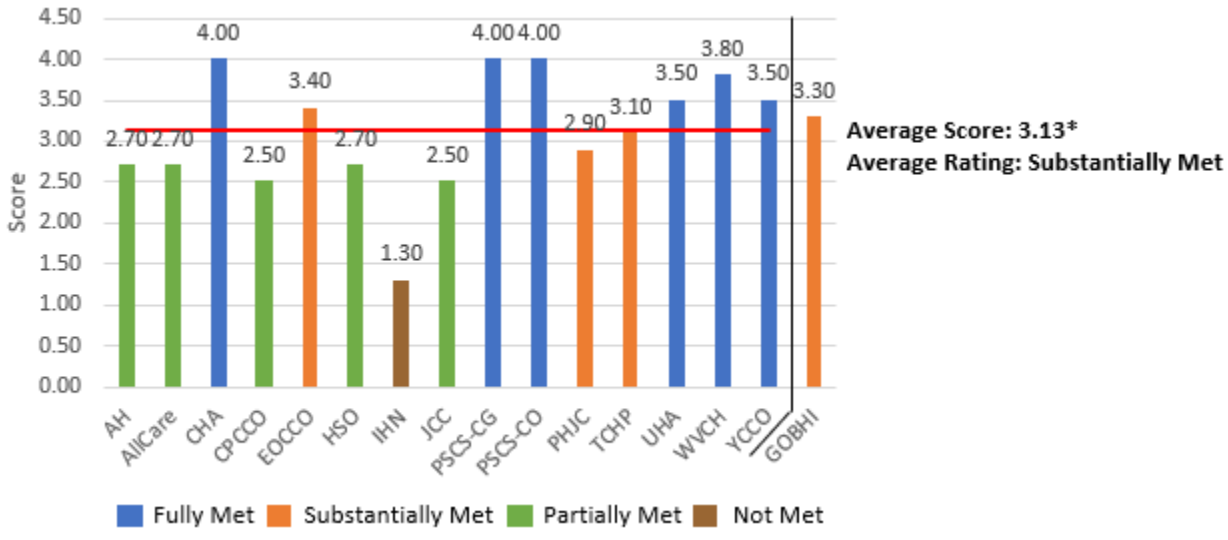
The *Security* section of the ISCA evaluated the MCE's documented policies and procedures for ensuring the security of its information systems and media devices, integrity of its data repositories, system recovery and incident mitigation strategies, and monitoring of subcontractors and partners. Specifically, the ISCA assessed whether policies and procedures addressed the following key information system areas:

- Data repositories, including data loss and corruption.
- Workstation, mobile device, and portable media security.
- Overall system security (SS), including antivirus protection, physical and electronic access, system back-up, and file management.
- BC/DR planning and testing.
- Incidence response planning and testing.

Overall, the CCOs scored a *Substantially Met* (i.e., 3.13) across the Security section with six CCOs achieving a *Fully Met* rating, three CCOs achieving a *Substantially Met* rating, and five CCOs achieving a *Partially Met*, indicating several opportunities for improvement. One CCO received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-7 displays the average CCO scores and rating across the ISCA Security section.

Figure 6-7—ISCA Scores: Security



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Most MCEs provided evidence documenting various data loss and corruption prevention activities, such as, documentation of encrypted backup media that is regularly transferred to an alternative site for storage, use of Uninterruptable Power Supplies (UPS) to maintain essential IT systems in the event of a power failure, and staff that regularly monitors data repository trends and alert the necessary people when deviations occur. The majority of MCEs demonstrated a consideration of the following factors related to the configuration, maintenance and operation of their respective information systems:

- Adequate and clear documentation ensuring Identity and Access Management policies and practices as based on determining staff access based on their role with the MCE.
- Mechanisms to ensure authorized access to data repositories, monitoring of active and securely stored transaction logs.
- Appropriate identity and access control systems requiring staff to have a unique user ID and password to access servers and networks. Additionally, mechanisms are in place to terminate access at the end of the staff member/contractor's shift on their last day.

Major Areas for Improvement

Security – Business Continuity/Disaster Recovery

Some MCEs had policies or procedures that would allow an outside IT professional to return the organization to full operational status within the timelines specified by the MCE leadership for the purposes of BC/DR. However, several MCEs did not have a documented BC/DR plan that was reviewed, updated, and/or tested in accordance with policies and procedures and applicable OHA/MCE contract and HIPAA requirements. Additionally, there were a few MCEs that had a BC/DR plan but did not have results to demonstrate the efficacy or the outcome of the plan.

Security – Incident Response

Most of the MCEs that did not provide the appropriate BC/DR plan testing results, also did not provide evidence that an IR plan was developed or that testing had been conducted within a time period in accordance with the OHA/MCE contract requirements. Additionally, several MCEs did not review and/or update their IR plan within a time period in accordance with policies and procedures and applicable OHA/MCE contract and HIPAA requirements.

Security – Monitoring Subcontractors and Partners

While most MCEs had evidence of documented policies, procedures, or processes for defining the oversight activities related to monitoring Subcontractors and providers, there were several gaps, including:

- Lack of documented requirements, including frequency and type of monitoring.

- No evidence ensuring that Subcontractors have documented policies, procedures or processes related to oversight activities and monitoring for their providers.
- Documented corrective action policies, procedures, describing how the MCE tracks and follows up on items/issues/findings through to the point of resolution.

Security – System Security Plan

Develop and Implementation of a comprehensive MCE System Security (SS) Plan that is current and reviewed annually. The SS plan must at a minimum include, all IT functions, systems, and equipment at the MCE. Additionally, the SS plan must describe the process for updating whenever significant changes are made to the IT functions, systems and/or equipment.

Information Systems – Tools, Languages

While most MCEs described mechanism to ensure security with computers, files, and portable media, such as laptops. However, some MCEs did not provide evidence that work cellphones (provided by the MCE or personal cell phone approved for work use) are configured to automatically lock the screen after a sort and defined time of unattended use.

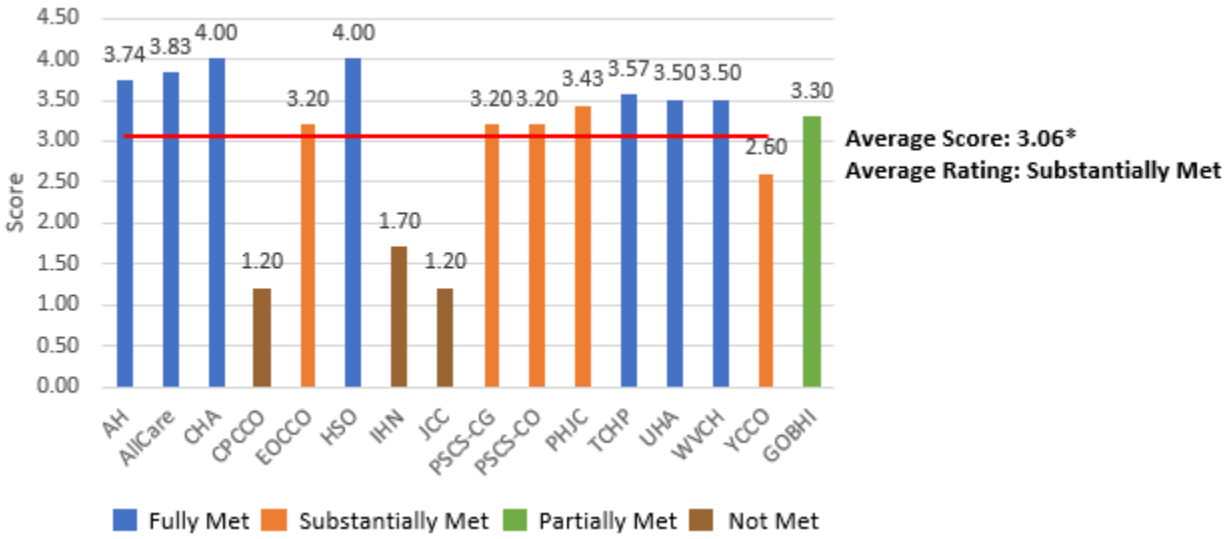
Section 7: Provider Data

The *Provider Data* section of the ISCA evaluated the MCE's management of its electronic provider directory and the system infrastructure and data processing procedures necessary to ensure provider data is managed efficiently, accurately, and securely. Moreover, this section solicits evidence that provider information is available to members. Additionally, the *Provider Data* section assesses the extent to which policies, procedures, and processes exist to ensure Medicaid fee schedules and compensation rules are accurately implemented with the MCEs information systems. Finally, the ISCA also reviewed documented policies and procedures for monitoring and updating incorrect National Provider Identifiers (NPIs).

Overall, the CCOs scored a *Substantially Met* (i.e., 3.06) across the Provider Data section with seven CCOs achieving a *Fully Met* rating, five CCOs achieving a *Substantially Met* rating, and three CCOs achieving a *Not Met*, indicating several opportunities for improvement. No CCO received a rating of *Partially Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-8 displays the average CCO scores and rating across the ISCA Provider Data section.

Figure 6-8—ISCA Scores: Provider Data



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

A majority of the MCEs provided evidence in the form of a process map, policy, and procedure that documented the flow of information and hand offs between people or departments from writing and submitting provider data change requests to final publishing and ability for public to view and use the information. Most provider data policies identified mechanisms or systems for providers to submit

provider directory changes and corrections to the MCEs for updates of published materials. The MCEs demonstrated a consideration of the following factors related to the configuration, maintenance and operation of their respective provider data systems:

- Defined processes for creating, modifying, and discontinuing provider data in support of its online and searchable directory.
- Mechanisms to monitor and validate provider data to ensure completeness, accuracy, and timeliness of provider data published for public view.
- Clear documented processes that define the staff responsible for managing provider compensation rules and feed schedules as well as monitoring this information, or implementing changes, as necessary.

Major Areas for Improvement

Provider Data

While most MCEs provided evidence of provider data maintenance, monitoring, and publishing for physical health providers, some failed to demonstrate oversight activities related to the flow of information; including provider data updates, change requests, and final publishing policies, procedures, and practices of MCE delegated providers and vendors. Additionally, the MCEs did not have documentation identifying the job roles that have access and change authority for fee schedules, compensation, and provider directory systems.

Provider Data – Provider Directory and Tracking Provider Directory Data

A majority of MCEs had policies, procedures, and practices that described gathering provider data that included accepting new patients or not and spoken language. However, several MCEs had electronic provider directories that the lack feature that allow the public to search for a provider by language preference.

Provider Data – Provider Directory Maintenance and Access

Several MCEs failed to provide evidence of a log used to keep historical documentation of any unauthorized access and resolution requirements.

Provider Data - NPI

While most MCEs had evidence of documented policies, procedures, or processes for defining the use of provider NPIs, there were several gaps, including:

- Lack of documented practices and mechanisms to identify correct and incorrect NPIs, including the process for resolving incorrect NPIs.
- No evidence documenting that CCO staff was trained and/or retrained to reduce occurrences of incorrect provider NPIs.

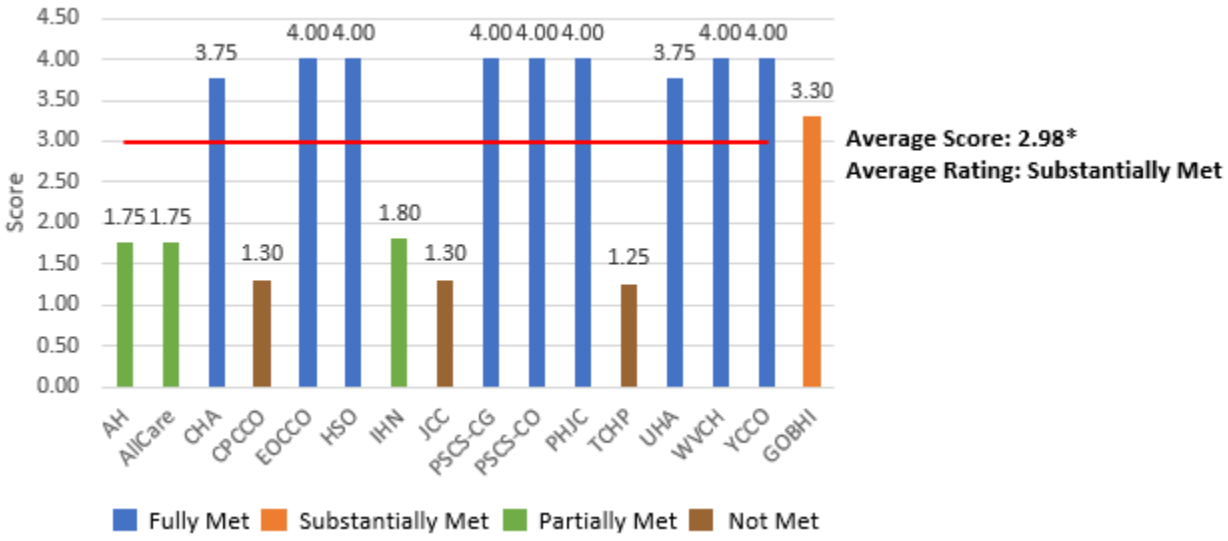
Section 8: Data Integration

The *Data Integration* section of the ISCA evaluated the extent to which MCEs established policies and procedures that define the collection, management, and integration of Medicaid data across the MCE's network to support the calculation of performance measures. ISCA elements assessed documentation of both data management process and subsequent validation activities.

Overall, the CCOs scored a *Substantially Met* (i.e., 2.98) across the Data Integration section with nine CCOs achieving a *Fully Met* rating, three CCOs achieving a *Partially Met*, and three CCOs achieved a score of *Not Met*, indicating several opportunities for improvement. No CCOs achieved a score of *Substantially Met.* The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-9 displays the average CCO scores and rating across the ISCA Data Integration section.

Figure 6-9—ISCA Scores: Data Integration



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

In many cases, MCEs provided documented evidence of policies, procedures, and practices used to manage, process, and integrate claims and operational data sources to produce valid and reliable reporting. MCEs provided documented evidence of policies, procedures, and practices used to manage, process, and integrate claims and operational data sources to produce valid and reliable reporting. Many MCEs demonstrated the following related to the configuration, maintenance, operation, and integration of their respective systems:

- Staff articulation relevant to the third-party vendor software used to evaluate Medicaid performance measures and any process relevant to patching the software.
- Comprehensive dashboards that support MCE monitoring and reporting of Medicaid performance metrics and health population management; and

Clearly documented data validation processes and evidence provided to demonstrate ongoing monitoring reports used to verify claims and encounter data submissions at both the organization and provider level.

Major Areas for Improvement

Data Integration – Data Collection and Methods

A few MCE's data integration policy, procedure, and/or practice requirements were lacking a few key aspects relevant to the methods of data collection, consolidation, processing, and validation of Medicaid performance measures including:

- Clear documentation describing the methodology of how data extractions are performed to support calculating Medicaid performance measurements and how the data extracts are archived for future need;
- Lack of documented mechanisms relevant to handling of claim and encounter submission and processing lags appropriately when evaluating Medicaid performance measures;
- No evidence of documented data structures involved in the process of evaluating Medicaid performance measures; and
- Lack of documentation relevant to validating performance measures, while ensuring the integrity of the MCE's Medicaid claims/encounter data once consolidated.

Data Integration – Data Collection and Methods

Most MCEs provided documented evidence of policies, procedures, and/or practices relevant to verifying Medicaid data and performance measures integrity. However, some MCEs did not provide documented evidence describing the mechanisms and tools relevant to archival data used to evaluate Medicaid performance measures.

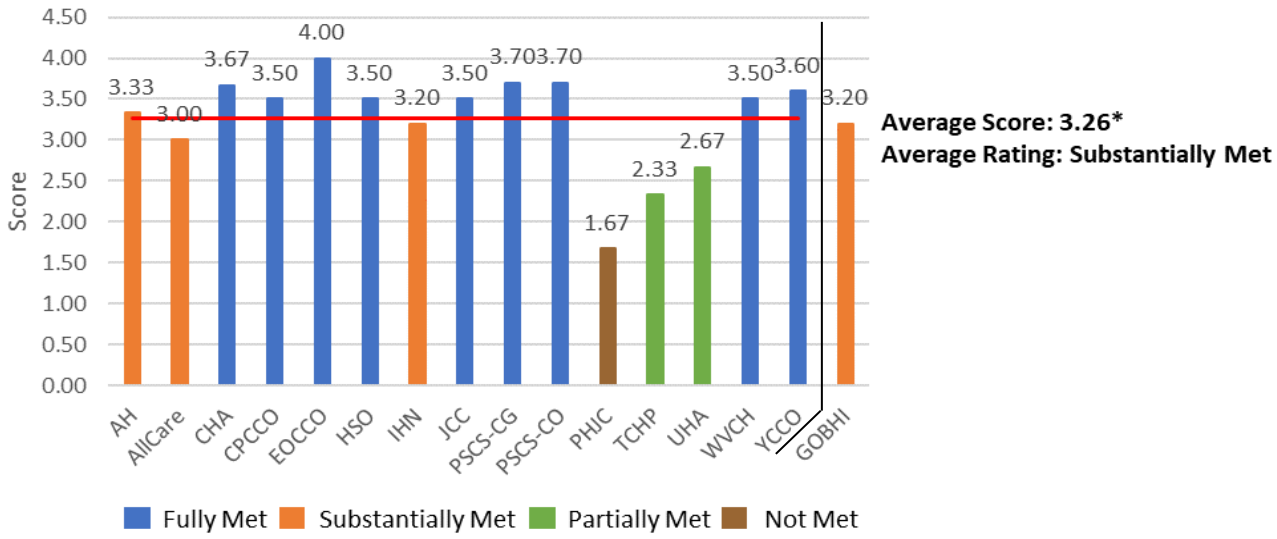
Section 9: Report Production

The *Report Production* section of the ISCA assessed the MCE's ability to capture data and produce reports. The ISCA questions assessed MCE documentation of its data repositories and the processes used to collect, manage, and analyze data in support of the organization's reporting activities. In particular, documented policies, procedures, and processes related to programming, data extracting, report generation, and validation were reviewed to ensure completeness, accuracy and timeliness of reporting. Additionally, this section the ISCAs evaluated the documentation of procedures to calculate internal performance metrics (e.g., enrollment) as well as the calculation of member months and years.

Overall, the CCOs scored a *Substantially Met* (i.e., 3.26) across the Report Production section with nine CCOs achieving a *Fully Met* rating, three CCOs achieving a *Substantially Met* rating, and two CCOs achieving a *Partially Met*, indicating several opportunities for improvement. One CCO received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-10 displays the average CCO scores and rating across the ISCA Report Production section.

Figure 6-10—ISCA Scores: Report Production



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Most of the MCEs provided adequate evidence of policies for the documentation of their report development, production and validation processes. The majority of submitted documentation demonstrated a consideration of the following factors related to management of computer programming, report generation, data extracts and analytics as it relates to each MCE's respective systems:

- Clearly documented and detailed listings and network diagrams of its data repositories to illustrate the integrated data pathways used to generate reports and business analytics;
- Demonstrated mechanisms for monitoring claims and/or encounter data repositories; trending and to evaluating historical; and
- MCE staff articulated and demonstrated sample reports that showed a variety of claim-, member-, and provider-based metrics used to monitor and guide internal operations.

Major Areas for Improvement

Report Production - Enrollment Performance Measures

Several MCEs lacked developed and implemented policies and procedures that define the process for managing the internal performance metrics and include, at a minimum, the mechanisms to add, remove, and modify internal measures. Additionally, these MCEs did not have written processes (e.g., specifications, reporting frequency, validation) for calculating internal performance measures.

Report Production - Calculation of Member Months and Years

Most MCEs provided documented policies, procedures, and practices describing methodologies used to calculate member months for the purpose of internal MCE and Medicaid performance measure report production. However, the MCEs lacked written processes and practices related to calculating member years. Additionally, many of these MCEs did not have lacked documented tracking mechanisms specifically for evaluating member months and years.

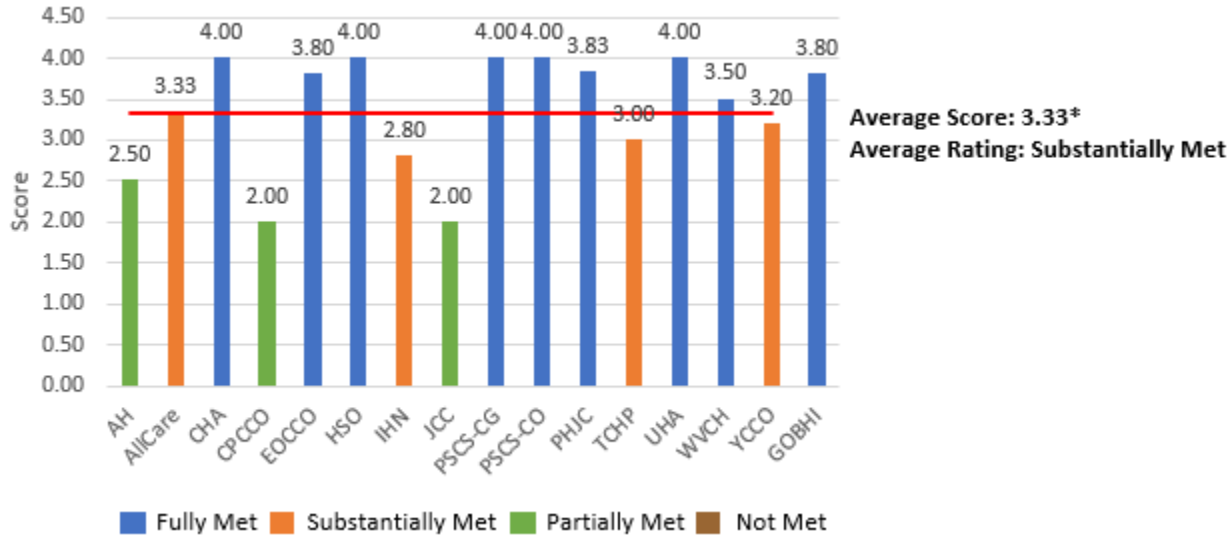
Section 10: Vendor Management

The *Vendor Management* section of the ISCA assessed the MCE's policies, procedures, and processes for oversight of contracted vendors responsible for conducting data and reporting activities on behalf of the MCEs. The ISCA evaluated the extent to which the MCE has established comprehensive contracts that define the specific work to be done, expectations regarding quality and timeliness, reporting and oversight, and a documented corrective action process. In particular, policies and procedures related to data processing, the calculation of performance measures, and reporting were reviewed.

Overall, the CCOs scored a *Substantially Met* (i.e., 3.33) across the Vendor Management section with eight CCOs achieving a *Fully Met* rating, four CCOs achieving a *Substantially Met* rating, and three CCOs achieving a *Partially Met*, indicating some opportunities for improvement. None of the CCOs received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-11 displays the average CCO scores and rating across the ISCA Vendor Management section.

Figure 6-11—ISCA Scores: Vendor Management



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

Many of the MCEs provided documented policies or procedures for outsourcing of work involving Medicaid data which demonstrated their oversight and management of delegated entities. These policies and procedures included requirements for reporting, monitoring, and corrective actions. The majority of MCEs demonstrated a consideration of the following factors and provided adequate documentation of several other key vendor management components:

- Clear mechanisms and documentation for how member data is submitted; ensuring data received from outside sources contains 999 files, is integrated, and is received regularly.
- Corrective action policies specific to data integrity; ensuring any issues with member data supplied by contracted vendor(s) has been fully documented and that any issues with the member is fully resolved.

  Adequate documentation demonstrating MCE monitoring of vendor owned systems used to adjudicate and tracking of Medicaid benefits adjudicated using vendor owned systems.

Major Areas for Improvement

Vendor Management - Outsourced Data Processing

Five MCEs did not provide documentation of procedures for handling and storage of offsite Medicaid claims/encounter data.

Vendor Management - Vendor Data and Performance Metrics

Several MCEs lacked documented evidence of policies and procedures for governing the use of vendor supplied data in the calculation of performance metrics, and did not provide documented calculations for performance metrics and/or quality improvement programs for vendor supplied data. Nearly half of the MCEs did not provide documentation of policies, procedures, or processes to validate that delegated entities are submitting all zero- and low- dollar claims/encounters.

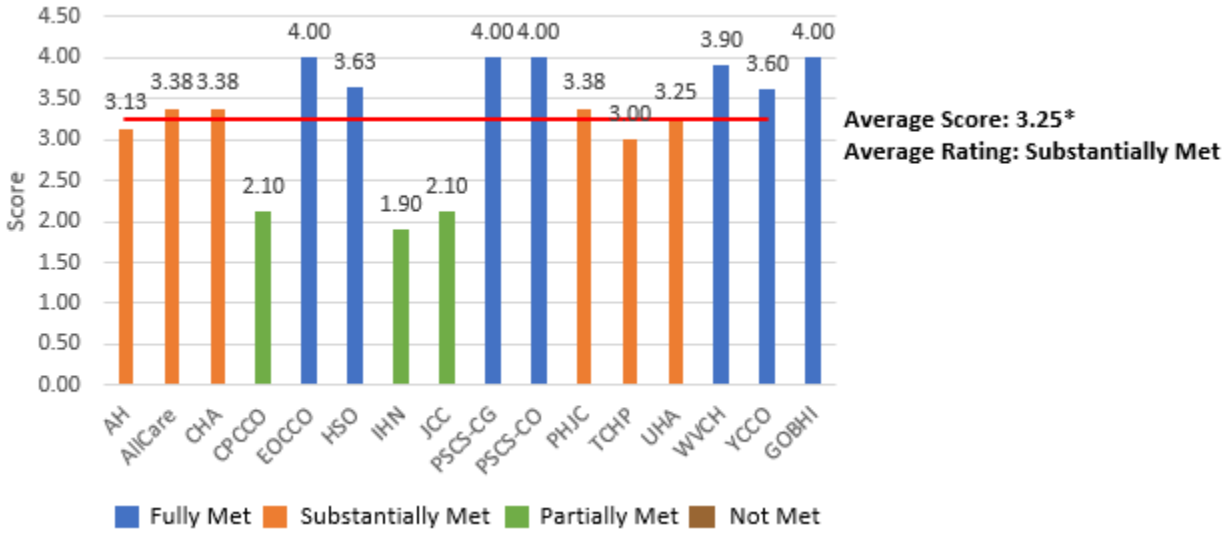
Section 11: Administrative Data

The *Administrative Data* section of the ISCA assessed MCE policies, procedures, and processes related to the processing of claims and encounters and steps taken to ensure the timeliness, accuracy, and completeness of its data. The ISCA also evaluated MCE encounter data validation (EDV) procedures.

Overall, the CCOs scored a *Substantially Met* (i.e., 3.25) across the Administrative Data section with six CCOs achieving a *Fully Met* rating, six CCOs achieving a *Substantially Met* rating, and three CCOs achieving a *Partially Met*, indicating some opportunities for improvement. None of the CCOs received a rating of *Not Met*. The MHO's scores and ratings were not included in in this section's average score due to the entity being considered a PIHP with a slightly different scope than the CCOs.

Figure 6-12 displays the average CCO scores and rating across the ISCA Administrative Data section.

Figure 6-12—ISCA Scores: Administrative Data



**Averages do not include the MHO's performance as a PIHP.*

Major Strengths

A majority of the MCEs demonstrated the inclusion of key data fields within their claims/encounter data, and provided evidence of sufficient policies and procedures for monitoring the completeness of claims and encounters. The majority of MCEs demonstrated a consideration of the following factors related to the timeliness, accuracy, and completeness of claims and encounter processing, data management, maintenance and operation of their respective systems:

- Appropriate handling of incomplete claims/encounters.

- Documentation for auditing the processing of Medicaid data, including validating the accuracy of submitted Medicaid claims/encounters and tracking and remediating findings resulting from auditing the processing of claims/encounters.
- Demonstrating monitoring activities related to the trending of Medicaid data three months after the closure of the reporting period.
- Adequate mechanisms for scanning and processing of in-house paper claims within a timely manner, with adequate staffing to support processing of paper claims.
- Clean and defined monitoring activities relative to third party processing of claims and adjudication of encounters.

While the majority of MCEs provided documented policies, procedures and processes for the validation of encounter data being performed on a regular basis, four MCEs did not provide evidence of these audits being performed on an annual basis.

Major Areas for Improvement

Administrative Data - Claims and Encounter Data Completeness

While the majority of MCEs provided sufficient policies and procedures for monitoring the accuracy and completeness of claims and encounters. However, eight MCEs lacked documented policies and procedures for defining the completeness of this data. Some MCEs with policies and procedures failed to incorporate a definition of completeness, nor a definition of how to estimate the completeness of Medicaid claims and encounter data.

Administrative Data - Tracking of Claims/Encounters for Capitated or Alternative Payment Model Services

Nine MCEs did not provide evidence of policies, procedures or processes for the tracking of claims and encounters for capitated or alternative payment model services.

7. Performance Improvement Projects

Overview

PIPs allow managed care entities the opportunity to identify areas of concern affecting its membership and strategize ways to improve care. Designed to assess and improve health care processes, the purpose of a PIP is to impact health care delivery and the outcomes of care. For such projects to achieve real improvements in care, and to ensure confidence in reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner that meets all state and federal requirements.

To ensure compliance with federal requirements, HSAG incorporated the use of guidelines established by CMS to validate the quality and effectiveness of MCE PIPs. These guidelines are provided in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[7-1] If conducted effectively, PIPs can:

- Improve performance measurement rates in targeted and non-targeted areas,
- Keep MCEs focused on improving performance and outcomes of care, and
- Improve member satisfaction.

The OHA contract requires each CCO to conduct three PIPs and one focus study designed to improve care in at least four of the seven quality improvement focus areas:

1. Reducing preventable rehospitalizations
2. Addressing population health issues (e.g., 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

[7-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: June 26, 2018.

7. Improving primary care for all populations through increased adoption of the PCPCH model of care throughout the CCO network.

One of the three PIPs was required to address the statewide PIP topic, focused on improving opioid safety by reducing the prescription of high morphine milligram equivalent MME/day. The CCOs were responsible for developing interventions that meet local community needs and for documenting the development and implementation of their interventions in quarterly reports to OHA. From the date of initiation through the first quarter of 2018 (March 31, 2018), HIA evaluated the statewide PIP for improvement by testing for statistically significant differences between the aggregate baseline and measurement periods.

For the remaining two PIPs and the focus study, the CCOs can select a topic, however; the topics must be selected to improve care within the quality improvement focus areas listed above. All selected topics were expected to align with the CCO's Transformation Plan and OHA quality and incentive requirements. Each CCO submitted status updates, including results, to the EQRO on a quarterly basis which were evaluated, validated, and suggested recommendations for improvement were identified. A summary of the EQRO's recommendations for improvement were submitted to OHA and subsequently used to define potential areas for targeted technical assistance with the CCOs.

HSAG conducted the quarterly PIP reviews for the second quarter and third quarter of 2018 following previously approved protocols and review tools developed by HIA and provided to HSAG by OHA. These materials included a PIP Progress Report template to guide the CCO's submission of required PIP elements develop by HIA and the OHA. To conduct its evaluation, HSAG employed a PIP Progress Review Tool that is used review elements derived from the PIP Progress Report template and adapted from CMS' protocols and HSAG's PIP Progress Review Tool.

The goal of HSAG's PIP validation is to ensure that the health plan and key stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies and activities conducted during the life of the PIP. HSAG's validation of PIPs includes the following two key components of the quality improvement process:

8. Evaluation of the technical structure to determine whether a PIP's initiation (e.g., topic rationale, PIP team, aims, key driver diagram, and data collection methodology) is based on sound methods and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
9. Evaluation of the quality improvement activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing and evaluation, sustainability, and spreading successful change. This component evaluates how well the health plan executed its quality improvement activities and whether the desired aim was achieved and sustained.

Statewide PIP: Improving the Safety of Opioid Management

The Statewide PIP, initiated in 2015, focused on improving opioid safety by reducing the prescription of high morphine milligram equivalent MME/day. After reviewing literature and receiving feedback from the Quality and Health Outcomes Committee (QHOC) discussions and OHA's quality committee comprised of CCO clinical leadership, OHA selected the following as the statewide PIP on opioid safety study metrics for the first two remeasurement periods (January 1, 2016–December 31, 2017):

- Percentage of OHP enrollees ages 12 years and older with opioid prescriptions for ≥ 120 MME/day and for ≥ 90 MME/day for at least one day during the measurement period
- Percentage of OHP enrollees ages 12 years and older with opioid prescriptions for ≥ 120 MME/day and for ≥ 90 MME/day for consecutive 30 days or more during the measurement period

In spring 2017, HIA facilitated several discussions about next steps for the Statewide PIP with medical and quality improvement directors at 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:

- Percentage of OHP enrollees ages 12 years and older with opioid prescriptions for ≥ 90 MME/day and for ≥ 50 MME/day for at least one day during the measurement period
- Percentage of OHP enrollees ages 12 years and older with opioid prescriptions for ≥ 90 MME/day and for ≥ 50 MME/day for consecutive 30 days or more during the measurement period

Technical Assistance

HSAG's PIP team reviewed the 2018 second and third quarter PIP progress reports and documented observations and findings for each CCO in the PIP Progress Review tool. HSAG analyzed the information to prepare a listing of technical assistance needs associated with each PIP element and CCO. Each CCO's identified strengths and areas in need of improvement are included in the CCO's profile in *Appendix A. MCE Profiles*. Additionally, HSAG developed a dashboard that identified the highest priorities regarding CCO technical assistance needs by plan and review element. The dashboard was color-coded to clearly identify areas for improvement. HSAG shared the CCO-specific PIP progress review tools and the dashboard with OHA to communicate progress review findings a facilitate identification of high-priority technical assistance needs.

After completing the review of the 2018 second quarter PIP progress reports, HSAG offered technical assistance to the CCOs via teleconference to discuss the Statewide PIP progress review findings and submission requirements for the next annual validation, which HSAG will conduct in 2019. HSAG also presented the 2019 PIP validation submission requirements and scoring criteria to the CCOs and OHA during the October 8, 2018 on-site QHOC meeting in Salem, Oregon.

Validation and Scoring

Prior to July 2018, HIA conducted EQR activities, including performance improvement project validation and review. The 2018 validation results of the Statewide PIP presented in this report are based on HIA's Statewide PIP report, *Oregon Statewide PIP on Opioid Safety: Reducing Prescribing on High Morphine Milligram Equivalent/Day Doses*, published in June 2018.

The June 2018 Statewide PIP report documented that HIA evaluated each CCO's performance on the Statewide PIP based on the CCO's documentation addressing Standard 8: Improvement Strategies. HIA assigned each CCO a score of *Met*, *Partially Met*, or *Not Met* in the following areas of Standard 8:

- Root cause analysis or quality improvement process
- Intervention development and implementation
- Linkage between interventions and study indicator outcomes
- Cultural and linguistic appropriateness of interventions
- Evaluation of intervention effectiveness
- Resolution of barriers to intervention implementation
- Linkage between evaluation results and next steps documented for each intervention

Interventions

Based on the 2018 annual validation of the Statewide PIP, HIA summarized interventions developed and implemented by the CCOs and identified that some interventions were carried out independently while others were conducted in collaboration with other CCOs and organizations. HIA reported that many CCOs implemented prior authorization processes and quantity limit guidelines to address the opioid problem. HIA noted the following additional common interventions:

- Provider education and training
- Member education
- Targeted interventions with members and providers, such as top opioid prescribers
- Taper plans
- Alternative therapies
- Medication-assisted treatment (MAT)
- Collaboration with community organizations
- Collaboration with other CCOs

Statewide PIP Results

This report includes results from the second remeasurement period of the Statewide PIP. The results are based on HIA's June 2018 report, *Oregon Statewide PIP on Opioid Safety: Reducing Prescribing on High Morphine Milligram Equivalent/Day Doses*. The CCOs and OHA agreed to continue the PIP for a third remeasurement period and the results of the third remeasurement period will be included in next year's technical report. Measurement periods include:

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

CCOs, OHA, and HIA 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.

Table 7-1 displays statewide aggregate results for the 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 period. The table includes results for the baseline, Remeasurement 1, and Remeasurement 2 period.

Table 7-1. 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.

Study indicator	Baseline January 1–December 31, 2014	1st remeasurement January 1–December 31, 2016	2nd remeasurement January 1–December 31, 2017
Numerator	11,945	9,394	6,840
Denominator	112,768	100,586	88,637
Calculated indicator	10.6%	9.3%*	8.0%*

* $p < 0.001$

There was a decrease in the study indicator rate from 10.6 percent at baseline to 9.3 percent at Remeasurement 1, and a further decrease to 8.0 percent at Remeasurement 2. HIA reported that there was a statistically significant difference between baseline and Remeasurement 1 and between baseline and Remeasurement 2, based on results of a chi-square test.

Table 7-2 displays statewide aggregate results for the 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 period. The table includes results for the baseline, Remeasurement 1, and Remeasurement 2 period.

Table 7-2. 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.			
Study indicator	**Baseline** January 1–December 31, 2014	**1st remeasurement** January 1–December 31, 2016	**2nd remeasurement** January 1–December 31, 2017
Numerator	20,235	16,778	13,056
Denominator	112,768	100,586	88,637
Calculated indicator	17.9%	16.7%*	14.7%*

* $p < 0.001$

There was a decrease in the study indicator rate from 17.9 percent at baseline to 16.7 percent at Remeasurement 1, and a further decrease to 14.7 percent at Remeasurement 2. HIA reported that there was a statistically significant difference between baseline and Remeasurement 1 and between baseline and Remeasurement 2, based on results of a chi-square test.

Table 7-3 displays statewide aggregate results for the percentage of OHP enrollees, age 12 years and older, who filled opioid prescriptions for at least ≥120 MME for 30 consecutive days or more during the measurement period. The table includes results for the baseline, Remeasurement 1, and Remeasurement 2 period.

Table 7-3. 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	**2nd remeasurement** January 1–December 31, 2017
Numerator	3,129	1,967	1,185
Denominator	112,768	100,586	88,637
Calculated indicator	2.8%	2.0%*	1.3%*

* $p < 0.001$

There was a decrease in the study indicator rate from 2.8 percent at baseline to 2.0 percent at Remeasurement 1, and a further decrease to 1.3 percent at Remeasurement 2. HIA reported that there was a statistically significant difference between baseline and Remeasurement 1 and between baseline and Remeasurement 2, based on results of a chi-square test.

Table 7-4 displays statewide aggregate results for the percentage of OHP enrollees, age 12 years and older, who filled opioid prescriptions for at least ≥120 MME for 30 consecutive days or more during the

measurement period. The table includes results for the baseline, Remeasurement 1, and Remeasurement 2 period.

Table 7-4. 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	2nd remeasurement January 1–December 31, 2017
Numerator	4,448	3,201	2,354
Denominator	112,768	100,586	88,637
Calculated indicator	3.9%	3.2%*	2.7%*

* $p<0.001$

There was a decrease in the study indicator rate from 3.9 percent at baseline to 3.2 percent at Remeasurement 1, and a further decrease to 2.7 percent at Remeasurement 2. HIA reported that there was a statistically significant difference between baseline and Remeasurement 1 and between baseline and Remeasurement 2, based on results of a chi-square test.

The aggregate results reported for the Statewide PIP showed a decreasing trend in the rates of all four study indicators, from baseline to Remeasurement 2. All four indicators were inverse indicators, where a lower rate represents improvement in outcomes. The reported results suggest that the Statewide PIP has been successful in decreasing the percentage of OHP enrollees who filled high-dose opioid prescriptions.

In the June 2018 Statewide PIP report, HIA documented some factors that may impact the validity of the PIP 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 under Standard 7, these factors should not have had a significant impact on the results nor have altered conclusions about improvement in the study indicators." A full discussion of factors impacting validity and potential confounding factors is provided in the HIA report.

Future Steps

- HSAG will continue to offer technical assistance opportunities to the CCOs to discuss progress review findings and recommendations on a quarterly basis, and upon request.
- HSAG will provide feedback on the metrics and study design for the new Statewide PIP that will be initiated by the CCOs in calendar year 2019.

- CCOs and OHA will collaborate to develop the study design for the new Statewide PIP, focused on acute opioid prescribing. The CCOs and OHA will define the study question, study population, study indicators, and data collection methodology that will be used to evaluate improvement.
- OHA will provide historical data to guide development of the new Statewide PIP study design and rolling monthly study indicator data to the CCOs during each measurement period.
- CCOs will evaluate baseline study indicator data for the new Statewide PIP to identify and develop interventions to drive improvement in remeasurement outcomes.

Recommendations

Based on quarterly PIP progress reviews and technical assistance discussions with the CCOs and OHA conducted between July and December 2018, HSAG offers the following recommendations for the 2019 PIP activities:

1. CCOs and OHA should develop the Statewide PIP study design based on analyses of historical study indicator data. Historical data should guide the development of the study question, study population, and study indicator(s).
2. CCOs should use historical and baseline study indicator data to develop SMART goals and aim statements that are Specific, Measurable, Attainable, Relevant, and Timebound for all PIPs and focus studies.
3. CCOs should conduct thorough casual/barrier analyses to identify root causes impeding improvement and opportunities for high-impact interventions.
4. CCOs should develop innovative interventions to address high-priority barriers to improvement. The deployment of each intervention should include ongoing evaluation of effectiveness and use of evaluation results to refine and improve interventions.
5. CCOs should provide clear, thorough, and accurate documentation of PIP design, activities, and outcomes to address the requirements described in CMS' protocols.[7-2]
6. OHA should consider a re-design of the quarterly PIP progress report template to better align with CMS' protocols,[7-3] support clearer documentation of PIP activities by the CCOs, and facilitate more effective technical assistance.

[7-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Nov 6, 2018.
[7-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Nov 6, 2018.

CCO-Specific PIPs and Focus Projects

Each CCO was required to provide quarterly reports on three additional projects. HSAG's PIP team reviewed and documented their observations and findings for each CCO in the PIP Progress Review tool. HSAG then analyzed the information to prepare a listing of technical assistance needs associated with each PIP element and CCO. Additionally, HSAG developed a dashboard that identified the highest priorities regarding CCO technical assistance needs by plan and review element. The dashboard was color-coded to clearly identify areas with the greatest need for improvement.

Table 7-5 summarizes the CCO-specific PIP topics conducted in third quarter of 2018, which addressed various issues of health care access, timeliness, and quality. Details of the interventions, strengths and areas for improvement for each PIP are included in the individual CCO profiles in *Appendix A. MCE Profiles*.

Table 7-5—CCO-Specific PIP Topics

CCO	PIP topics
Advanced Health	• CRC Screening • One Key Question: Reproductive Planning • ED Utilization
AllCare Health Plan	• Adolescent Well-child • Contraceptive Care • Colorectal Cancer
Cascade Health Alliance	• Oral Health Care • Tobacco Cessation • ED Utilization
Columbia Pacific	• ED Utilization • Tobacco Cessation • Adverse Experience
Eastern Oregon	• Colorectal Cancer • Adolescent Well-child • Substance Use
Health Share of Oregon	• RAPID Assessment Process • Contraception Rates • Expanding Access to MAT Services
Intercommunity Health Network	• ED Usage • Pregnancy and Oral Health • Reduce Re-hospitalization

CCO	PIP topics
Jackson Care Connect	• Social Determinants of Health Screening and Follow-Up • Higher Utilizers • Improving Maternal and Perinatal Care
PacificSource Community-Solutions-Central Oregon	• Adolescent Well-care • Oral Health During Pregnancy • Contraceptive Use
PacificSource Community-Solutions-Columbia Gorge	• Social Determinants • Contraceptive Use • Oral Health During Pregnancy
Primary Health of Josephine County	• Community Health Workers • Maternal Medical Home • Colorectal Cancer Screening
Trillium Community Health Plan	• Start Smart for Baby • Transitions of Care • Screening for Depression
Umpqua Health Alliance	• Emergency Room Use • Newborns with Neonatal Abstinence Syndrome • Re-admission Reduction
Willamette Valley Community Health	• Tobacco Cessation • Pharmacy-Integrated Care Teams • Colorectal Cancer Screening
Yamhill Community Care Organization	• ED Utilization • Increased Adoption of Patient-Centered Primary Care Home Engagement (PCPCH) Model • Hepatitis C Screening and Treatment

CCO-Specific PIPs and Focus Study Review Results

The CCO-specific PIPs and focus studies addressed a wide range of topics, as noted in Table 7-5 above. While the CCOs reported extensive updates on improvement strategies and activities from Quarter 2 to third quarter, HSAG identified similar areas of strengths and areas for improvement during the progress

review for each quarter. Detailed descriptions of strengths and areas for improvement for each CCO-specific PIP and focus study are provided in *Appendix A. MCE Profiles*.

HSAG identified the following three strengths common across the CCO-specific PIP and focus study progress reports:

1. The problem statement for the project was clearly stated and aligned with one of the OHA-required seven clinical focus areas.
2. Interventions were logically linked to study indicators.
3. The CCOs addressed and documented the resolutions to barrier identified during intervention implementation.

HSAG identified the following four common areas for improvement for the CCOs, based on progress report documentation:

1. CCOs did not fully document a measurement and data collection plan for the study indicators.
2. CCOs did not describe a comprehensive, up-to-date causal/barrier analysis process for guiding improvement activities.
3. CCOs documented incomplete aim statements for some projects.
4. CCOs did not sufficiently document intervention evaluation results and how evaluation results guided intervention next steps.

8. Performance Measure Validation

Overview

In accordance with 42 CFR §438.330(c), states must require that managed care organizations (MCOs) submit performance measurement data as part of their quality assessment and performance improvement programs. The validation of performance measures is one of the mandatory external quality review (EQR) activities that the state Medicaid agencies are required to perform per the Medicaid managed care regulations as described in 42 CFR §438.358(b)(2).

The purpose of performance measure validation (PMV) is to assess the accuracy of performance measures reported and determine the extent to which the reported rates follow the measure specifications and reporting requirements. According to CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012,[8-1] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not an MCO, or an EQRO.

In accordance with CMS' EQR Protocol 2, OHA selected HSAG to evaluate the accuracy and validity of OHA's calculation of the performance measure rates for the 15 CCOs. OHA identified a set of six incentive performance measures for validation, and HSAG's PMV activities were performed during calendar year 2018. OHA's performance measure rate calculations were based on administrative data only (i.e., enrollment and claims/encounters) for the calendar year 2017 measurement period. An overview of the PMV activities and findings are included in the sections below.

Performance Measures for Validation

HSAG validated rates for a set of performance measures that were selected by OHA for validation. These measures represented HEDIS-like measures and measures developed by OHA. The measures were calculated by OHA for the CCOs on an annual basis. Table 8-1 lists the performance measure indicators that HSAG validated.

Table 8-1—List of Performance Measure Indicators for Oregon Health Authority

Performance Measure
Adolescent Well Care Visits

[8-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 30, 2018.

Performance Measure
Ambulatory Care: Emergency Department (ED) Utilization
Dental Sealants
Developmental Screening in the First There Years of Life
Effective Contraceptive Use
Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up

Review Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV Protocol. To complete the validation activities for OHA, HSAG obtained a list of the performance measures for validation.

HSAG prepared a document request letter that was submitted to OHA outlining the steps in the PMV process. The document request letter included a request for the source code for each performance measure, a completed Information Systems Capabilities Assessment Tool (ISCAT), additional supporting documentation necessary to complete the audit, a timeline for completion, and instructions for submission. When requested, HSAG addressed ISCAT-related questions directly from OHA during the pre-onsite phase.

At least two weeks prior to the onsite visit, OHA and HSAG finalized the agenda for the onsite visit, which described all onsite activities and indicated the type of staff members needed for each session. HSAG also conducted a pre-onsite conference call with OHA to discuss onsite logistics and expectations, important deadlines, outstanding documentation, and answered questions from OHA.

Validation Team

The HSAG PMV team was composed of a lead auditor and several validation team members. HSAG assembled the team based on the skills required for the validation and requirements of OHA. Some team members, including the lead auditor, participated in the onsite meetings at OHA; others conducted their work at HSAG's offices.

Technical Methods of Data Collection and Analysis

The CMS PMV Protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how it was analyzed by HSAG:

- **Information Systems Capabilities Assessment Tool (ISCAT):** OHA completed and submitted an ISCAT of the required measures for HSAG's review. HSAG used the responses from the ISCAT to complete the pre-onsite assessment of information systems.
- **Source code (programming language) for performance measures:** OHA calculated the performance indicators using source code and was required to submit the source code used to generate each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). If OHA did not use source code to generate the performance measures, they were required to submit documentation describing the steps taken for the calculation of each of the required performance measures.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow up.

Onsite Activities

HSAG conducted an onsite visit with OHA. HSAG collected information using several methods including interviews, system demonstration, review of data output files, observation of data processing, and review of data reports. The onsite visit activities are described as follows:

- **Opening session:** The opening session included introductions of the validation team and key staff members from OHA involved in the PMV activities. The review purpose, required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT and supportive documentation:** This session was designed to be interactive with key staff members from OHA, so the validation team could obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, and claims system and processes:** The evaluation included a review of the information systems, with a focus on the processing of claims and encounters, enrollment and disenrollment data, and provider data. HSAG conducted interviews with key staff members familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key staff members included executive leadership, enrollment specialists, business analysts, and data analytics staff members familiar with the processing, monitoring, and generating of the performance measure.
- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, an analysis of how all data sources were combined, and a review of

how the analytic file was produced for the reporting of the selected performance indicators. HSAG also addressed data control and security procedures during this session.

- **Closing conference:** The closing conference included a summation of preliminary findings based on the onsite visit and the review of the ISCAT. In addition, the documentation requirements for any post-onsite visit activities were reviewed.

Post-Onsite Activities

Following the onsite visit, HSAG performed the following post-onsite activities:

Primary Source Verification (PSV): HSAG used PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. OHA provided a listing of the data reported from which HSAG selected sample records.

HSAG selected a random sample from the submitted data and reviewed the date in OHA's systems during the onsite review for verification. This method provided OHA an opportunity to explain their processes as needed for any unique, case-specific nuances that may have impacted final measure reporting. There were specific instances in which a sample case was acceptable based on onsite clarification and follow-up documentation provided by OHA.

Using this method, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that OHA have system documentation that supports the inclusion of the appropriate records for measure reporting.

This method did not rely on a specific number of cases reviewed to determine compliance; rather, it was used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Submission of any remaining supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow up.

Validation Results

Based on all validation activities, HSAG determined results for each performance indicator. The CMS Performance Measure Validation Protocol identifies two possible validation finding designations for performance indicators, which are defined in Table 8-2.

Table 8-2—Designation Categories for Performance Indicators

Report (R)	Indicator was compliant with the measure specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to measure for which (1) the rate was materially biased or (2) OHA chose not required to report the measure.

According to the protocol, the validation finding for each indicator is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of "NR" because the impact of the error biased the reported performance indicator by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of "R."

Table 8-3 lists the validation result for each performance measure indicator for OHA.

Table 8-3—Performance Measure Validation Ratings

Performance Measure	Validation Result
Adolescent Well Care Visits	*R*
Ambulatory Care: Emergency Department (ED) Utilization	*R*
Dental Sealants	*R*
Developmental Screening in the First There Years of Life	*R*
Effective Contraceptive Use	*R*
Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	*R*

Recommendations

In summary, all six performance measure indicators in the scope of HSAG's PMV activities for calendar year 2018 were given a validation result of Report (R) indicating that the measures were compliant with the measure specifications and the rates can be reported. For the measure selected for PMV, HSAG did not identify any issues or concerns with the accuracy or validity of OHA's calculation of the performance measure rates.

9. Delivery System Network Evaluation

Overview

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in the 42 CFR §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While this protocol is scheduled to be released in 2018, time/distance analysis described in this report aligns with current federal regulations and will help prepare HFS to meet the network adequacy validation requirements once the provisions go into effect.

Current network adequacy assessment work is done by evaluating annual integrated DSN reports, which consist of two components, a Provider Narrative Report and a Provider Capacity Report, required to be submitted to OHA by each CCO on July 1st every year. OHA requested HSAG provide a comprehensive review of the 2018 CCO DSN reports with findings regarding provider capacity compliance in accordance with the state's standards for access to care, network adequacy to provide covered services to all enrollees, and strengths and gaps regarding the delivery system network. HSAG presented these findings in a preliminary 2018 DSN Evaluation Report for CCOs to review and have an opportunity to provide feedback. This feedback will be considered and incorporated into the final report as appropriate.

DSN Evaluation Objectives and Methodology

Based on the requirements outlined in the OHA 2018 CCO Health Plan Services Contract Exhibit G (1)(a)(b), HSAG developed a DSN Evaluation Report that provided OHA with an evaluation and findings on CCO network compliance with established network standards and timely access to care and services requirements. To conduct the evaluation, HSAG reviewed:

1. Each CCO's DSN Narrative Report and supplemental documentation.
2. Distribution and documentation of each CCO's inventory of each provider and facility.

HSAG reviewed each CCOs DSN Narrative Report, assessed each category, and evaluated the elements of each category. Elements evaluated received a score ranging from 0 (*Not Met*) to 3 (*Fully Met*) based on the scoring criteria defined in Table below. Element scores were then aggregated into category scores and an overall summary score.

Table 9-1—DSN Provider Narrative Report Scoring Criteria

Score	Score Description	Score Definition
0	Not Met	No discussion of topic
1	Partially Met	Discussion minimally addresses topic
2	Substantially Met	Discussion adequately addresses topic
3	Fully Met	Discussion comprehensively addresses topic

The points possible for each narrative report category is outlined in Table 9-2—DSN Provider Narrative Report Categories below. A maximum of 78 total points was possible across all five categories.

Table 9-2—DSN Provider Narrative Report Categories

Category Number	Category	Number of Elements	Maximum Points
1	Description of the Delivery Network and Adequacy	12	36.0
2	Description of Members	3	9.0
3	Additional Analysis of the CCO's Provider Network to Meet Member Needs	4	12.0
4	Coordination of Care	5	15.0
5	Performance on Metrics	2	6.0
	Totals	**26**	**78.0**

Note: *Maximum points possible differs from the 2017 DSN Evaluation due to variations in the scoring of elements. Rather than adding scoring for select sub-elements, HSAG scored the narrative categories at the element level.*

HSAG also assessed the quality and completeness of CCO provider networks using submitted 2018 DSN Provider Capacity Reports. HSAG processed, cleaned, and assessed each CCOs' compliance with the required provider file layout, as well as aggregate counts of providers by category of service and key demographics. While the DSN Provider Capacity Reports were not directly scored, HSAG conducted comparative evaluations across CCOs and highlighted variations in the quality and completeness of data.

DSN Evaluation Results

Results of the 2018 DSN Evaluation were not yet finalize at the time this report was developed; however, preliminary results suggest the overall aggregate performance across the CCOs was fair but revealed several areas for improvement. One major area for improvement identified was the need to align and standardize DSN reporting. Reporting recommendations are identified below.

DSN Provider Narrative Report Recommendations

HSAG recommends OHA make adjustments to the required DSN Provider Narrative Report Template to minimize inconsistent interpretations of the elements and ambiguity around the appropriate type of supplemental documentation. These adjustments include:

- Aligning Category Elements with Requirements.
- Identifying Elements that Require Specific Responses.
- Including Proper Citations.
- Indicating when Supporting Documentation is Necessary.

DSN Provider Capacity Report Recommendations

HSAG recommends that OHA consider revisions to the Provider Capacity Report Template and to improve the accuracy of network capacity data submitted to the state. CCO adherence to clearer guidelines will result in the submission of more consistent and accurate provider and facility inventories. Specific recommendations include:

- Expanding the Categories of Services List.
- Utilizing the Standardized Healthcare Provider Taxonomy Code Set.
- Establishing a Standardized Provider File Layout (PFL) with an Instruction Manual.
- Conducting CCO Training on Proper Provider Capacity Reporting.
- Establishing Compliance Expectations.
- Expanding the Provider Capacity Report for Broader Use

10. Recommendations

Overview

HSAG used its analyses and evaluations of EQR activity findings and conclusions from the 2018 review period to develop overarching recommendations for the OHA. For more detailed discussion of the strengths, weaknesses, conclusions, and recommendations for the OHA and its MCEs, please refer to Sections 5 through 9 of this report. There are additional findings detailed by MCE in *Appendix A. MCE Profiles*. Below are the overarching recommendations by EQR Activity.

Overarching Recommendations

Compliance with Standards

- **Documentation:** Across the MCEs, clear documentation on processes and delegation activities was not demonstrated. For many MCEs, policies were in place that provided evidence of activities being conducted, but the procedural detail, timeframes, and roles and responsible parties was lacking. In some cases, the applicability of policies was also unclear due to policies not including the MCE's name or accompanied by clear delegation agreements when they are directed from a delegate. Documentation (e.g., policies and procedures, contracts, etc.) should be developed and maintained to clearly and effectively define MCE operational and delegated activities, ensuring compliance with regulations and contractual provisions related to Medicaid members.
- **Care Coordination and Treatment Plans:** While coordination of care occurs at the MCE level, most MCEs did not provide evidence of formalized care plans, the incorporation of other providers' treatment plans, or the periodic monitoring of those plans. This was also true of care coordination for SHCNs members in that they receive intensive care coordination as necessary across the MCE, but without a formal plan. In most cases, proper identification of member diagnoses and tracking of these individuals was not evident. Member assessments also varied greatly, with some allowing for a more member-focused experience than others. Additionally, the systems most MCEs are using allow the tracking of care coordination in the form of notes, but do not clearly contain care plan information, specific diagnostic/referral criteria, treatment goals or a crosswalk of care activities with claims. OHA can work with MCEs to provide guidance on care planning and effective care coordination system functionality. It is additionally necessary for MCEs to be able to properly identify and track individuals with SHCNs to proactively ensure they are receiving the services they need.
- **Ensuring Coverage at No Cost:** The MCEs provided evidence of member handbooks and provider manuals that identified coverage for emergency/post/stabilization services and second opinions for OHP members. However, documentation provided lacked clear detail on the extent of liability for payment of such covered services outside of separate language stating members should contact the CCO should they receive a bill for services in general. MCEs should ensure their documentation is

clear regarding members' liability for payment of covered services. Additionally, MCEs should monitor payment denials for covered services to ensure they are occurring appropriately.

- **Appropriate Provider Selection Policies:** While most of the MCEs have and follow robust credentialing policies, some of them do not have credentialing policies at the MCE level when fully delegating that activity to another organization and as such, do not monitor those activities. As part of provider selection, many MCEs noted they ensure a non-discriminatory provider compensation structure by not adjusting the fee schedule by provider type for payment of covered services. Efforts should be made to directly ensure that policies are in place to mitigate issues of discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- **Comprehensive Practice Guidelines:** While the MCEs utilized HERC guidelines and guidances contained within the State's prioritized list, along with developing select guidelines for the treatment of specific conditions, several MCEs could not demonstrate the adoption or maintenance of a comprehensive set of clinical practice guidelines based on valid and reliable clinical evidence for the services they provide to their members. Additionally, most of the MCEs could not demonstrate evidence of disseminating adopted guidelines to providers, or to member upon request. MCEs should be aware the HERC guidelines and the guidances contained in the prioritized lists do not comprehensively address all conditions and should not be the only source of guidelines used to provide care for their members. MCEs should also have a mechanism to appropriately disseminate adopted practice guidelines to providers, and to members upon request.
- **Delegation Accountability:** OHA should continue working with MCEs on identifying clear expectations for oversight activities is needed to ensure that accountability. The concept of the care coordination brings together a broad array of organizations that partner together in order to integrate care across physical, behavioral, and oral health for Medicaid members. While this integration can enhance quality of care for members, the complexity of managing those partnerships may lead to a decrease in quality due to a lack of clarity in expectations and oversight. Many of the Oregon MCEs have contractual relationships with delivery partners that are clear, but the monitoring of delegated activities is being done inconsistently, in a way that does not define what is being reviewed on a regular basis, and not at all in some cases. MCEs are ultimately accountable for all activity subcontracted or delegated to other organizations or providers.

Information Systems Capability Assessment

- **Documentation:** HSAG recommends that MCEs document policies and procedures to the extent possible. While MCE staff demonstrated knowledge and experience with the majority of processes in place to manage Medicaid data and information systems, they lacked documented policies and procedures for some elements. The availability of documentation (e.g., policies and procedures, plans, practices, contracts, etc.) is critical to ensuring operational procedures and guidelines are available to guide health care operations as well as training and monitoring of staff performance.
- **Providing Security Guidance:** Ensuring the security of information systems and media devices, integrity of its data repositories, system recovery and incident mitigation strategies, and monitoring of subcontractors and partners are key components of managing health care IT infrastructure. While MCEs provided evidence of documented policies, procedures and plans associated with BC/DR and

IR plans, the efficacy or outcome of the plans had not been tested by the time of the 2018 ISCA onsite reviews. There was also no evidence that appropriate procedures were followed in the event of a suspected or confirmed breach of unsecured protected health information. Additionally, several MCEs could not demonstrate evidence of a current SS plan that covers all IT functions, systems, and equipment. OHA should work with MCEs to provide guidance in the area of IT security applicable to OHA contract and Health Insurance Portability and Accountability Act requirements.

- **Ensuring Vendor Management:** Many of the MCE's delegation agreements and subcontracts contained specific information regarding the data security, processing, and reporting requirements related to Medicaid data, separate policies and procedures but did not always support and define organizational operations and management of outsourced data processing. Additionally, some MCEs could not demonstrate ongoing monitoring and trending of data and calculations related to performance measures provided by delegates. MCEs are ultimately accountable for all activities subcontracted or delegated to other entities. Efforts should be made to directly ensure that MCEs clearly define expectations and accountability for oversight of contracted vendors responsible for ISCA related activities.
- **Streamlining the ISCA:** The ISCA included an evaluation tool listing the standards and elements for review, preliminary questions, and documentation requirements to guide the MCE's submission of compliance information. HSAG recommends these materials and the ISCA activity be streamlined for clarity and alignment with State and federal requirements to ensure submission represents a more focused review the MCEs' information systems and data processing and reporting procedures to determine the extent to which the MCE maintains the capacity to manage the health care of its members and support the collection, management, and use of valid and reliable data.

Performance Improvement Projects

- **Quarterly Progress Report Redesign:** HSAG recommends that OHA consider a re-design of the quarterly PIP progress report template to better align with CMS' protocols,[10-1] support clearer documentation of PIP activities by the CCOs, and facilitate more effective technical assistance.
- **Feedback to CCOs on Quarterly Progress Reports:** HSAG recommends that OHA consider sharing HSAG's written feedback on the quarterly Statewide PIP progress reports directly with the CCOs to facilitate communication and technical assistance opportunities.
- **Analysis to Guide Development of the New Statewide PIP:** HSAG recommends that OHA work with the CCOs to analyze recent statewide data trends, lessons learned from the current Statewide PIP on improving the safety of opioid management, and input from key stakeholders, members, and providers to guide development of the new Statewide PIP focused on acute opioid prescribing.

[10-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Nov 6, 2018.

- **Work with CCOs on Statewide PIP Topic and Goals:** HSAG recommends that OHA work with the CCOs to ensure the topic, measures, and goals for the new Statewide PIP focused on acute opioid prescribing are clearly defined to address requirements in CMS' protocols.[10-2]
- **Ensuring Improvement Strategies Directly Impact Defined Outcome Measures:** HSAG recommends that OHA work with the CCOs to ensure the improvement strategies developed for the new Statewide PIP on acute opioid prescribing address barriers identified through root cause analysis and can be expected to directly impact the outcome measures defined for the PIP.

Performance Measure Validation

There are no recommendations for this activity as all six performance measure indicators in the scope of HSAG's PMV activities for calendar year 2018 were given a validation result of Report (R) indicating that the measures were compliant with the measure specifications and the rates can be reported.

Delivery System Network Evaluation

- **Standardizing DSN Reporting:** HSAG recommends further standardization of OHA DSN reporting templates to ensure alignment with contractual provisions, minimize inconsistent interpretations of the elements, and reduce ambiguity around appropriate types supplemental documentation. This should include expanding the categories of service list, using the Standardized Healthcare Provider Taxonomy Code Set, and establishing a PFL with an Instruction Manual.
- **Technical Assistance to CCOs:** Due to inconsistencies in CCO reporting of DSN data elements, OHA should provide additional DSN reporting guidance in the form of technical assistance on compliance expectations and proper reporting.

[10-2] ibid.

Appendix A. MCE Profiles

Advanced Health

Advanced Health External Quality Review Results	
Based in Coos Bay, Advanced Health provides physical, behavioral and dental health services to OHP members in Coos and Curry counties. Southwest Oregon IPA (SWOIPA) administers all CCO activities for AH. AH 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. AH contracts with MedImpact as the pharmacy benefit manager. The CCO also contracts with Bay City Brokerage to provide NEMT to its members.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Partially Met (2.67)
Standard III: Coordination and Continuity of Care	Partially Met (1.90)
Standard IV: Coverage and Authorization of Services	Substantially Met (3.14)
Standard V: Provider Selection	Substantially Met (3.33)
Standard VI: Subcontractual Relationships and Delegation	Not Met (1.00)
Standard XI: Practice Guidelines	Partially Met (2.67)
Standard XII: Quality Assessment and Performance Improvement	Fully Met (3.63)
Overall Strengths and Areas for Improvement	
Strengths: AH's greatest area of strength was its QAPI program and demonstrated an ability to collect, report, and analyze data to measure performance against goals and benchmarks, specifically in addressing utilization of services. Additionally, AH has developed innovative approaches to assess the quality and appropriateness of care furnished to SHCN members, such as partnering with nursing and rural health college programs to provide home visits to members with uncontrolled diabetes. Other notable areas of strength included an innovative approach to reducing dental-related ED visits, timely authorization decisions, and following a documented process for individual provider credentialing and recredentialing. **Areas for Improvement:** While staff were notably knowledgeable, AH's written documentation lacked essential detail and was also labeled inconsistently with either the CCO's legal name or that of one of its delegates, making it difficult to understand their applicability. Similarly, AH's documentation of its organizational structure and the extent of its delegated managed care functions lacked clarity and consistency and was, in some cases, not provided by the CCO. This resulted in the inability to fully assess AH's compliance in areas related to subcontracts and delegation oversight.	
Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.00)**
1. Staffing	Fully Met (3.67)
2. Meaningful Use of Electronic Records	Partially Met (2.00)

Advanced Health External Quality Review Results	
3. Configuration Management	Fully Met (4.00)
4. Member Enrollment Systems	Substantially Met (3.20)
5. Information Systems	Fully Met (3.75)
6. Security	Partially Met (2.70)
7. Provider Data	Fully Met (3.74)
8. Data Integration	Partially Met (1.75)
9. Report Production	Substantially Met (3.33)
10. Vendor Management	Partially Met (2.50)
11. Administrative Data	Substantially Met (3.25)

Overall Strengths and Areas for Improvement

Strengths: AH received an overall ISCA rating of Substantially Met and demonstrated its implementation of comprehensive set of policies, procedures, and processes that govern its information systems, that data it manages, and subsequent reporting. In particular, AH's ISCA responses, network diagrams, and IT systems subcontracts documented compliant policies and procedures that governed system configuration, maintenance, and operation of CCO networks. Moreover, its system security plan addressed all key IT systems (hardware and software) and operations and was augmented by a set of individual policies and procedures to governed access, management, and security of data and network systems. In addition to documented policies and procedures, AH staff were able to articulate its documented processes and provide examples of monitoring reports that support its oversight of managed care operations.

Areas for Improvement: Despite receiving a Substantially Met rating across all ISCA sections, there was considerable variability in AH's performance across the individual sections indicating an opportunity for improvement with ISCA scores ranging from 1.75 (Partially Met) to 4.00 (Fully Met). Overall, AH staff demonstrated knowledge and experience with the majority of processes, and its staff were able to describe processes in place to manage Medicaid data and information systems, but lacked documented policies and procedures for some elements. The availability of documented processes is critical to ensuring operational procedures and guidelines are available to guide health care operations as well as training and monitoring of staff performance.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Participation in an advisory group, an education workgroup, a pain management modalities workgroup, a CCO collaborative, a heroin town hall opiate work group, and a community drug take-back and disposal workgroup.
- Conducting a pain symposium.
- Expanding availability of naloxone and educating providers, pharmacists, first responders, and patients.
- Development of a MED dashboard displaying members' daily MED levels.
- Offering medication-assisted treatment options.

Overall Strengths and Areas for Improvement

Advanced Health External Quality Review Results
Strengths: • The CCO documented interventions and/or quality improvement activities conducted during the quarter. • The CCO addressed and documented the resolution(s) to barriers identified during the intervention's implementation. **Areas for Improvement:** • Document the aim statement, target population, and outcome measures in the progress report, and align with the statewide specifications for the PIP. • Document the interventions for the PIP the activities and improvement strategies undertaken through collaboratives, committees, and workgroups and which are expected to directly impact study indicator outcomes. • Provide complete descriptions of interventions, demonstrating potential impact on study indicator outcomes. • Have evaluation processes in place to determine intervention-specific effectiveness and impact of individual interventions on the study indicator outcomes. The CCO should begin evaluating effectiveness of an intervention as soon as the intervention is deployed and should report intervention-specific evaluation results for each intervention quarterly. • Provide accurate and up-to-date data on all measures required for the statewide PIP. • Report numerators, denominators, and percentages for outcome measures rather than percentages.
CCO-Specific PIP/Focus Study
• Reducing preventable ED utilization • One key question implementation • Increasing colorectal cancer screening rate in Coos and Curry counties

AllCare Health

AllCare External Quality Review Results
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 NEMT; and with MedImpact for pharmacy benefit management.

Compliance with Regulatory and Contractual Standards

Compliance Standard	Score (Out of 4.00)
Standard I: Availability of Services	Substantially Met (3.17)
Standard III: Coordination and Continuity of Care	Partially Met (2.30)
Standard IV: Coverage and Authorization of Services	Substantially Met (2.86)
Standard V: Provider Selection	Substantially Met (3.33)
Standard VI: Subcontractual Relationships and Delegation	Fully Met (4.00)
Standard XI: Practice Guidelines	Partially Met (2.67)
Standard XII: Quality Assessment and Performance Improvement	Fully Met (4.00)

Overall Strengths and Areas for Improvement

Strengths: AllCare's greatest area of strength was related to the QAPI Standard, which achieved a *Fully Met* rating. Specific to QAPI, AllCare coordinated training and listening sessions related to health equity and cultural competency that effectively informed its quality priorities. The CCO produced and delivered training for staff and providers in health equity, health literacy, and cultural humility. This included facilitating listening sessions that highlighted the voices and perspectives of members of diverse cultural and ethnic groups, including Native Americans and individuals with Serious and Persistent Mental Illness. Data and insight collected from these groups informed AllCare in its planning and implementation of performance improvement projects and annual quality priorities, including the design of the 2018 Transformation and Quality Strategy. AllCare also displayed strength in its efforts to direct and manage the training of additional qualified interpreters to serve residents of the Josephine, Jackson, Curry, and Douglas county regions. The AllCare offices, where much of the trainings and outreach events were conducted, also served as a community resource that could be used by local non-profit groups for non-CCO activities that relate to the organization's mission and vision.

Other notable areas of strength include the following:

- Adherence to standard and expedited service authorization standards and timely notice as evidenced during the onsite record review process;
- Evidence of a daily monitoring and interrater reliability process to make sure timely authorization standards were consistently upheld;
- Clear policies and procedures outlining evaluation of AllCare subcontractors, and written agreements specifying managed care activities that are delegated; and,

- Adoption of several clinical practice guidelines for the management and treatment of members with certain health conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, mental health, and substance use disorders.

Areas for Improvement: HSAG identified care coordination and continuity of care as an area in need of improvement. While AllCare had care coordination policies that included conducting health risk assessments and care planning activities, there was an absence of detail regarding the frequency of member care plan monitoring. Care plans reviewed onsite listed only general information about members' conditions without a comprehensive plan for the care of all of the members' conditions or consensus from each of the members' providers.

Other areas for improvement include the following:

- Consideration of the anticipated enrollment of Medicaid members and Medicaid-Medicare (dual) eligible members when establishing and maintaining the CCO provider network;
- Monitoring the use of emergency services for inappropriate or avoidable use that was related to a lack of access to routine care;
- Revising the Clinical Practice Guidelines policy to explain the process for adopting clinical practice guidelines and for consulting with health care professionals during the adoption and revision process; and,
- Ensuring a nondiscriminatory process for compensating providers in the CCO's policies and procedures.

Information Systems Capabilities Assessment

ISCA Section	Score (Out of 4.0)
1. Staffing	Substantially Met (3.33)
2. Meaningful Use of Electronic Records	Substantially Met (3.00)
3. Configuration Management	Fully Met (4.00)
4. Member Enrollment Systems	Fully Met (4.00)
5. Information Systems	Fully Met (3.75)
6. Security	Partially Met (2.70)
7. Provider Data	Fully Met (3.83)
8. Data Integration	Partially Met (1.75)
9. Report Production	Substantially Met (3.00)
10. Vendor Management	Substantially Met (3.33)
11. Administrative Data	Substantially Met (3.38)

Overall Strengths and Areas for Improvement

Strengths: AllCare received an overall ISCA rating of *Substantially Met* and demonstrated its implementation of comprehensive set of policies, procedures, and processes that govern its information systems, that data it manages, and subsequent reporting. In particular, AllCare's ISCA responses, network diagrams, and IT systems documented compliant policies and procedures that governed system configuration, maintenance, and operation of the CCO networks. While paper documentation

was comparatively limited, AllCare's IT team had implemented an integrated system of software and reporting dashboard to manage, monitor, report, and address IT-related activities. The CCO's systems have led to an effective suite of tools to manage the CCO's managed care operations.

Areas for Improvement: Despite receiving a *Substantially Met* rating across all ISCA sections, there was some variability in AllCare's performance across the individual sections indicating an opportunity for improvement with ISCA scores ranging from 1.75 (*Partially Met*) to 4.00 *(Fully Met).* Overall, AllCare staff demonstrated knowledge and experience with the majority of processes, and its staff were able to describe processes in place to manage Medicaid data and information systems, but lacked documented policies and procedures for many elements. The availability of documented processes is critical to ensuring operational procedures and guidelines are available to guide health care operations as well as training and monitoring of staff performance.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Review of pre-service opioid request and request for other modality treatments.
- Implemented new post-op management policy.

Overall Strengths and Areas for Improvement

Strengths:

- The problem statement was clearly stated and aligned with one of the seven clinical focus areas.
- Interventions were logically linked to the outcome measures.

Areas for Improvement:

- Align the measures in the progress report with the specifications for the statewide PIP.
- Provide numerators and denominators for raw data reported.
- Provide accurate, up-to-date data on all measures required for the statewide PIP.
- Provide complete documentation of quality improvement activities and processes.
- Provide the date of implementation for each intervention.
- Provide complete descriptions of intervention evaluation methodologies and data.
- Provide complete descriptions of each intervention.
- Provide the rationale supporting the next steps and intervention status.
- Provide complete descriptions of how barriers were addressed and overcome or resolved.
- Define acronyms used.

CCO-Specific PIP/Focus Study

- Colorectal cancer screening
- Adolescent well visit
- Effective contraceptive care

Cascade Health Alliance, LLC

Cascade Health Alliance, LLC	
CHA is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to OHP members in Klamath county. Based in Klamath Falls, CHA contracts with Klamath Basin Behavioral Health, BestCare Treatment Services, and Transformations Wellness Center to provide behavioral health and substance abuse treatment and related functions. CHA delegates pharmacy benefit management to MedImpact, mediation services to Excelsior Solutions, data and analytics to PH Tech, and NEMT to Sky Lakes Medical Center, TransLink, and Klamath Medical Transport.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Fully Met (4.00)
Standard III: Coordination and Continuity of Care	Partially Met (2.40)
Standard IV: Coverage and Authorization of Services	Fully Met (3.71)
Standard V: Provider Selection	Substantially Met (3.33)
Standard VI: Subcontractual Relationships and Delegation	Fully Met (4.00)
Standard XI: Practice Guidelines	Substantially Met (3.33)
Standard XII: Quality Assessment and Performance Improvement	Substantially Met (3.00)
Overall Strengths and Areas for Improvement	

Strengths: CHA's greatest areas of strength included a well-rounded approach to providing education for and collaborating with community partners and providers, adoption of nationally-accepted best practices that ensure improved quality of care, and oversight of delegates through comprehensive agreements and communication.

CHA's efforts to educate providers on clinical best practices are also noteworthy. It was noted that when outcomes fell outside of expected treatment norms, providers were engaged and educated regarding accepted practice guidelines in the respective treatment area. From inviting subject matter experts on chronic obstructive pulmonary disease to speak to providers about treatment strategies to providing widespread communication about managing the shortage of EpiPens, CHA exceeded expectations in community collaboration and education by taking a proactive posture.

- Other notable areas of strength include:
- Ensuring all appealed denials of dental services that are reviewed by the CCO's delegates are further reviewed by CHA, and
- Partnering with local resources to offer services such as afterschool care for children and healthy food programs, including delivery of fresh produce to community members in need, and investing in the community's parks.

Areas for Improvement: While CHA described significant progress in the development and dissemination of a comprehensive provider manual, many policies and procedures were only recently developed, and their implementation could not be assured. Other policies and procedures could be bolstered, including defining nondiscrimination in provider compensation and steps to proactively track payment denials for emergency and post-stabilization services.

Cascade Health Alliance, LLC	
While it was clear that communication amongst providers and thoughtful assignment of case managers based on members' individual needs was occurring, CHA has an opportunity to improve the quality of its care coordination approach. The CCO should ensure it engages providers, case managers, and members in developing fully integrated formalized care plans with clearly delineated objectives and roles, and a mechanism to regularly monitor progress. This would also increase efficiency and prevent duplication of efforts. Clearly identifying the SHCN population would aid in care coordination prioritization, as would full implementation of the CHA's draft screening tool for new members.	
Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.00)**
1. Staffing	Fully Met (4.00)
2. Meaningful Use of Electronic Records	Partially Met (2.00)
3. Configuration Management	Fully Met (4.00)
4. Member Enrollment Systems	Fully Met (4.00)
5. Information Systems	Fully Met (3.75)
6. Security	Fully Met (4.00)
7. Provider Data	Fully Met (4.00)
8. Data Integration	Fully Met (3.75)
9. Report Production	Fully Met (3.67)
10. Vendor Management	Fully Met (4.00)
11. Administrative Data	Substantially Met (3.38)
Overall Strengths and Areas for Improvement	
Strengths: CHA received an overall ISCA rating of *Fully Met* and provided evidence of its implementation of a comprehensive set of policies, procedures, and processes to govern its information systems, that data it manages, and subsequent reporting. In particular, CHA's ISCA responses, network diagrams, and IT infrastructure demonstrated compliant policies and procedures related to the configuration, maintenance, and operation of the CCO's networks and its collaborative relationships with external IT vendors. Moreover, its system security plan addressed all key IT systems (hardware and software) and operations and was augmented by a set of individual policies and procedures to governed access, management, and security of data and network systems. In addition to documented policies and procedures, CHA staff were able to articulate its documented processes and provide examples of monitoring reports that support its oversight of managed care operations. **Areas for Improvement:** Despite receiving a *Fully Met* rating across all ISCA sections, scoring for several elements indicated an opportunity for improvement with five of the ISCA scores falling below 4.00 (i.e., ranging from 2.00 (*Partially Met*) to 3.75 *(Fully Met).* Overall, CHA staff demonstrated knowledge and experience through the implementation of robust policies and procedures, augmented by its staff member's ability to describe the processes in place to manage Medicaid data and information systems. In most cases, modification to existing policies and procedures will be sufficient to addresses the identified deficiencies.	
Performance Improvement Projects (PIPs)	
Statewide PIP on Opioid Safety	

Cascade Health Alliance, LLC

Interventions:

- Collaboration with Sky Lakes Medical Center to establish a pain management/navigation services program.
- Add alternative treatment options to the formulary and approved treatment options.
- Participates in the southern Oregon collaborative, advisory group, and community education workgroup,
- Distributes training video links for patient services representatives and support staff.
- Considering MAT induction in the ED.

Overall Strengths and Areas for Improvement

Strengths:

- The problem statement was clearly stated and aligned with one of the seven clinical focus areas.
- Interventions and/or quality improvement activities were conducted during the quarter.
- Rationale supporting the quarterly status selected for the PIP was provided.

Areas for Improvement:

- The aim statement, target population, and outcome measures documented in the progress report should align with the statewide specifications for the PIP.
- Document as the interventions for the PIP the activities and improvement strategies undertaken through collaboratives, committees, and workgroups and which are expected to directly impact study indicator outcomes.
- Provide complete descriptions of interventions, demonstrating potential impact on the study indicator outcomes.
- Have evaluation processes in place to determine intervention-specific effectiveness and impact of individual interventions on the study indicator outcomes. The CCO should begin evaluating effectiveness of an intervention as soon as the intervention is deployed and should report intervention-specific evaluation results for each intervention quarterly.
- Provide completed descriptions of how barriers were addressed and overcome or resolved.
- Provide accurate and up-to-date data on all measures required for the statewide PIP.
- Report numerators, denominators, and percentages for the outcome measures, rather than reporting only raw numbers.
- Define acronyms used.

CCO-Specific PIP/Focus Studies

- ED Utilization
- Preventive oral health care at all ages
- Tobacco cessation and use prevention

Columbia Pacific CCO, LLC

Columbia Pacific CCO, LLC
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

Compliance Standard	Score (Out of 4.00)
Standard I: Availability of Services	Fully met (3.7)
Standard III: Coordination and Continuity of Care	Partially met (2.6)
Standard IV: Coverage and Authorization of Services	Substantially met (2.9)
Standard V: Provider Selection	Fully met (4.0)
Standard VI: Subcontractual Relationships and Delegation	Fully met (4.0)
Standard XI: Practice Guidelines	Substantially met (3.0)
Standard XII: Quality Assessment and Performance Improvement	Substantially met (3.25)

Overall Strengths and Areas for Improvement

Strengths: CPCCO continues to work on integration and is now placing behavioral health staff in primary care clinics. The CCO is also working on integrating oral health into their medical clinics. They have implemented the "First Tooth" program and is also focusing on oral health for pregnant women. CPCCO is working on creative solutions to their provider recruitment issues. Below are some additional strengths:

- The CCO demonstrated strengths in their credentialing processes.
- The CCO has written agreements for subcontractors that specify required activities and report responsibilities. They actively monitor performance and require corrective action plans for unsatisfactory performance. The CCO audits delegates annually and audits them for compliance with the EQR requirements (not all standards are reviewed or scored ever year as it depends on risk identified by the CCO.
- The CCO is implementing regional care teams to provide support to local coordination activities.
- A Health Equity Advisor staff position was developed. Among other tasks, this individual works with tribal organizations and is developing a language access plan to help members with limited English proficiency with meaningful access.

Areas for Improvement: The CCO delegates responsibilities for dental and behavioral health. The majority of CPCCO policies and processes are not integrated to demonstrate consideration of physical health, dental and behavioral health. Expectations for delegated activities are not included in CPCCO policies.

CPCCO recently updated a policy to use the state's definition of special heath care needs (as defined in the CCO contract with OHA). The CCO needs to operationalize this definition and implement a mechanism to identify

Columbia Pacific CCO, LLC	
and assess these members, and monitor for periodic assessment. The CCO needs to analyze the quality and appropriateness of care furnished to SHCN members. The CCO needs to provide care coordination and develop a way to track members (other than high-cost claims) with special needs even if they are inactive in their care coordination program. The CCO needs to identify these members (e.g., flag after a certain number of claims, members with ongoing congenital issues, etc.) to ensure ongoing appropriate care. In addition, the CCO needs formalize a way to coordinate care with the dental plans.	
Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.0)**
1. Staffing	Partially met (2.7)
2. Meaningful Use of Electronic Records	Not met (1.0)
3. Configuration Management	Fully met (4.0)
4. Member Enrollment Systems	Substantially met (3.4)
5. Information Systems	Substantially met (3.3)
6. Security	Partially met (2.5)
7. Provider Data	Not met (1.2)
8. Data Integration	Not met (1.3)
9. Report Production	Fully met (3.5)
10. Vendor Management	Partially met (2.0)
11. Administrative Data	Partially met (2.1)
Overall Strengths and Areas for Improvement	
Strengths: • Overall, the CCO provided documentation for physical health providers, which is handled by CareOregon. Most of these processes were well documented. • The CCO provides incentives for EHR use for physical health providers through their person-centered primary care home alternative payment methodologies. • The data submission occurs from delegates who process claims and encounters directly to OHA with a copy to the CCO. • Data review and attestation of completeness and accuracy by the CCO's designated staff occurs parallel or after data is submitted to OHA. • The data center where storage and backups occur in Hillsboro demonstrates a best practice in terms of secure data storage/back-ups. A walk through was arranged through CareOregon, which contracts with the facility to store all their data, including the CCO data. The security features and redundancy in power sources are impressive and state of the art. **Areas for Improvement:** • The CCO did not provide documentation regarding dental delegates or monitoring efforts with respect to information systems capabilities. In fact, very few CCO policies were provided, leaving gaps in the CCO	

Columbia Pacific CCO, LLC

processes for their Medicaid membership. A CCO document that identifies what work CareOregon does for the CCO, including how CareOregon does this work and oversight of same, would be very helpful to understand all the processes and oversight of work for the CCO membership.

- The CCO did not provide complete information regarding how productivity goals are set. The CCO did not provide information describing, tracking of training and how programming staff are evaluated.
- Documentation was not submitted demonstrating that EHR use or certification status is tracked for all contracted providers who fall under meaningful use. The CCO's education efforts regarding utilizing EHRs only include physical health providers. No documentation was provided relevant to quality improvement program data sources for dental and behavioral health data for reporting and analytics. Documentation regarding sources, loading, storing and using EHR data was not provided.
- The CCO provided no documentation showing that Medicaid enrollment is verified at the time a service is requested. Also, no documentation was provided showing the CCO's process for when enrollment changes between the time of the service request and time of service.
- HealthInsight Assure reviewers were told that all CCO data is stored in this data center, but no CCO documentation was provided to support this.
- The CCO did not provide documentation regarding monitoring subcontractor and provider security efforts, including monitoring of subcontractors and partners for business continuity/disaster recovery.
- The system security plan document provided is current, but does not include a comprehensive CCO plan and does not include a review or revision date.
- The CCO's security efforts regarding computers, files, portable media were clarified after the CCO reviewed the draft report, which included further explanation. However, the CCO should more adequately document how they meet these criteria.
- The CCO has made efforts to oversee their delegates' provider directories. However, more details are needed regarding processes for handling information flow, writing, submitting and changing delegates' provider directories. Delegates' provider data, updates and change processes, staff training regarding access and change authority, or data storage of provider directories also need continued attention.
- The CCO provided little information regarding provider compensation rules, job roles with access and change authority, fee schedules and compensation rules, how fee schedules are updated by delegates, or any documentation on how Medicaid provider compensation rules are implemented.
- The submitted documents regarding data collection are unbranded and it was not clear who is producing the data and how they are connected to the CCO.
- No documentation was provided on this process including processing lags, maintaining data integrity or evaluation of performance measures. No documentation was provided about data extracts for the CCO's performance metrics or how data extracts are archived for future need.
- The CCO did not provide policies or processes relevant to consolidation of Medicaid data from all sources for performance measurement reporting, including how data integrity is maintained and how claims/processing lags are handled when evaluating performance metrics. The CCO did not describe how data integrity is maintained when consolidating Medicaid claims and encounter data for performance measures.
- No documentation was provided regarding how the CCO ensures accuracy, timeliness and completeness of data, or reports generated from data repositories.
- No documentation was provided on how the CCO validates that all zero/low-dollar claims are submitted by delegates. This was identified as an issue in the provider interviews conducted for this ISCA review.

Columbia Pacific CCO, LLC
• Regarding edits and audits, audit instructions provided are for claims examiners to move to the next audit level (this information does include dental claims). No frequency, audit tool, or policy regarding claims audits was provided. CCO data was not provided for regular audit processing of Medicaid claims and encounters. The audit example provided to HealthInsight Assure for this review was one provider with no mention of the CCO. No mention of frequency of audits was provided. No documentation was provided regarding storing data in a claim/encounter field labelled for different data. • The CCO did not provide documentation demonstrating tracking of claims/encounters for capitated or alternative payment model services. • No information was provided about timeliness, ensuring no delays, adequate staffing to support work, volume of paper claims, documentation of timeliness or process for scanners. There was also no mention of delegates and if they have paper claims, how the CCO is monitoring their work. • No indication that EDV is performed on a regular basis, either by policy or by example and no frequency of EDV audits was documented. This was verified in the provider interviews that were conducted as part of this ISCA review.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Developing an interactive opioid dashboard available to providers and clinic systems allowing them to view information regarding their prescribing patterns on a quarterly basis. • To increase utilization of the pain clinics, billboard and radio ads were developed to advertise the wellness centers in CPCCO. • Quarter three dashboards are being produced and will be sent to primary care clinics along with lists of members with chronic opioid use. • The 2019 summit date has been selected and the space has been reserved. • Community engagement and education efforts overlapped with the Wellness Center intervention through education and awareness campaigns. • OHSU Scappoose continues to provide MAT services that are billable under the CCOs new payment model with GOBHI. • Clatsop county has exchanged: over 150,000 syringes since its inception in October 2017. • Posters to improve community knowledge of how to safely dispose of pills distributed to all Clatsop and Columbia county pharmacies. • Opioid audit process set up with the pharmacy department. • A one-day training for Acceptance and Commitment Therapy (ACT) for our mental health partners was scheduled and will be held October 30th.
Overall Strengths and Areas for Improvement
Strengths: • The problem statement was clearly stated and aligned with one of the seven clinical focus areas. **Areas for Improvement:**

Columbia Pacific CCO, LLC
• Align the aim statement, target population, and outcome measures documented in the progress report with the statewide specifications for the PIP. • Document the activities and improvement strategies undertaken through collaboratives, committees, and workgroups that are expected to directly impact study indicator outcomes. • Provide complete descriptions of interventions, demonstrating potential impact on study indicator outcomes. • Have evaluation processes in place to determine intervention-specific effectiveness and impact of individual interventions on the study indicator outcomes. The CCO should begin evaluating effectiveness of an intervention as soon as the intervention is deployed and should report intervention-specific evaluation results for each intervention quarterly. • Provide complete descriptions of how barriers were addressed and overcome or resolved. • Provide accurate and up-to-date data on all measures required for the statewide PIP. • Report numerators, denominators, and percentages for the outcome measures rather than reporting only raw numbers. • Define acronyms used.
CCO-Specific PIP/Focus Study
• Adverse childhood experience • ED utilization • Tobacco cessation

Eastern Oregon CCO

Eastern Oregon CCO	
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 comprised of two entities: GOBHI and ODS. Mid-Columbia Council of Governments Transportation Network provides NEMT services for EOCCO. Moda Health provides medical and pharmacy services. Dental care is provided by Advantage Dental, Capitol Dental Care and ODS Dental.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Fully met (4.0)
Standard III: Coordination and Continuity of Care	Substantially met (2.8)
Standard IV: Coverage and Authorization of Services	Fully met (3.7)
Standard V: Provider Selection	Fully met (4.0)
Standard VI: Subcontractual Relationships and Delegation	Fully met (4.0)
Standard XI: Practice Guidelines	Substantially met (3.0)
Standard XII: Quality Assessment and Performance Improvement	Substantially met (3.3)

Overall Strengths and Areas for Improvement

Strengths: EOCCO provides OHP services to members in rural and frontier counties in eastern Oregon. Although it is a constant challenge to provide access in these counties, the CCO demonstrates strength in its network access and adequacy analysis and reporting. EOCCO continues to make investments in primary care. The CCO has demonstrated a decline in inpatient stays, and according to self-report, has kept their rate of growth low.

The CCO provides funding for the community advisory councils in each of the 12 counties it serves. EOCCO has invested in grants to fund new ideas and increase their compliance with metrics. The CCO has provided alternative payment methodologies, and many primary care providers are voluntarily moving to a partially capitated payment model. Quality-based payments are also being provided to primary care providers. The CCO has used shared savings models for hospitals and providers, supplying the providers with necessary reports to enable them to guide improvements and improve quality. GOBHI has begun a pay-for-performance program with its providers.

Additional strengths include:

- The CCO utilizes Arcadia for real-time access to data, along with ED information exchange and PreManage to support efforts to reduce ED utilization and improve care coordination and management.
- EOCCO has developed a methodology to track community health worker (CHW) services and will reimburse clinics for their use of
- CHWs as they see the need, and that fit the regulation. The CCO provides tools and training.
- Training for EOCCO providers is comprehensive and includes performance metrics and incentive metrics information. The CCO includes information on flexible services.

Eastern Oregon CCO
• EOCCO contracts with Yellowhawk Tribal Health Center, and has claims processes in place to allow for bypass of referral requirements. CCO staff have been trained to allow for referrals from Yellowhawk. • The CCO has developed county collaboratives in each of their 12 counties that include department of human services, adults and people with disabilities staff and other stakeholders. These collaboratives meet regularly and review common members and assess for service duplication to ensure members are receiving necessary health and social services and supports. • The CCO has demonstrated comprehensive care coordination in the documentation provided for the adult mental health population. This documentation addressed physical health, dental, transportation, social services and other member needs. • Credentialing files provided by the CCO were comprehensive and well organized. **Areas for Improvement:** The CCO should consider developing overarching policies and processes to address SHCN members. The CCO needs to demonstrate processes to ensure that enrollees with special health care needs are assessed periodically by appropriate providers, and also ensure periodic care monitoring for this population. • The CCO needs to address providing direct access to specialists for enrollees with special health care needs related to dental and behavioral health. EOCCO needs to demonstrate that direct access is provided to specialists in a timely manner, as well as a process for monitoring direct access to specialists for this population. • The CCO needs a mechanism to assess the quality and appropriateness of care furnished to enrollees with special health care needs. • The CCO needs to ensure there are no payment denials for all emergency room and post-stabilization services. • The CCO needs to establish a process to ensure that decisions made by delegates and behavioral health providers are consistent with guidelines.

Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.0)**
1. Staffing	Fully met (3.8)
2. Meaningful Use of Electronic Records	Not met (1.0)
3. Configuration Management	Fully met (4.0)
4. Member Enrollment Systems	Fully met (4.0)
5. Information Systems	Fully met (4.0)
6. Security	Fully met (3.7)
7. Provider Data	Substantially met (3.2)
8. Data Integration	Fully met (4.0)
9. Report Production	Fully met (4.0)
10. Vendor Management	Fully met (3.8)
11. Administrative Data	Fully met (4.0)

Eastern Oregon CCO

Overall Strengths and Areas for Improvement

Strengths:

- EOCCO clearly defines productions goals, especially as changes are noted. Additional processes outlining evaluation of processor productivity goals for both new hires and seasoned staff is user-friendly.
- EOCCO's Data Flow Diagrams and Encounter Data 2018 Policy and Procedure outline clear and understandable processes.
- The CCO's business continuity and disaster recovery plan is based on standard best practice (the National Institute of Standards and Technology Special Publications) and is clearly documented and tested. This was a finding for EOCCO in their last ISCA review, which has been corrected with a best practice plan, documentation and testing.
- EOCCO's edits and audits meeting notes demonstrate a steady decrease in processing errors.

Areas for Improvement:

- The CCO needs to have a policy or procedure for tracking IT personnel training and qualifications.
- EOCCO lacks a process to encourage and assess dental plan networks to either move to a certified EHR or gain certification of an existing EHR. The CCO does not have regular communications, including outreach and education with providers regarding these efforts. The CCO has plans to include claims data and some clinical data via Arcadia for some physical health and mental health providers. Future quality improvement efforts need to include dental EHR.
- The CCO's current system security plan, which is under review and revision, does not include all IT functions, systems, equipment and related functions essential to business operations.
- The CCO receives data from outside sources and has processes to certify and validate, but not all data received is confirmed using a 999 file. Each DPN reviews the 999 accepted/rejected encounters in order to accurately complete the encounter validation report.
- The CCO states that incorrect member data is corrected yet provided no documentation of an issue regarding member data from their contracted NEMT provider that was identified and has been corrected. Ideally, there should be a policy or process for correction of member data.
- EOCCO's integrated provider directory lists many types of providers (including peer specialists). However, not all directories are searchable for features such as language. The public is unable to search for the language of providers. Based on the EQRO's interpretation of CMS language, approved by OHA, a provider directory should be accessible to the public and searchable to the practitioner level, including required elements such as language.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Progress reports are sent to providers and contain a roster of members with at least one opioid fill > 0mg MED in the previous 12 months.
- La Grande, Baker City, and Wallowa have successful brick and mortar pain schools up and running.

Eastern Oregon CCO
• Through MedImpact, Moda and EOCCO launched a Morphine Equivalence Daily Dose Edit Initiative on 6/1/18. This includes both soft and hard edits at the point of sale. • Oregon State University's CHW Management of Chronic Health Conditions course runs as a self-paced module. • Advantage Dental has requested a prescription drug monitoring program utilization reporting tool from EOCCO.
Overall Strengths and Areas for Improvement
Strengths: • None identified. **Areas for Improvement:** • Align the aim statement, target population, and outcome measures documented in the progress report with the statewide specifications for the PIP. • Document the activities and improvement strategies undertaken through collaboratives, committees, and workgroups that are expected to directly impact study indicator outcomes, and the interventions. • Provide complete descriptions of interventions, demonstrating potential impact on study indicator outcomes. • Have evaluation processes in place to determine intervention-specific effectiveness and impact of individual interventions on the study indicator outcomes. The CCO should begin evaluating effectiveness of an intervention as soon as the intervention is deployed and should report intervention-specific evaluation results for each intervention quarterly. • Provide completed descriptions of how barriers were addressed and overcome or resolved. • Provide accurate and up-to-date data on all measures required for the statewide PIP. • Report numerators, denominators, and percentages for the outcome measures rather than reporting only raw numbers. • Define acronyms used.
CCO-Specific PIP/Focus Study
PIPs/Focus Study: • Colorectal cancer screening • Addressing substance use disorders in older adults • Improving adolescent well care visits, access and services

Greater Oregon Behavioral Health, Inc.

Greater Oregon Behavioral Health, Inc.	
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	
Compliance Standard	**Score (Out of 4.0)**
Standard I: Availability of Services	Fully met (3.8)
Standard III: Coordination and Continuity of Care	Substantially met (3.3)
Standard IV: Coverage and Authorization of Services	Fully met (4.0)
Standard V: Provider Selection	Fully met (4.0)
Standard VI: Subcontractual Relationships and Delegation	Fully met (4.0)
Standard XI: Practice Guidelines	Fully met (4.0)
Standard XII: Quality Assessment and Performance Improvement	Fully met (4.0)

Overall Strengths and Areas for Improvement

Strengths: Overall, GOBHI has made significant strides in meeting the managed care standards reviewed by the external quality review organization (EQRO). GOBHI recently became accredited by the National Committee for Quality Assurance (NCQA) and as a result, their processes, policies and procedures have been updated to meet these standards.

An annual member experience survey has been implemented for feedback related to access. Technology to improve care coordination has included e-visits, electronic refill reminders for meds, e-enrollment in care management, and online personal health records. Altruista has been implemented for utilization management, complex case management, grievances and appeals. Arcadia has also been implemented for aggregating member data. Additional technology has included Premanage, Tableau, and telehealth equipment at each CMHP. An interrater reliability process has been implemented using MCG®, a Milliman tool for compliance with practice guidelines.

- GOBHI has increased their investment in training. A member service representative has become a qualified health interpreter for Spanish. Member service representatives have become certified community health workers. GOBHI has a staff member dedicated to implementing an organization-wide trauma-informed care program. Training for mental health providers on how to talk to physicians about health issues has also been implemented.
- GOBHI conducted secret shopper calls to each CMHP to ensure members could easily access interpreter services. These calls revealed that improvement was needed. Information went out to each CMHP, and repeat secret shopper calls will be used to determine improvement.
- GOBHI has a strong focus on cultural considerations throughout their organization with staff, providers and members.
- A complex case management program is being implemented for adults with complex needs.

Greater Oregon Behavioral Health, Inc.

- GOBHI conducted a comprehensive utilization management review for 2017, including improvement plans, which focused on the MHO.
- GOBHI's quality improvement work plan was well-written and comprehensive.

The MHO is working with the PCPCHs in their area to increase the tier level by integrating behavioral health into their clinics. In addition, they are implementing the Impact model to provide psychiatric support to primary care providers. GOBHI is exploring paying clinics (federally qualified health centers and rural health clinics) to coordinate care for MHO members (as they are doing for CCO members).

Areas for Improvement: Although process, policies and procedures have been updated, the MHO's care coordination documentation did not reflect coordination with other services and providers outside of the mental health setting. The MHO did not demonstrate consultation and communication with members' providers or coordination with services received from other health plans or providers. MHO members receive their physical health care and oral health care from providers outside of GOBHI or its affiliated CCOs, however, no documentation of this coordination was provided.

All MHO members meet the definition of "special health care needs"; however, the care planning documentation that GOBHI submitted did not always address needed additional services identified in the assessment for these members.

The MHO is monitoring and working toward meeting state standards for timely access to care and services (OAR 410-141-3220); however, they did not meet these standards in a recent internal review performed by GOBHI.

- Many GOBHI practices, policies and procedures seem to apply to all of their business arrangements, whether as a CCO, MHO or delegate. For example, MHO contract does not include substance use disorder treatment, even though their policies and documentation address these services. Clarification regarding which entity each applies to may help GOBHI, members and providers understand how to apply their policies.

Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.00)**
1. Staffing	Fully met (4.0)
2. Meaningful Use of Electronic Records	NA
3. Configuration Management	Fully met (4.0)
4. Member Enrollment Systems	Fully met (4.0)
5. Information Systems	Substantially met (3.3)
6. Security	Substantially met (3.3)
7. Provider Data	Substantially met (3.3)
8. Data Integration	Substantially met (3.3)
9. Report Production	Substantially met (3.2)
10. Vendor Management	Fully met (3.8)

Greater Oregon Behavioral Health, Inc.	
11. Administrative Data	Fully met (4.0)

Overall Strengths and Areas for Improvement

Strengths:

- GOBHI continues to work on documenting its data processing procedures and is working on several projects to improve oversight of its IT contractors. GOBHI has made great progress in improving IT processes and providing oversight of their delegates.
- GOBHI has a documented process for credentialing their providers and maintains a database of provider data. The database is updated whenever a provider contract is created, modified or dissolved. There is also a change request form available online to providers who wish to change or add data at other times. Provider payment is fully automated for all providers.
- In addition to Altruista and Arcadia, GOBHI is using Tableau and SQL internally to meet some reporting needs. These tools provide a wealth of reports and performance measures to assist with population management and administrative monitoring of their business lines and delegates.

Areas for Improvement:

- The MHO needs to continue to document data IT processes in policies and procedures, and actively engage in oversight of all delegates.
- The online provider directory displays a list of facilities by county and does not allow the public to search at the practitioner level. Clicking on the facility will take you to their websites and, depending on the facility, may or may not produce a list of practitioners at that site. The public is unable to search for gender and/or language appropriate providers. Based on the EQRO interpretation of CMS language, approved by OHA, a provider directory should be accessible to the public and searchable to the practitioner level including required elements such as language.
- The MHO should continue working on documenting their reporting procedures.

Health Share of Oregon

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 Ride to Care to provide NEMT as a capitated service.

Compliance with Regulatory and Contractual Standards

Compliance Standard	Score (Out of 4.00)
Standard I: Availability of Services	Fully Met (4.00)
Standard III: Coordination and Continuity of Care	Substantially Met (3.40)
Standard IV: Coverage and Authorization of Services	Fully Met (3.71)
Standard V: Provider Selection	Substantially Met (3.33)
Standard VI: Subcontractual Relationships and Delegation	Fully Met (4.00)
Standard XI: Practice Guidelines	Partially Met (2.67)
Standard XII: Quality Assessment and Performance Improvement	Fully Met (4.00)

Overall Strengths and Areas for Improvement

Strengths: HSAG's review revealed that HSO has a number of strengths as a CCO. While HSO delegates many of its required functions to numerous risk accepting entities (RAEs), it assumes ultimate accountability by conducting comprehensive audits of its subcontractors, as evidenced by oversight policies and audit reports provided. The communication and collaboration with their delegates is exceptional and HSO should also be commended for its monitoring of contracted provider organizations.

Much of HSO's success regarding coordination of care can be attributed to their adoption of *Health Share Bridge (the Bridge)*. The *Bridge* is an enterprise data warehouse populated daily with claims and member enrollment data including information such as member demographics (e.g., age, gender, language spoken, race, and ethnicity), Severe and Persistent Mental Illness status, foster care status, diagnoses, as well as risk accepting entities and primary care location assignments. HSO demonstrated how it utilizes the *Bridge* as a tool to securely and conveniently share member data with its contracted RAEs and providers. Its functionality also supports utilization management and process improvement activities by displaying various data on how members access services, informing a significant part of HSO's decision making. The *Bridge* was evidenced as an integral tool in achieving outstanding quality and compliance with many of the standards reviewed during this EQR such as network adequacy, coordination and continuity of care, and QAPI.

Health Share of Oregon	
Aside from the *Bridge*, HSO's success can also be attributed to its orchestration of a bi-monthly care integration workgroup, as well as the implementation of two separate coordination of care policies and procedures that address the needs of its population with SHCNs, as well as its general member population. HSO's member-centeredness was apparent in the quality of its assessments and care coordination activities, its dedicated QAPI committee, and the prompt turnaround time for authorization decisions, which were commonly found to have been issued the day after the request was submitted. **Areas for Improvement:** Areas for improvement included ensuring periodic assessments of individuals with special health care needs, increased uniformity in the care planning and assessment process across RAEs, and utilization of the Care Integration Workgroup and other processes to ensure collaboration and consistency between HSO RAEs and other contracted providers. Treatment consistency for all members could be improved by ensuring that HSO delegates have a sound process for the adoption, maintenance, and dissemination of clinical practice guidelines. Based on delegation audit outcomes, it was evident that clinical practice guidelines were not available or accessible either by providers or by members that may request them. Other areas for improvement include: • Enhancing the tracking and monitoring process for payment of emergency services; • Ensuring a nondiscriminatory provider compensation structure; and, • Leveraging of collected data to further advance quality improvement efforts.	
Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.00)**
1. Staffing	Fully Met (4.00)
2. Meaningful Use of Electronic Records	Partially Met (2.67)
3. Configuration Management	Fully Met (4.00)
4. Member Enrollment Systems	Fully Met (4.00)
5. Information Systems	Fully Met (4.00)
6. Security	Partially Met (2.70)
7. Provider Data	Fully Met (4.00)
8. Data Integration	Fully Met (4.00)
9. Report Production	Fully Met (3.50)
10. Vendor Management	Fully Met (4.00)
11. Administrative Data	Fully Met (3.63)
Overall Strengths and Areas for Improvement	
Strengths: HSO received an overall ISCA rating of *Substantially Met* and demonstrated its implementation of a comprehensive set of policies, procedures, and processes that govern its information systems, the data it manages, and subsequent reporting. In particular, HSO's ISCA responses, IT systems subcontracts, policies and procedures documented compliant management and oversight of contracted vendors responsible for conducting data and reporting activities on behalf of the CCO. Moreover, its EDI Services Portfolio addressed the processes and procedures regarding enrollment, member renewals, and claims/encounter activities such as file processing, reconciliation, report production, report validation and follow through to ensure that deficiencies and areas of	

Health Share of Oregon
non-compliance are appropriately and timely mitigated. In addition to documented policies and procedures, HSO staff were able to articulate its documented processes and provide a comprehensive diagram illustrating its EDI data. **Areas for Improvement:** Despite receiving an overall *Fully Met* rating, there was considerable variability in HSO's performance across the individual sections indicating an opportunity for improvement with ISCA scores ranging from 2.67 (*Partially Met*) to 4.00 *(Fully Met).* Overall, HSO staff demonstrated knowledge and experience with the majority of processes, and its staff were able to describe processes in place to manage Medicaid data and information systems, but lacked documented policies and procedures for some elements. The availability of documented processes is critical to ensuring operational procedures and guidelines are available to guide health care operations as well as training and monitoring of staff performance.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Distributes pain education classes and videos to patients. • Comprehensive medical review based on quarterly reports. • Initiate PHP distribution of member letter. • Increase pain management focus through additional outreach and claims mining for early intervention. • Contact patients on an established schedule. • Providing technical assistance to "high risk" clinics. • Reinforce recommendations for restrictions on new starts for long-acting (LA) opioids if available. • Set expectations for all providers that patients need to be on tapering plans and/or below 90 MED. • Establish a high-priority measure tied to incentive pay to decrease the percentage of patients > 90 MED. • Establish new guidelines for surgeons to reduce post-surgery opioid quantity. • Clinical onsite review program (CORP) to review charts for pain contracts. • Providence Rethinking Pain Toolkit. • Requirement of pain contract, including guidelines for providers in treating acute and chronic pain. • Expanding access to MAT in primary care and specialty addictions settings. • Expanding access to acupuncture including unlimited services to patients with chronic pain and addiction. • KPNW Pharmacy is working to implement recent passed regulations allowing pharmacists to prescribe naloxone in Oregon. • PMG Medical Home Behavioral Health is developing a pain protocol. • Increase the use of Flexible Services and community resources. • Involve Pain Management Specialists. • Prior authorization is required for all new starts for morphine sulfate extended-release for 15mg, 30 mg, and 60 mg doses. • Implemented cap at 60 MED to avoid new prescription risks, limit starting new patients on long-acting opioids.

Health Share of Oregon
• STORM review of any patients with MED > 300 mg to develop a care plan with the provider when needed. • Member-level data sharing for PCPs, including the development of a self-service Tableau solution. • Investigating adding a quality measure that would look at decreasing the prescribing of opioids and benzodiazepines. • Quarterly lists of prescribers with members having greater than 120 MED for at least 90 consecutive days. • Patients on >120MED are reviewed by a multidisciplinary team to develop proper persistent pain treatment and tapering of opioid(s). • Quarterly pharmacy reporting to ID members with high doses. Continue to evaluate opioid reports to improve meaningful information. • Review of reporting and trending increase/decline of MED levels. • Identified termination of members with pain contract. • Gain an understanding of the PreManage system and establish standards of use. • Request data from Pharmacy & Therapeutics Committee. • A project team has been established in Q3 2016, to create best practice for pain care across disciplines inpatient and outpatient setting for Providence Oregon region. • Health Share Data Analytics. Health Share continues to analyze the data received from OHA each month and to distribute data to each plan partner. • Wheelhouse: Expanding Recovery Options, is a Health Share initiative aimed at expanding access to medication assisted treatment (MAT) for people with opioid use disorders in the Tri-County area. • Expanding MAT within primary care. • Participation in the tri-county opioid safety coalition.
Overall Strengths and Areas for Improvement
Strengths: • The problem statement was clearly stated and aligned with one of the seven clinical focus areas. • Interventions were logically linked to the outcome measures. **Areas for Improvement:** • Align measures in the progress report with the specifications for the statewide PIP. • Provide numerators and denominators for data reported. • Provide complete documentation of quality improvement activities and processes. • Provide implementation date for each intervention. • Provide complete descriptions of intervention evaluation methodologies and data. • Provide the rationale supporting the next steps and intervention status. • Provide complete descriptions of how barriers were addressed and overcome or resolved.
CCO-Specific PIP/Focus Study
PIPs/Focus Study: • Improve effective contraception rates

Health Share of Oregon
• Improving the foster care relational health, academic, psychological, intellectual, developmental (RAPID) assessment process • Expanding access to medication assisted treatment (MAT) services for people with opioid use disorder

InterCommunity Health Plan, Inc.

InterCommunity Health Plan, Inc.	
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 NEMT services for IHN members.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Substantially met (2.75)
Standard III: Coordination and Continuity of Care	Substantially met (3.2)
Standard IV: Coverage and Authorization of Services	Partially met (2.0)
Standard V: Provider Selection	Partially met (2.0)
Standard VI: Subcontractual Relationships and Delegation	Partially met (2.0)
Standard XI: Practice Guidelines	Partially met (2.7)
Standard XII: Quality Assessment and Performance Improvement	Substantially met (3.0)

Overall Strengths and Areas for Improvement

Strengths:

- IHN has a vision that includes capitalizing on data and identifying gaps. The CCO is working on data integration to identify and improve gaps in care.
- IHN has provided trauma-informed training for 100% of the CCO staff.
- The CCO participates in the state's efforts to promote delivery of services in a culturally competent manner.
- IHN provided high-quality examples of care coordination. The CCO has identified and is working on a member-focused care coordination effort for the youth in out-of-area behavioral rehabilitation services programs to ensure all care needs are met.
- The CCO ensures emergency and post-stabilization services are covered by the CCO and monitors the use of emergency services for inappropriate or avoidable emergency room use related to lack of access to routine care
- IHN provided a quality grievance analysis including data from dental, physical health, and mental health.
- IHN's member handbook is comprehensive and very user friendly. In collaboration with the City of Albany, IHN (Samaritan Health Plans) has developed and implemented a community paramedics program to assist members to improve their health status, connect with available services and provider intervention for members who are unable or unwilling to take an active role in the management of their ongoing healthcare.
- As part of the development of its transformation and quality strategy, IHN is working to bring quality into all departments, rather than just having a quality department.

InterCommunity Health Plan, Inc.	
Areas for Improvement: Overall, the CCO needed to provide supporting documentation to demonstrate compliance with the CFRs and CCO contract requirements reviewed during this EQR. Although a contract or policy may require dental delegates to comply with regulations, little documentation was provided demonstrating oversight of the delegated tasks. IHN provided a nice report on network adequacy that included provider type and specialty. However, dental and behavioral health providers and specialists (other than psychiatrists) were not included. The CCO needs to provide documentation demonstrating how they maintain and monitor a network of appropriate providers for all covered services, including timely access to services. The CCO needs to provide direct access to specialists for enrollees with special health care needs and have a mechanism in place to ensure treatment plans for enrollees with special health care needs are reviewed and revised as required. The CCO needs to follow its own process found in its policy for credentialing providers and ensure that credentialing and recredentialing of CCO staff is monitored. IHN needs to ensure dental practice guidelines are periodically reviewed and revised, as appropriate, and ensure dissemination of behavioral health and dental care practice guidelines. The CCO needs to ensure decisions made by dental plan networks are consistent with their practice guidelines. Also, the CCO needs to routinely monitor over- and under-utilization including racial, ethnic, cultural, and linguistic disparities. The CCO needs to have a mechanism in place to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	
Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.00)**
1. Staffing	Not met (1.5)
2. Meaningful Use of Electronic Records	Partially met (2.0)
3. Configuration Management	Partially met (2.0)
4. Member Enrollment Systems	Partially met (2.0)
5. Information Systems	Substantially met (3.0)
6. Security	Not met (1.3)
7. Provider Data	Not met (1.7)
8. Data Integration	Partially met (1.8)
9. Report Production	Substantially met (3.2)
10. Vendor Management	Substantially met (2.8)
11. Administrative Data	Partially met (1.9)
Overall Strengths and Areas for Improvement	
Strengths: None documented. **Areas for Improvement:** Overall, IHN provided little documentation supporting their efforts related to information systems capabilities. Little information was provided regarding how their delegates meet the contract expectations or any documentation of monitoring and oversight by the CCO. HealthInsight Assure	

InterCommunity Health Plan, Inc.

conducted interviews with three contracted providers as part of IHN's ISCA review. The first provider reported good management processes and security, with the exception of no business recovery plan. They do have a "downtime procedure," but nothing for a situation when the stoppage is greater than 24 hours. The provider also reported that they have submitted no documents to the CCO and have not had any encounter data validation (EDV) performed except by the State of Oregon in March 2018.

The second provider also reported that no EDV was performed by the CCO, only by OHA. The CCO did ask for policies when they contracted with this provider, but the provider has not been asked to submit any paperwork since that occurred. The provider's basic business practices are adequate, with the exception of the following: this provider only checks eligibility at the time of member intake (day treatment and outpatient treatment facility). This provider has no formal password policy, and all protected health information is stored in the cloud and accessed there by staff. They also reported no knowledge of retired device destruction processes. Lastly, they do not have a business recover/disaster plan.

The third provider, a larger multi-specialty physical health clinic, reported good management and business practices, including a business continuity/disaster recovery plan that is desktop-tested annually. This provider reported no oversight by the CCO, and that they have had EDV done by Samaritan Health, but only for their Medicare Advantage line of business. The provider has not had any EDV performed on their Medicaid claims.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Provider and public education is through the Regional Taskforce (now PainWise Taskforce) and its subcommittees.
- Decrease upper limit of prescription opioid quantities.
- Member education will focus primarily on prevention.

Overall Strengths and Areas for Improvement

Strengths:

- None identified.

Areas for Improvement:

- Provide a complete and clear aim statement and problem statement which align with the target population.
- Provide, for the target population, complete documentation of the inclusion and exclusion criteria as well as age and enrollment requirements.
- Provide complete documentation of quality improvement activities and processes.
- Provide complete intervention evaluation data which support decisions to continue, revise, or discontinue an intervention.
- Document how data are collected and calculated for the outcome measures of the project.
- Provide complete descriptions of how barriers were addressed and overcome or resolved.
- Provide the rationale supporting the next steps and intervention status.
- Define acronyms used.

InterCommunity Health Plan, Inc.
CCO-Specific PIP/Focus Study
• Reduce costly and frequent ED usage • Pregnancy and oral health • Reduce re-hospitalization at Good Samaritan Regional Medical Center

Jackson Care Connect

Jackson Care Connect	
JCC provides physical, behavioral, and dental health services for approximately 29,000 OHP members in Jackson County. JCC is a wholly owned subsidiary of CareOregon. CareOregon provides administrative and management support for the CCO and contracts with Advantage Dental, Capitol Dental, ODS and Willamette Dental Group for dental services.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Fully Met (3.8)
Standard III: Coordination and Continuity of Care	Partially Met (2.6)
Standard IV: Coverage and Authorization of Services	Substantially Met (2.9)
Standard V: Provider Selection	Fully Met (4.0)
Standard VI: Subcontractual Relationships and Delegation	Fully Met (4.0)
Standard XI: Practice Guidelines	Substantially Met (3.0)
Standard XII: Quality Assessment and Performance Improvement	Substantially Met (3.25)

Overall Strengths and Areas for Improvement

Strengths: Over the past year, JCC has shifted the behavioral health risk from the community mental health program and CareOregon is now managing the behavioral health network. JCC has the highest percentage of members flagged with mental health concerns. The CCO has increased their adult and children's outpatient providers and continues to work with the county for more intensive services. The CCO has increased capacity for walk-in assessment availability.

Below are some additional strengths:

- The CCO demonstrated strengths in their credentialing processes.
- The CCO has written agreements for subcontractors that specify required activities and report responsibilities. The CCO actively monitors performance and requires corrective action plans for unsatisfactory performance. The CCO audits delegates annually and audits them for compliance with the EQR requirements (not all standards are reviewed or scored ever year as it depends on risk identified by the CCO).
- The CCO is implementing regional care teams to provide support to local coordination activities.
- A Health Equity Advisor staff position was developed. Among other tasks, this staff member works with tribal organizations and is working on a language access plan to help members with limited English proficiency with meaningful access.

Areas for Improvement: The CCO delegates responsibilities for dental health. The majority of JCC policies and processes are not integrated to demonstrate consideration of physical health, dental and behavioral health. Expectations for delegated activities are not included in JCC policies.

JCC recently updated a policy to use the state's definition of special heath care needs (as defined in the CCO contract with OHA). The CCO needs to operationalize this definition and implement a mechanism to identify

Jackson Care Connect	
and assess these members, and monitor for periodic assessment. The CCO needs to analyze the quality and appropriateness of care furnished to SHCN members. The CCO needs to provide care coordination and develop a way to track members (other than high-cost claims) with special needs even if they are inactive in their care coordination program. The CCO needs to identify these members (e.g., flag after a certain number of claims, members with ongoing congenital issues, etc.) to ensure ongoing appropriate care. In addition, the CCO needs formalize a way to coordinate care with the dental plans.	
Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.00)**
1. Staffing	Partially Met (2.7)
2. Meaningful Use of Electronic Records	Not Met (1.0)
3. Configuration Management	Fully Met (4.0)
4. Member Enrollment Systems	Substantially Met (3.4)
5. Information Systems	Substantially Met (3.3)
6. Security	Partially Met (2.5)
7. Provider Data	Not Met (1.2)
8. Data Integration	Not Met (1.3)
9. Report Production	Substantially Met (3.5)
10. Vendor Management	Partially Met (2.0)
11. Administrative Data	Partially Met (2.1)
Overall Strengths and Areas for Improvement	
Strengths: • The CCO provides incentives for EHR use for physical health providers through their person-centered primary care home alternative payment methodologies. • The data submission occurs from delegates who process claims and encounters directly to OHA with a copy to the CCO. Data review and attestation of completeness and accuracy by the CCO's designated staff occurs parallel or after data is submitted to OHA. • The data center where storage and backups occur in Hillsboro demonstrates a best practice in terms of secure data storage/back-ups. A walk through was arranged through CareOregon, which contracts with the facility to store all their data, including the CCO data. The security features and redundancy in power sources are impressive and state of the art. **Areas for Improvement:** • The CCO did not provide complete information regarding how productivity goals are set. The CCO did not provide information describing tracking of training and how programming staff are evaluated. • Documentation was not submitted demonstrating that EHR use or certification status is tracked for all contracted providers who fall under meaningful use. The CCO's education efforts regarding utilizing EHRs only include physical health providers. No documentation was provided relevant to quality improvement	

Jackson Care Connect

program data sources for dental data for reporting and analytics. Documentation regarding sources, loading, storing and using EHR data was not provided.

- The CCO provided no documentation showing that Medicaid enrollment is verified at the time a service is requested. Also, no documentation was provided showing the CCO's process for when enrollment changes between the time of the service request and time of service.
- HealthInsight Assure reviewers were told that all CCO data is stored in the Hillsboro data center, but no CCO documentation was provided to support this.
- The CCO has made efforts to oversee their delegates' provider directories. However, more details are needed regarding processes for handling information flow, writing, submitting and changing delegates' provider directories.
- Delegates' provider data, updates and change processes, staff training regarding access and change authority, or data storage of provider directories also need continued attention. No documentation was provided regarding a system in which delegates collect provider directory updates and corrections.
- The CCO provided little information regarding provider compensation rules, job roles with access and change authority, fee schedules and compensation rules, how fee schedules are updated by delegates, or any documentation on how Medicaid provider compensation rules are implemented.
- The submitted documents regarding data collection are unbranded and it was not clear who is producing the data and how they are connected to the CCO.
- No documentation was provided on processing lags, maintaining data integrity or evaluation of performance measures. No documentation was provided about data extracts for the CCO's performance metrics or how data extracts are archived for future need.
- The CCO did not provide policies or processes relevant to consolidation of Medicaid data from all sources for performance measurement reporting, including how data integrity is maintained and how claims /processing lags are handled when evaluating performance metrics. The CCO did not describe how data integrity is maintained when consolidating Medicaid claims and encounter data for performance measures.
- No documentation was provided regarding how the CCO ensures accuracy, timeliness and completeness of data, or reports generated from data repositories.
- Information was not provided regarding CCO processes for oversight of the functions they have delegated to outsourced work (not performed by the CCO). No work agreements identifying specific work to be done, quality and time expectations were provided.
- No documentation was provided on how the CCO validates that all zero/low-dollar claims are submitted by delegates. This was identified as an issue in the provider interviews conducted for this ISCA review.
- No documentation was provided on how the CCO validates that all zero/low-dollar claims are submitted by delegates. This was identified as an issue in the provider interviews conducted for this ISCA review.
- The CCO did not provide documentation demonstrating tracking of claims/encounters for capitated or alternative payment model services.
- No information was provided about timeliness, ensuring no delays, adequate staffing to support work, volume of paper claims, documentation of timeliness or process for scanners. There was also no mention of delegates and if they have paper claims, how the CCO is monitoring their work.
- No indication that EDV is performed on a regular basis, either by policy or by example and no frequency of EDV audits was documented.

Jackson Care Connect

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Participation in the advisory group collaborative and community education workgroup.
- JCC pharmacists review taper plans and opiate blocks.
- Behavioral health integration specialist (BHIS) and pharmacist continue to provide technical assistance and prescribing support to JCC's primary care network.
- Hosted monthly community education event entitled "Spotlight on Practice."
- Different sites and times were tested for the Addiction Medicine Journal Club, The CCO landed on Jackson county HHS at 5pm on the second Thursday of each month.
- Expand services at RVYMCA to include chronic pain diagnosis.
- Initiating MAT for individuals who self-refer from the Jackson county public health syringe exchange program.

Overall Strengths and Areas for Improvement

Strengths:

- Barriers identified and addressed during intervention implementation.

Areas for Improvement:

- The measures in the progress report should align with the specifications for the statewide PIP.
- Provide accurate, up-to-date data on all measures required for the statewide PIP.
- Provide complete documentation of quality improvement activities and processes.
- Provide the date of implementation for each intervention.
- Provide complete descriptions of intervention evaluation methodologies and data.
- Provide complete descriptions of each intervention.
- Provide the rationale supporting the next steps and intervention status.
- Provide complete descriptions of how barriers were addressed and overcome or resolved.
- Define acronyms used.

CCO-Specific PIP/Focus Study

- High utilizers
- Social determinants of health screening and follow-up
- Improving maternal and perinatal care

Pacific Source Community Solutions – Central Oregon

Pacific Source Community Solutions – Central Oregon	
PacificSource Community Solutions, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-Central Oregon (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. PSCS-CO contracts with Capitol Dental, Willamette Dental Group, Advantage Dental and ODS to provide dental services. The CCO contracts primarily with Deschutes County Health Services to provide behavioral health services. Caremark handles pharmacy claims for PSCS-CO. For NEMT, PSCS-CO contracts with Cascades East Ride Center (Central Oregon Intergovernmental Council).	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Fully met (4.0)
Standard III: Coordination and Continuity of Care	Fully met (4.0)
Standard IV: Coverage and Authorization of Services	Substantially met (3.3)
Standard V: Provider Selection	Substantially met (3.3)
Standard VI: Subcontractual Relationships and Delegation	Fully met (4.0)
Standard XI: Practice Guidelines	Fully met (4.0)
Standard XII: Quality Assessment and Performance Improvement	Fully met (4.0)
Overall Strengths and Areas for Improvement	
Strengths: The CCO has demonstrated many strengths, including holding quarterly medical assistant workshops. PSCS has designated a practice facilitator for each CCO, and an ED improvement coordinator. A community engagement team is working on a variety of meaningful engagement opportunities for the CCO. The CCO has communicated expectations to all providers caring for members with complex/elevated care needs. To help dental care organizations understand their SHCN members, including pregnant members and those with diabetes, the CCO provides them with a monthly "Member Insight report." The CCO expanded its behavioral health provider panel to include specialties, such as eating disorders and providers who address gender dysphoria needs, and services in frontier counties. The CCO has recruited behavioral health providers beyond the community mental health programs, and provided open access to all behavioral health providers for assessment without requiring prior authorization. In 2017, the CCO enhanced efforts to increase workforce diversity, training and the availability of interpreters. The CCO also demonstrated the following: • Comprehensive delegation oversight and integrated data analysis of all services • Gathering data, with reporting capabilities to review and analyze second opinions provided to their members • Providing direct access to specialists for all CCO members	

Pacific Source Community Solutions – Central Oregon	
Areas for Improvement: The CCO needs to have a policy and procedure or contract language regarding compensation not being structured to provide incentives to deny, limit or discontinue medically necessary services to enrollees. In addition, the CCO needs to ensure contracted providers do not provide incentives to deny, limit, or discontinue medically necessary services to enrollees. • The CCO is financially responsible for payment of emergency and urgently needed services, as well as stabilization and post-stabilization services. The CCO needs to monitor to ensure there is no payment denial for emergency or post-stabilization services. • The CCO needs to have a policy and procedure that ensures nondiscriminatory process for selecting providers based on their treatment of high-risk populations or populations that require costly treatment.	
Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.00)**
1. Staffing	Fully met (4.0)
2. Meaningful Use of Electronic Records	Partially met (2.0)
3. Configuration Management	Fully met (4.0)
4. Member Enrollment Systems	Substantially met (3.6)
5. Information Systems	Fully met (4.0)
6. Security	Fully met (4.0)
7. Provider Data	Substantially met (3.2)
8. Data Integration	Fully met (4.0)
9. Report Production	Fully met (3.7)
10. Vendor Management	Fully met (4.0)
11. Administrative Data	Fully met (4.0)
Overall Strengths and Areas for Improvement	
Strengths: • The CCO has good staff support for its information systems, with low staff turnover. The CCO demonstrates excellent procedures for setting processor productivity goals. Standard training is provided as well as "brown bag. • lunch" training opportunities to focus on specific developer topics. • The CCO documents and oversees the meaningful use work for physical health providers regarding outreach, education and moving to certified electronic health record technology CEHRT. • The change request form is well constructed. The CCO demonstrates excellent use of a subject matter expert to conduct quality testing and validation. The CCO has good use of a check-and-balance version control system. • Overall, the CCO maintains strong security measures. The CCO provided a "Information Security – Vendor Self-Assessment Questionnaire," which provides important information for the CCO to manage security. **Areas for Improvement:**	

Pacific Source Community Solutions – Central Oregon
• Meaningful use work for DPNs regarding outreach, education and moving to CEHRT is lacking. • The CCO lacks documented processes for testing system and enrollment data integrity. In addition, the CCO lacks documentation for establishing new product lines in an existing enrollment system, importing data for new product lines into an existing data repository, and processes for handling new product lines on existing enrollment system while protecting the integrity of the data. • The CCO does not test data and validate records related to enhancements and implementation of these enhancement on an existing enrollment system. • The CCO lacks a documented process related to detecting unauthorized access and resolution. No historical documentation was provided regarding unauthorized access and resolution. The CCO lacks processes to audit or monitor to ensure correct national provider identifier numbers (NPIs) are identified, errors corrected, resolution process and training to reduce reoccurrence. • The CCO did not provide documentation or complete information regarding calculation of member months. • The CCO lacks documented processes for testing system and enrollment data integrity. In addition, the CCO lacks documentation for establishing new product lines in an existing enrollment system, importing data for new product lines into an existing data repository, and processes for handling new product lines on existing enrollment system while protecting the integrity of the data. The CCO does not test data and validate records related to enhancements and implementation of these enhancement on an existing enrollment system. • For provider data, the CCO lacks processes to audit or monitor to ensure correct national provider identifier numbers (NPIs) are identified, errors corrected, resolution process and training to reduce reoccurrence.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Provider education • Pharmacy sent letters to Medicaid members and their providers for members who have been identified with opioid regimens at or exceeding 90 MME. • Member and provider letters were mailed on 7/3/18 to notify each of the dangers associated with co-prescribing. • Increase PDMP enrollment. • Increase access to medication assisted treatment.
Overall Strengths and Areas for Improvement
Strengths: • None identified. **Areas for Improvement:** • Provide a complete and clear aim statement and a problem statement that aligns with the target population. • Provide, for the target population, complete documentation of the inclusion and exclusion criteria as well as age and enrollment requirements. • Provide complete documentation of quality improvement activities and processes.

Pacific Source Community Solutions – Central Oregon
• Provide complete intervention evaluation data which support decisions to continue, revise, or discontinue an intervention. • Document how data are collected and calculated for the outcome measures of the project. • Provide complete descriptions of how barriers were addressed and overcome or resolved. • Provide the rationale supporting the next steps and intervention status. • Define acronyms used.
CCO-Specific PIP/Focus Study
• Adolescent well-care visits • Effective contraceptive use • Oral health care during pregnancy

Pacific Source Community Solutions – Columbia Gorge

Pacific Source Community Solutions – Columbia Gorge
PacificSource Community Solutions, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-Columbia Gorge (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. PSCS-CG contracts with Capitol Dental, Willamette Dental Group, Advantage Dental and ODS to provide dental services. PSCS-CG contracts with Greater Oregon Behavioral Health Inc. (GOBHI) for mental health services and substance use disorders. This is a new mental health services and substance use disorders provider since 2017 ISCA follow up review. Pharmacy claims are handled by Caremark for both PSCS CCOs. PSCS-CG contracts with Transportation Network (Mid-Columbia Council of Governments) for NEMT.

Compliance with Regulatory and Contractual Standards

Compliance Standard	Score (Out of 4.00)
Standard I: Availability of Services	Fully met (4.0)
Standard III: Coordination and Continuity of Care	Fully met (4.0)
Standard IV: Coverage and Authorization of Services	Substantially met (3.3)
Standard V: Provider Selection	Substantially met (3.3)
Standard VI: Subcontractual Relationships and Delegation	Fully met (4.0)
Standard XI: Practice Guidelines	Fully met (4.0)
Standard XII: Quality Assessment and Performance Improvement	Fully met (4.0)

Overall Strengths and Areas for Improvement

Strengths: The CCO has demonstrated many strengths, including holding quarterly medical assistant workshops. PSCS has designated a practice facilitator for each CCO, and an ED improvement coordinator. A community engagement team is working on a variety of meaningful engagement opportunities for the CCO.

The CCO has communicated expectations to all providers caring for members with complex/elevated care needs. To help dental care organizations understand their SHCN members, including pregnant members and those with diabetes, the CCO provides them with a monthly "Member Insight report."

The CCO expanded its behavioral health provider panel to include specialties, such as eating disorders and providers who address gender dysphoria needs, and services in frontier counties. The CCO has recruited behavioral health providers beyond the community mental health programs and provided open access to all behavioral health providers for assessment without requiring prior authorization.

In 2017, the CCO enhanced efforts to increase workforce diversity, training, and the availability of interpreters. PSCS-CG provided a 60-hour training for health care language interpreters to be certified. More than 30 staff members from the Columbia Gorge region completed the training.

The CCO also demonstrated the following:

- Comprehensive delegation oversight and integrated data analysis of all services

Pacific Source Community Solutions – Columbia Gorge
• Gathering data, with reporting capabilities to review and analyze second opinions provided to their members • Providing direct access to specialists for all CCO members **Areas for Improvement:** The CCO needs to have a policy and procedure or contract language regarding compensation not being structured to provide incentives to deny, limit or discontinue medically necessary services to enrollees. In addition, the CCO needs to ensure contracted providers do not provide incentives to deny, limit or discontinue medically necessary services to enrollees. The CCO is financially responsible for payment of emergency and urgently needed services, as well as stabilization and post-stabilization services. The CCO needs to monitor to ensure there is no payment denial for emergency or post-stabilization services. The CCO needs to have a policy and procedure that ensures nondiscriminatory process for selecting providers based on their treatment of high-risk populations or populations that require costly treatment.

Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.0)**
1. Staffing	Fully met (4.0)
2. Meaningful Use of Electronic Records	Partially met (2.0)
3. Configuration Management	Fully met (4.0)
4. Member Enrollment Systems	Substantially met (3.6)
5. Information Systems	Fully met (4.0)
6. Security	Fully met (4.0)
7. Provider Data	Substantially met (3.2)
8. Data Integration	Fully met (4.0)
9. Report Production	Fully met (3.7)
10. Vendor Management	Fully met (4.0)
11. Administrative Data	Fully met (4.0)

Overall Strengths and Areas for Improvement

Strengths:

- The CCO has good staff support for its information systems, with low staff turnover. The CCO demonstrates excellent procedures for setting processor productivity goals. Standard training is provided as well as "brown bag.
- lunch" training opportunities to focus on specific developer topics.
- The CCO documents and oversees the meaningful use work for physical health providers regarding outreach, education and moving to certified electronic health record technology CEHRT.
- The change request form is well constructed. The CCO demonstrates excellent use of a subject matter expert to conduct quality testing and validation. The CCO has good use of a check-and-balance version control system.

Pacific Source Community Solutions – Columbia Gorge
• Overall, the CCO maintains strong security measures. The CCO provided a "Information Security – Vendor Self-Assessment Questionnaire," which provides important information for the CCO to manage security. **Areas for Improvement:** • Meaningful use work for DPNs regarding outreach, education and moving to CEHRT is lacking. • The CCO lacks documented processes for testing system and enrollment data integrity. In addition, the CCO lacks documentation for establishing new product lines in an existing enrollment system, importing data for new product lines into an existing data repository, and processes for handling new product lines on existing enrollment system while protecting the integrity of the data. • The CCO does not test data and validate records related to enhancements and implementation of these enhancement on an existing enrollment system. • The CCO lacks a documented process related to detecting unauthorized access and resolution. No historical documentation was provided regarding unauthorized access and resolution. The CCO lacks processes to audit or monitor to ensure correct national provider identifier numbers (NPIs) are identified, errors corrected, resolution process and training to reduce reoccurrence. • The CCO did not provide documentation or complete information regarding calculation of member months. • The CCO lacks documented processes for testing system and enrollment data integrity. In addition, the CCO lacks documentation for establishing new product lines in an existing enrollment system, importing data for new product lines into an existing data repository, and processes for handling new product lines on existing enrollment system while protecting the integrity of the data. • The CCO does not test data and validate records related to enhancements and implementation of these enhancement on an existing enrollment system.For provider data, the CCO lacks processes to audit or monitor to ensure correct national provider identifier numbers (NPIs) are identified, errors corrected, resolution process and training to reduce reoccurrence
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Clinical Advisory Panel (CAP) will continue to receive quarterly reports from the medical director/QI coordinator, drawing on PS, OHA, and PDMP data. • Pharmacy sent letters to Medicaid members and their providers for members who have been identified with opioid regimens at or exceeding 90 MME. • Member and provider letters were mailed on 7/3/18 to notify each of the dangers associated with co-prescribing. • With passage of the HB 4143, PS drafted a letter to providers notifying them of this change included in the provider newsletter.
Overall Strengths and Areas for Improvement

Pacific Source Community Solutions – Columbia Gorge
Strengths: • None identified. **Areas for Improvement:** • Provide a complete and clear aim statement and a problem statement that aligns with the target population. • Provide, for the target population, complete documentation of the inclusion and exclusion criteria as well as age and enrollment requirements. • Provide complete documentation of quality improvement activities and processes. • Provide complete intervention evaluation data which support decisions to continue, revise, or discontinue an intervention. • Document how data are collected and calculated for the outcome measures of the project. • Provide complete descriptions of how barriers were addressed and overcome or resolved. • Provide the rationale supporting the next steps and intervention status. • Define acronyms used.
CCO-Specific PIP/Focus Study
• Effective contraceptive use • Oral health care during pregnancy • Assessing and addressing social

Primary Health of Josephine County

Primary Health of Josephine County	
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	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Substantially Met (2.75)
Standard III: Coordination and Continuity of Care	Not Met (1.70)
Standard IV: Coverage and Authorization of Services	Not Met (1.71)
Standard V: Provider Selection	Partially Met (2.00)
Standard VI: Subcontractual Relationships and Delegation	Fully Met (4.00)
Standard XI: Practice Guidelines	Not Met (1.00)
Standard XII: Quality Assessment and Performance Improvement	Fully Met (3.75)
Overall Strengths and Areas for Improvement	
Strengths: PH's greatest areas of strength were QAPI and Subcontractual Relationships and Delegation, which each achieved a Fully Met rating. The CCO had clearly identified contractual requirements for entities that performed delegated managed care activities on its behalf and provided evidence of oversight and review of these entities, including a corrective action template and an audit report example. PH's overall quality strategy approach was also well documented, and incorporated annual work plans and evaluations, integrated use of PIP themes and topics into the overall QAPI and Transformation and Quality Strategy, and maintained a strong committee structure that included staff, providers, members, and delegated entities. **Areas for Improvement:** Prior to the onsite review, PH did not provide abundant evidence of compliance with standards. The CCO instead preferred to supply reviewers with most materials requested during the interview and after the onsite review had concluded. In part because adequate documentation was not provided to reviewers, PH did not meet requirements for timely decision making with regard to expedited and standard service authorization decisions or providing notice of those decisions. For the Practice Guidelines standard, PH did provide evidence of limited adoption of practice guidelines (GOLD guidelines and Health Evidence Review Commission [HERC] guidances). However, the CCO's practice guideline review, consultation with contracted health care providers, and dissemination to providers and members was not well-documented. Other areas for improvement include: • Developing, documenting, and implementing of procedures to ensure SHCN members are periodically assessed by appropriate providers and individuals, and that care plans are updated at least every 12 months, or when the member requests it or when his/her condition requires it.	

Primary Health of Josephine County	
• Ensuring that the treatment/service/care plans incorporate the treatment/recommendations/plan of other agencies and specialty providers, including input from the member and his/her family. • Documenting and implementing a process to monitor direct access to specialists and developing and implementing policies for providing direct access to specialists for SHCN members. • Developing processes to ensure consistent decision making among reviewers when handling authorization requests. • Providing written notification when a provider is not selected to participate in the CCO's network.	
Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.00)**
1. Staffing	Substantially Met (3.33)
2. Meaningful Use of Electronic Records	Substantially Met (3.00)
3. Configuration Management	Fully Met (4.00)
4. Member Enrollment Systems	Fully Met (4.00)
5. Information Systems	Fully Met (4.00)
6. Security	Substantially Met (2.90)
7. Provider Data	Substantially Met (3.43)
8. Data Integration	Fully Met (4.00)
9. Report Production	Not Met (1.67)
10. Vendor Management	Fully Met (3.83)
11. Administrative Data	Substantially Met (3.38)
Overall Strengths and Areas for Improvement	
Strengths: PH received an overall ISCA rating of *Substantially Met* and demonstrated its implementation of comprehensive set of policies, procedures, and processes that govern its information systems, the data it manages, and subsequent reporting. In particular, PH's ISCA responses, network diagrams, and IT systems subcontracts documented compliant policies and procedures that governed system configuration, maintenance, and operation of CCO networks. Moreover, its oversight and management of key IT vendors supported strong system security plans addressing key IT systems (hardware and software) and encounter data processing and reporting. Additionally, its operations were augmented by an internal set of individual policies and procedures. **Areas for Improvement:** Despite receiving a *Substantially Met* rating across all ISCA sections, there was some variability in PH's performance across the individual sections indicating an opportunity for improvement with ISCA scores ranging from 1.67 (*Not Met*) to 4.00 *(Fully Met),* although most non-compliant sections were *Substantially Met.* Overall, PH staff demonstrated knowledge and experience with the majority of processes, and its staff were able to describe processes in place to manage Medicaid data and information systems, but lacked documented policies and procedures for some elements. The availability of documented processes is critical to ensuring operational procedures and	

Primary Health of Josephine County
guidelines are available to guide health care operations as well as training and monitoring of staff performance.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Participation in an advisory group, a community education workgroup, and a pain management modalities workgroup. • Exploring and evaluating treatment models and infrastructure development. • Support clinicians treating individuals with chronic pain. • Primary Health identified a gap in access to contracted providers for alternate medicine. • Evaluate the rate of naloxone prescribing in the region by physicians (co-prescribing) and pharmacists.
Overall Strengths and Areas for Improvement
Strengths: • Interventions and/or quality improvement activities conducted during the quarter were documented. **Areas for Improvement:** • Provide complete documentation of statewide PIP progress to address all components of the progress report template. • Document the aim statement, target population, and outcome measures in the progress report and align with the statewide specifications for the PIP. • Document as interventions for the PIP the activities and improvement strategies undertaken through collaboratives, committees, and workgroups and which are expected to directly impact study indicator outcomes. • Provide complete descriptions of interventions, demonstrating potential impact on study indicator outcomes. • Have evaluation processes in place to determine intervention-specific effectiveness and impact of individual interventions on the study indicator outcomes. The CCO should begin evaluating effectiveness of an intervention as soon as the intervention is deployed and should report intervention-specific evaluation results for each intervention quarterly. • Provide accurate and up-to-date data on all measures required for the statewide PIP.
CCO-Specific PIP/Focus Study
• Improving population rates of colorectal cancer screening • Community health workers • Improving perinatal screening and outcomes-maternal medical home

Trillium Community Health Plan, Inc.

Trillium Community Health Plan, Inc.	
Trillium Community Health Plan was contracted with OHA as a CCO to provide physical, dental, and behavioral health services to OHP members in Lane County, the City of Reedsport, and select zip codes in Western Douglas County since 2012. According to OHA's March 2018 report, TCHP serves 85,243[1] members and is now owned and by Centene Corporation, a national managed care organization. TCHP provides dental services through contracts with Willamette Dental Group, Advantage Dental, Capitol Dental Care and ODS. NEMT services are delegated to Lane County Transit District. TCHP contracts with Envolve Pharmacy Solutions to manage pharmacy benefits and Envolve Vision for vision care services.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Substantially Met (3.25)
Standard III: Coordination and Continuity of Care	Substantially Met (3.40)
Standard IV: Coverage and Authorization of Services	Substantially Met (3.43)
Standard V: Provider Selection	Partially Met (2.67)
Standard VI: Subcontractual Relationships and Delegation	Fully Met (4.00)
Standard XI: Practice Guidelines	Substantially Met (3.33)
Standard XII: Quality Assessment and Performance Improvement	Fully Met (3.75)
Overall Strengths and Areas for Improvement	

Strengths: The greatest areas of strength during HSAG's compliance review of TCHP were the CCO's compliance related to the Subcontractual Relationships and Delegation and QAPI standards, which each achieved a Fully Met rating. TCHP's overall quality strategy approach incorporated a comprehensive program description, annual work plans and evaluations, and an assessment of outcomes using robust reporting methods, encompassing a variety of datasets. Strengths of the QAPI program also included:

- A strong committee structure.
- Accountability to the organization's board of directors for meeting goals and objectives.
- Integration of TCHP's PIP themes and topics into the overall QAPI strategy.

During HSAG's review of the Subcontractural Relationships and Delegation standard, TCHP provided evidence of policies and procedures used to oversee the subcontractors that are performing delegated managed care activities on its behalf. TCHP submitted evidence that it reviews, monitors, and identifies subcontractor performance, at minimum annually. The methodology for ongoing monitoring and oversight takes into consideration the National Committee for Quality Assurance- (NCQA-), CMS-, OHA-, and organization-specific requirements and includes revocation or other remedies to address unsatisfactory performance.

[1] Oregon Health Authority. March 2018 Total CCO Managed Care and FFS Enrollment. Available at: https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/March%202018%20Total%20CCO%20Managed%20Care%20and%20FFS%20Enrollment.pdf. Accessed on: Nov. 27, 2018.

Trillium Community Health Plan, Inc.	
The comprehensive tools and resources available to TCHP from the corporate-level were leveraged by TCHP to advance its member care goals. The Centene Corporation presence offered TCHP advantages in the local Oregon market that included a suite of policies, tools and procedures that provided tailored solutions such as: • Processes for adopting evidence-based practice guidelines. • Listings of practice guidelines for over 25 conditions, including mental health and substance use disorders. • A robust electronic medical record system to facilitate care coordination and care planning activities. • Decision support tools (Centelligence). • Enterprise-wide commitment to cultural and ethnic diversity, including special populations (youth and homeless). **Areas for Improvement:** Although the Centene Corporation infrastructure offered many strengths to the CCO, TCHP should review and streamline their policies and procedures so that those written from the national-level perspective reflect the true nature of Oregon-based business operations. In addition, when there are times national-level policies contradict local-level policies or practices, there should be clarity for staff to operationalize the intent to ensure that OHA requirements are met. TCHP displayed evidence of adopting practice guidelines, but practice guideline dissemination was not well-documented. The practice guidelines were not available on the provider portal and there was no evidence of a process for members to receive guidelines upon request. While an actual definition for SHCN was not present in policies and procedures, TCHP's application of criteria and documentation of practices in the records reviewed onsite provided evidence that TCHP uses and operationalizes the State's definition of SHCN. The CCO also did not display evidence of direct access to specialists for SHCN members. During the onsite interview, it was not clear which types of services required prior authorization, specific to meeting the requirement for direct access to specialists for SHCN members. Although TCHP's policies and procedures reflected an awareness of timelines for both standard and expedited service authorizations, the onsite records review and report monitoring reflected an inconsistency with required timeliness standards. This was specifically evident in those decisions from Trillium Behavioral Health (TBH) that correspond with behavioral health conditions. Other areas for improvement include assurances for the following: • Members incur no cost for seeking a second opinion, • There is a process for tracking second opinions and payment denial for emergency services, • Consistency with processes undertaken by delegated entities, and • Consideration for TCHP's dual population in network decision making.	
Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.00)**
1. Staffing	Partially Met (2.33)
2. Meaningful Use of Electronic Records	Not Met (1.00)

Trillium Community Health Plan, Inc.	
3. Configuration Management	Fully Met (4.00)
4. Member Enrollment Systems	Fully Met (3.80)
5. Information Systems	Partially Met (2.50)
6. Security	Substantially Met (3.10)
7. Provider Data	Fully Met (3.57)
8. Data Integration	Not Met (1.25)
9. Report Production	Partially Met (2.33)
10. Vendor Management	Substantially Met (3.00)
11. Administrative Data	Substantially Met (3.00)

Overall Strengths and Areas for Improvement

Strengths: TCHP received an overall ISCA rating of *Partially Met* and demonstrated implementation of a robust information system capable of supporting its managed care operation and reporting. In particular, TCHP's ISCA responses and onsite responses demonstrated compliant policies and procedures that governed system configuration, maintenance, and operation of CCO networks. Moreover, its system security plan addressed all key information technology (IT) systems (hardware and software) and operations and was augmented by a set of individual policies and procedures to governed access, management, and security of data and network systems. In addition to documented policies and procedures, TCHP staff were able to articulate its documented processes for managing Medicaid enrollment and provider data.

Areas for Improvement: As evidenced by the overall *Partially Met* rating received by TCHP, there was considerable variability in TCHP's performance across the individual sections indicating an opportunity for improvement with ISCA scores ranging from 1.00 (*Not Met*) to 4.00 *(Fully Met).* Overall, TCHP local staff demonstrated minimal knowledge and experience with the majority of processes, and its staff were limited in their ability to describe processes in place to manage Medicaid data and information systems. Additionally, while TCHP's information systems are centralized and governed by its parent organization (i.e., Centene Corporation), existing policies and procedures were out-of-sync with some Oregon-specific requirements. The availability of documented processes is critical to ensuring operational procedures and guidelines are available to guide health care operations as well as training and monitoring of staff performance.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Offer and assist with access to behavioral medicine interventions for managing chronic pain. Day-to-day resources provided.
- Offer and assist with Living Well with Chronic Pain classes. Day-to-day activity to offer program to Trillium members.
- Continuing to follow the formulary PA requirements on long- and short-acting opioids.
- Taper plans: Send to provider for members who have been prescribed opiates more frequently than 120 tablets in the past 120 days (or for over 90 days without care gaps) for conditions of pain related to neck, back, or spine.

Trillium Community Health Plan, Inc.
• Community Outreach/Education/Trainings. • Naloxone: Increased awareness to prescribers, monitored utilization, and collaborated with community partners. • DEA waiver process: increase probably due to new search parameters. • Drug take-back locations.
Overall Strengths and Areas for Improvement
Strengths: • None identified. **Areas for Improvement:** • The aim statement, target population, and outcome measures documented in the progress report should align with the statewide specifications for the PIP. • Document as interventions for the PIP the activities and improvement strategies undertaken through collaboratives, committees, and workgroups and which are expected to directly impact study indicator outcomes. • Provide complete descriptions of interventions, demonstrating potential impact on the study indicator outcomes. • Have evaluation processes in place to determine intervention-specific effectiveness and impact of individual interventions on the study indicator outcomes. The CCO should begin evaluating effectiveness of an intervention as soon as the intervention is deployed and should report intervention-specific evaluation results for each intervention quarterly. • Provide completed descriptions of how barriers were addressed and overcome or resolved. • Define acronyms used.
CCO-Specific PIP/Focus Study
• Start smart for baby • Screening for depression • Transitions of care

Umpqua Health Alliance, Inc.

Umpqua Health Alliance, LLC	
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 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	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Fully Met (3.50)
Standard III: Coordination and Continuity of Care	Partially Met (2.60)
Standard IV: Coverage and Authorization of Services	Partially Met (2.57)
Standard V: Provider Selection	Partially Met (2.67)
Standard VI: Subcontractual Relationships and Delegation	Substantially Met (3.00)
Standard XI: Practice Guidelines	Not Met (1.67)
Standard XII: Quality Assessment and Performance Improvement	Fully Met (4.00)
Overall Strengths and Areas for Improvement	
Strengths: Among UHA's strengths was its multi-faceted examination of the CCO's provider network and availability of services. This examination included assessments of time and distance standards, member-to-PCP ratios, access to care grievance analyses, utilization trends, community needs assessments, and member survey results. UHA demonstrated how its use of regular reporting allowed close monitoring of the adequacy of its provider network, including a Network Adequacy Study in 2018 that revealed a comprehensive approach to ensuring access and availability standards were met. UHA's Network Performance Committee met monthly to review the adequacy and performance of its network. Also noteworthy was UHA's formal utilization monitoring program. In particular, UHA's efforts in monitoring and impacting the ED overuse were commendable. UHA had implemented intervention strategies to increase care coordination and outpatient visits to redirect care for members with patterns of ED overuse. The development of UHA's Transitional Care program has additionally been aimed at reducing hospital readmission, while also enhancing quality of care. UHA also boasted a Palliative Care program to support SHCN members that have life-limiting illnesses. UHA's use of performance metrics regarding over- and under-utilization and their assessment of member characteristics have effectively guided improvement efforts. This is an important factor in targeting intervention strategies since the CCO's member population is disproportionately high in terms of seniors, veterans, and persons with disabilities. UHA demonstrated its ability to run care monitoring reports specific to its SHCN members, providing an advantage in addressing the needs for a specific population.	

Umpqua Health Alliance, LLC

Other notable areas of strength included:

- Processes to ensure timely authorization decisions and notices to members.
- Robust pre-delegation processes and comprehensive delegation contracts containing specific information about delegated activities, reporting responsibilities, and remedy and revocation to address unsatisfactory performance.
- Significant strides made regarding coordination and continuity of care in the past year.

Areas for Improvement: UHA's greatest weakness was identified upon review of the Practice Guidelines standard. In addition to posting four outdated medication guidelines on UHA's provider website, there was no formal adoption of clinical practice guidelines and no evidence of a process for adopting or maintaining evidence-based practice guidelines in consultation with contracted health care professionals or considering the needs of its enrollees. The CCO also did not have a process for disseminating guidelines or a mechanism to ensure that contracted providers were consistently adhering to adopted practice guidelines, which is critical in ensuring quality care.

Other areas for improvement included the need for:

- Added accountability in subcontractual and delegation relationships as the lack of a UHA credentialing and recredentialing policy and delegate oversight of MedImpact specifically exposes the CCO to significant risk.
- Prioritization of a cultural competency program that reaches well beyond linguistic aptitude to include development of a training program for CCO staff and contracted providers.

There are many areas for improvement in the development and implementation of policies and procedures with enriched specificity to guide UHA's day-to-day operations. The CCO's awareness of this need has resulted in the recent development of new operational policies. Due to the recent adoption of these policies, UHA's implementation of new processes was often indiscernible, leaving UHA at a disadvantage going into the compliance review. The next review will provide the CCO with an opportunity to showcase full implementation outcomes of those policies and procedures.

Information Systems Capabilities Assessment

ISCA Section	Score (Out of 4.00)
1. Staffing	Fully Met (4.00)
2. Meaningful Use of Electronic Records	Fully Met (4.00)
3. Configuration Management	Fully Met (4.00)
4. Member Enrollment Systems	Fully Met (4.00)
5. Information Systems	FullyMet (4.00)
6. Security	Fully Met (3.50)
7. Provider Data	Fully Met (3.50)
8. Data Integration	Fully Met (3.75)
9. Report Production	Partially Met (2.67)
10. Vendor Management	Fully Met (4.00)

Umpqua Health Alliance, LLC	
11. Administrative Data	Substantially Met (3.25)
Overall Strengths and Areas for Improvement	
Strengths: UHA received an overall ISCA rating of *Fully Met* and demonstrated its implementation of comprehensive sets of policies, procedures, and processes that govern its information systems, the data it manages, and subsequent reporting. Additionally, UHA's ISCA responses and documentation demonstrated appropriate management and oversight of contracted vendors responsible for conducting data and reporting activities on behalf of the CCO. Resulting corrective action plans demonstrated proper follow through to ensure that deficiencies and areas of non-compliance are appropriately and timely mitigated. UHA staff were also able to articulate the CCO's documented oversight processes and provide examples of audit report results and ongoing monitoring activities of its contracted vendors **Areas for Improvement:** Despite receiving an overall rating of *Fully Met* across all ISCA sections, there was considerable variability in UHA's performance across the individual sections with ISCA scores ranging from 2.33 (*Partially Met*) to 4.00 *(Fully Met),* indicating opportunities for improvement. Overall, UHA staff demonstrated knowledge and experience with the majority of the CCO's processes, including how its Medicaid data and information systems are managed but some ISCA elements lacked appropriate documented policies and procedures. The availability of documented processes is critical to ensuring operational procedures and guidelines are available to guide health care operations as well as training and monitoring of staff performance.	
Performance Improvement Projects (PIPs)	
Statewide PIP on Opioid Safety	
Interventions: • Opioid Utilization Management includes prior authorization and quantity restrictions, opioid coverage guideline. • Continued to require prior authorization to determine medication necessity for all benzodiazepine claims. • Participation in the community education workgroup	
Overall Strengths and Areas for Improvement	

Umpqua Health Alliance, LLC

Strengths:

- The problem statement was clearly stated and aligned with one of the seven clinical focus areas.
- Barriers identified and addressed during the intervention implementation.

Areas for Improvement:

- The aim statement, target population, and outcome measures documented in the progress report should align with the statewide specifications for the PIP.
- Document as interventions for the PIP the activities and improvement strategies undertaken through collaboratives, committees, and workgroups and which are expected to directly impact study indicator outcomes.
- Provide complete descriptions of interventions, demonstrating potential impact on study indicator outcomes.
- Have evaluation processes in place to determine intervention-specific effectiveness and impact of individual interventions on study indicator outcomes. The CCO should begin evaluating effectiveness of an intervention as soon as the intervention is deployed and should report intervention-specific evaluation results for each intervention quarterly.
- Provide complete descriptions of how barriers were addressed and overcome or resolved.
- Define acronyms used.

CCO-Specific PIP/Focus Study

PIPs/Focus Study:	Strengths:	Areas for Improvement:
• Emergency room use	• The problem statement was clearly stated and aligned with one of the seven clinical focus areas. • The outcome measures were objective, clearly defined, and aligned with the aim statement. • The CCO documented the interventions and/or quality improvement activities conducted during the quarter. • Interventions were logically linked to the outcome measures.	• Provide a complete and clear aim statement and problem statement which align with the target population. • Provide for the target population complete documentation of inclusion and exclusion criteria as well as age and enrollment requirements. • Provide complete intervention evaluation data which support decisions to continue, revise, or discontinue an intervention. • Document how data are collected and calculated for the outcome measures of the project.

Umpqua Health Alliance, LLC		
		• Document strategies or plans to address identified barriers. • Provide the rationale supporting next steps and intervention status. • Define acronyms used.
PIPs/Focus Study: • Prenatal-decreasing number of newborns with neonatal abstinence syndrome	**Strengths:** • The problem statement was clearly stated and aligned with one of the seven clinical focus areas.	**Areas for Improvement:** • Provide a complete and clear aim statement and problem statement which align with the target population. • Provide for the target population complete documentation of the inclusion and exclusion criteria as well as age and enrollment requirements. • In the absence of national standards or other benchmarks, consider setting a target based on statistically significant improvement over the baseline measurement. • Provide complete intervention evaluation data which support decisions to continue, revise, or discontinue an intervention. • Provide clear outcome results data, including denominator and numerator counts. • Document how data are collected and calculated for the outcome measures of the project. • Provide the rationale supporting the next steps and intervention status.

Umpqua Health Alliance, LLC		
		• Define acronyms used.
PIPs/Focus Study: • Re-admission reduction	**Strengths:** • Remeasurement outcomes met the target, benchmark, or national standard.	**Areas for Improvement:** • Provide a complete and clear aim statement and problem statement which align with the target population. • Provide for the target population complete documentation of inclusion and exclusion criteria as well as age and enrollment requirements. • In the absence of national standards or other benchmarks, consider setting a target based on statistically significant improvement over the baseline measurement. • Provide complete intervention evaluation data which support decisions to continue, revise, or discontinue an intervention. • Document how data are collected and calculated for the outcome measures of the project. • Provide the rationale supporting the next steps and intervention status. • Define acronyms used.

Willamette Valley Community Health, Inc.

Willamette Valley Community Health, LLC	
WVCH serves approximately 99,000 members, primarily in Marion and Polk counties.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Fully Met (4.00)
Standard III: Coordination and Continuity of Care	Fully Met (3.7)
Standard IV: Coverage and Authorization of Services	Substantially Met (3.1)
Standard V: Provider Selection	Fully Met (4.00)
Standard VI: Subcontractual Relationships and Delegation	Fully Met (4.00)
Standard XI: Practice Guidelines	Substantially Met (3.00)
Standard XII: Quality Assessment and Performance Improvement	Fully Met (4.00)
Overall Strengths and Areas for Improvement	

Strengths: WVCH continues to demonstrate improvements and innovations in quality and transformation of health care. The CCO fully or substantially met all compliance standards reviewed during this year's EQR.

The CCO has designed and implemented a small practice wraparound support team. This team includes a behavioral health worker, clinical QI coordinator, nutritionist and clinical pharmacist. This team is designed to support the small clinics that lack the resources to meet patient-centered primary care home (PCPCH) standards but provide members access to robust care teams regardless of which clinic they call home.

The CCO has made great efforts to address disparities in health care with transformation projects including Fostering Hope Initiative, Recovery Outreach Community Center, a dental van in Falls City, and adding a Community Engagement program manager.

WVCH hired an independent research group to conduct a member focus group to receive feedback from members. In addition, the CCO has other tools including consumer assessment of healthcare providers and systems surveys and the community advisory committee, to receive member feedback.

The QAPI submitted is a nice example of integrated data from community based dental settings and behavioral health.

Over the past year, the CCO has spent much time addressing quality and compliance concerns with their NEMT provider. The CCO put this work out to bid and chose to contract with a new NEMT provider with documented improvements.

WVCH picked up many new members who transitioned to them after another CCO ceased operation. WVCH is working on ensuring continuity of care for these members.

Willamette Valley Community Health, LLC
The CCO's behavioral health delegate, Behavioral Care Network, has been instrumental in increasing services and access to WVCH members, and has hosted two community summits to assist in this effort. **Areas for Improvement:** The CCO needs to have a mechanism in place to ensure treatment plans for enrollees with special health care needs are reviewed and revised at least every 12 months, or when the enrollee's circumstances change, the enrollee's needs change, or when the enrollee requests it. The CCO needs to have documentation regarding coverage and authorization of services that includes: • A mechanism to ensure consistent application of review criteria for authorization decisions for all authorized services • Policy or other documentation (by all delegates) about consulting with requesting providers when appropriate The CCO needs to ensure decisions for utilization management, enrollee education or coverage of services are made consistent with guidelines for all covered services. Also, the CCO needs monitor to ensure that decisions are consistent with practice guidelines, including decisions by subcontractors.

Information Systems Capabilities Assessment

This year, WVCH fully met nine of the 11 ISCA sections, substantially met one section and did not meet one section. WVCH has made great progress on improving their information technology (IT) processes and providing oversight of their delegates. WVCH should continue to document these oversight processes in policies and procedures, and actively oversee of all their delegates.

ISCA Section	Score (Out of 4.00)
1. Staffing	Fully Met (4.0)
2. Meaningful Use of Electronic Records	Not Met (1.3)
3. Configuration Management	Substantially Met (3.0)
4. Member Enrollment Systems	Fully Met (4.0)
5. Information Systems	Fully Met (4.0)
6. Security	Fully Met (3.8)
7. Provider Data	Fully Met (3.5)
8. Data Integration	Fully Met (4.0)
9. Report Production	Fully Met (3.5)
10. Vendor Management	Fully Met (3.5)
11. Administrative Data	Fully Met (3.9)

Overall Strengths and Areas for Improvement

Strengths:

- WVCH has made great progress in improving their IT processes and providing oversight of their delegates. For example, they are receiving a weekly dashboard report from PH TECH on claims processing and they have instituted quarterly meetings to discuss data issues. They need to continue to document those processes in policies and procedures and actively engage in oversight of all their delegates.

Willamette Valley Community Health, LLC
• WVCH selected a new vendor for their NEMT services beginning in March 2018. LogistiCare is a nation-wide, experienced vendor of services and has 27 call centers across the country. This should improve their services and their data collection for NEMT. • PH TECH processes the state eligibility monthly and daily files for WVCH. They work the error reports to resolve all discrepancies. They reconcile the enrollment data monthly and produce a report for WVCH. Providers are required to verify eligibility at initial contact and each encounter. They can verify it online in the CIM, via a query transaction to the state, or via phone call to provider services. **Areas for Improvement:** • WVCH did not meet the criteria in the meaningful use area of the ISCA despite developing several independent initiatives to achieve meaningful use throughout their provider network. • WVCH has developed an incurred but not reported document to monitor the claims submission and lag. • There is no formal encounter data validation process in place. Some metrics require review of the clinical chart against the encounters, but they involve small, non-random sampling techniques.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • The CCO distributed a provider letter communicating the requirement for all to enroll in the prescription drug monitoring program by July 1, 2018. • The CCO held prescription drug overdose trainings at TraQ committee meetings in July and September and requested participation by TraQ members, specifically the CCO Opioid Workgroup members, to join regional efforts through the PDO Program. • Buprenorphine product utilization data was collected and analyzed for trends over the time of this PIP (2016-2018). • The CCO revamped its website and plans to go live in October 2018, including an updated opioid education section for providers and community members. • Dental Networks have been actively engaged in this intervention and continue to be champions for reducing opioid misuse and reducing prescribing habits. • The CCO participates in the Regional Opioid Workgroup and promotes regional opioid-related events, trainings, and summits distributed through stakeholders. • The CCOs Chief Medical Officer, Pharmacy Director and Quality and Transformation Director met to discuss options for tailoring interventions to reduce opioid use among youth.
Overall Strengths and Areas for Improvement

Willamette Valley Community Health, LLC
Strengths: • Barriers identified and addressed during the intervention implementation. • Remeasurement outcomes met the target, benchmark, or national standard. **Areas for Improvement:** • The aim statement, target population, and outcome measures documented in the progress report should align with the statewide specifications for the PIP. • Document as interventions for the PIP the activities and improvement strategies undertaken through collaboratives, committees, and workgroups and which are expected to directly impact study indicator outcomes. • Provide complete descriptions of interventions, demonstrating potential impact on the study indicator outcomes. • Have evaluation processes in place to determine intervention-specific effectiveness and impact of individual interventions on study indicator outcomes. The CCO should begin evaluating effectiveness of an intervention as soon as the intervention is deployed and should report intervention-specific evaluation results for each intervention quarterly. • Consider, to achieve real improvement, setting a target based on statistically significant improvement over the baseline measurement. • Define acronyms used.
CCO-Specific PIP/Focus Study
• Pharmacy-integrated care teams • Colorectal cancer screening • Tobacco cessation

Yamhill Community Care

Yamhill Community Care	
YCCO contracts with OHA to provide services to OHP members under the health plan services contract. The CCO provides physical, behavioral and dental health services for OHP members in Yamhill County, as well as Washington and Polk counties. As of March 2018, the CCO had 23,193 enrollees.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score (Out of 4.00)**
Standard I: Availability of Services	Substantially Met (3.4)
Standard III: Coordination and Continuity of Care	Partially Met (2.2)
Standard IV: Coverage and Authorization of Services	Partially Met (2.3)
Standard V: Provider Selection	Full Met (4.0)
Standard VI: Subcontractual Relationships and Delegation	Substantially Met (3.0)
Standard XI: Practice Guidelines	Partially Met (2.0)
Standard XII: Quality Assessment and Performance Improvement	Fully Met (3.75)

Overall Strengths and Areas for Improvement

Strengths: YCCO demonstrated many strengths over the past year. They have expanded local infrastructure of the CCO, including finance, contracting and analytics. Their care management program has expanded to include inpatient outreach, a diabetes management program, and integration and tracking of more cases. The CCO has expanded its use of PreManage, a clinical communication tool, with the population with serious and persistent mental illness, and created a transitions program. YCCO has adopted evidence-based models for complex care teams in primary care and are promoting team-based structures.

- The CCO has made advances in quality metric performance and successfully decreased opioid prescribing in their service area. YCCO has developed local medication-assisted treatment services. They have also increased their weekend hours of operation for urgent care.
- YCCO has created a program for members with behavioral health needs and dental care through their exceptional needs dental services program.
- Yamhill County Health and Human Services, the CCO's behavioral health delegate, visits facilities and homes to increase access to their services.
- The CCO demonstrates high-quality care coordination.
- The CCO has added staff to its quality department.
- YCCO provides outreach for new members, assisting them in obtaining appointments with their primary care provider, primary dental provider, etc.
- YCCO has a data warehouse with integrated data available to reporting and analytics.
- The CCO monitors access to care in their rural areas.

Areas for Improvement: Member access is an issue for this CCO. They are focusing on recruiting new providers and increasing the efficiency of current providers.

The CCO needs to focus on requirements around SHCN members, including:

Yamhill Community Care
• Mechanisms to identify and assess members with behavioral health special health care needs • Processes to ensure that enrollees with special health care needs receive periodic assessment • Mechanisms to ensure periodic care monitoring • Monitoring to ensure treatment plans for enrollees with special health care needs are re-reviewed and revised at least every 12 months or when the enrollee's circumstances change or needs change or when requested • Direct access to specialists in a timely manner, including mechanisms to allow direct access and monitoring to ensure direct access Although YCCO now has an integrated data warehouse, the CCO provided no documentation demonstrating integration of oral health data with medical and mental health data that can be used for analysis of performance measurement. For example, the CCO provided documentation on timely notifications and monitoring of standard and expedited physical health authorizations. However, no documentation was provided to demonstrate timely notification and monitoring of dental and behavioral health authorizations. The CCO did not provide evidence of reviewing and updating practice guidelines. Also, no information was provided related to oral health interrater reliability, or assurance that decisions are made consistent with practice guidelines. YCCO's management services agreement with CareOregon (amendment #4) specifies activities and report responsibilities. The most recent amendment (#5) does not have a contract term, so it is not clear if this agreement is current.

Information Systems Capabilities Assessment	
ISCA Section	**Score (Out of 4.00)**
1. Staffing	Full Met (4.0)
2. Meaningful Use of Electronic Records	Full Met (4.0)
3. Configuration Management	Full Met (4.0)
4. Member Enrollment Systems	Full Met (4.0)
5. Information Systems	Full Met (4.0)
6. Security	Full Met (3.5)
7. Provider Data	Partially Met (2.6)
8. Data Integration	Full Met (4.0)
9. Report Production	Full Met (3.6)
10. Vendor Management	Substantially Met (3.2)
11. Administrative Data	Full Met (3.6)

Overall Strengths and Areas for Improvement
Strengths: • YCCO performs annual risk assessments with its IT contractors. The CCO has developed excellent tools and reports that are used in the management of their contracts.

Yamhill Community Care
• YCCO actively encourages providers to adopt certified EHRs through a variety of incentives and other programs. They created an Innovation Specialist program that provides direct support to clinics about how to use their EHRs to drive quality improvement initiatives. CareOregon tracks EHR usage down to the version level. All dental providers are using certified EHRs even though it is not a federal requirement. • A System Security Plan is a document that describes an organization's security and privacy environment for its information systems. The document records the security and privacy controls used in the protection of all data received, stored, processed and transmitted by the organization. • YCCO's delegates have them in place, which is an excellent baseline. These documents are dynamic and need to be reviewed, updated and tested at least annually. • Since all encounter processing is outsourced, YCCO has developed several processes to ensure that the encounter data is accurate and complete. They perform annual data reconciliation with each of their contractors where they compare the state's encounter data to their data, and work through the discrepancies with the providers, if necessary. The CCO generates an incurred-but-not-reported document to track the lag time and other submission trends and follow-up with their delegates when irregularities are seen. **Areas for Improvement:** • The CCO's delegates submitted organization charts and staffing information, meeting all criteria for the ISCA staffing section. The delegates have adequate staffing to meet the volume of claims required by YCCO. They provide ongoing training for both IT and claims processing staff in addition to training required at onboarding. • YCCO has not yet developed a security plan at the CCO level that describes their controls and security guidelines for its delegates. • YCCO needs to develop a comprehensive BC/DR plan for itself and see that all of its delegates perform the required testing and plan maintenance. • Over the past 18 months, YCCO has worked with PH TECH to develop a data warehouse for performance measure generation and business analytics. The warehouse repository has been completed and tested, and some ad hoc reports have been generated. YCCO is also in the process of building a small staff for developing a business analytics program. These initiatives are an excellent step toward to using data to drive business and quality improvement decisions. • YCCO does not have a policy to complete a formal EDV study annually. • The CCO did not submit documentation of delegates' processes for many criteria. YCCO lacked documentation of a corrective action process specific to data integrity. The CCO did not submit documentation of issues with member data supplied by any contracted vendor(s), or resolution of any issues identified. Also, YCCO did not provide documentation of a process for monitoring and tracking trends related to vendor supplied data. • The CCO lacked a policy regarding submission of zero and low-dollar claims; CCO representatives stated that they do receive some of these, but cannot determine if there are providers who chose not to submit these claims.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions:

Yamhill Community Care
• Alternative payment methodology. • Provider outreach and education. • Participation in the community committee. • Persistent pain program community pain management program. • Explore barriers to MAT. • PDMP Registration and use. • Physical health network actively worked to outreach and contract with complementary and alternative medicine providers (CAM) in the Yamhill County service area. • Opioid prescribing patient-level data shared with providers quarterly, which includes total MED.
Overall Strengths and Areas for Improvement
Strengths: • Barriers identified and addressed during the intervention implementation. **Areas for Improvement:** • The aim statement, target population, and outcome measures documented in the progress report should align with the statewide specifications for the PIP. • Document as interventions for the PIP the activities and improvement strategies undertaken through collaboratives, committees, and workgroups and which are expected to directly impact study indicator outcomes, as the interventions for the PIP. • Provide complete descriptions of interventions, demonstrating potential impact on the study indicator outcomes. • Have evaluation processes in place to determine intervention-specific effectiveness and impact of individual interventions on the study indicator outcomes. The CCO should begin evaluating effectiveness of an intervention as soon as the intervention is deployed and should report intervention-specific evaluation results for each intervention quarterly. • Provide outcome measure rates for comparability, including denominator and numerator counts for validation. • Define acronyms used.
CCO-Specific PIP/Focus Study
• Reduce ED utilization • Hepatitis C screening and treatment • Patient-centered primary care home engagement-improving primary care through increased adoption of PCPHC model

Appendix B. PH TECH 2018 ISCA Results

Purpose

HSAG is including this PH TECH ISCA report written by HealthInsight Assure as an appendix for EQR reports for the MHO and the CCOs that contract with PH TECH, and for those whose delegates contract with PH TECH.

PH TECH Operations

PH TECH provides claims processing, benefit and reimbursement configuration, encounter data management, population management, appeals/grievance support, customer service and a community portal to community health plans. PH TECH's internally developed Community Integration Manager (CIM) technology platform is flexible, scalable, and now offered as a SaaS (software as a service) option. The privately held company was founded in 1996 and has less than 500 employees.
PH TECH has a letter of intent to merge with a large healthcare organization. If this occurs, PH TECH expects to maintain their existing business mission and existing customer base.

In the last year, PH TECH made several staff structure changes. Staffing changes included removing the COO position, adding vice president roles in service operations and IT, and adding a new role—chief strategy officer. working on fee schedules and provider profiles have been consolidated to a single team for operational efficiencies. Team members do not have dual responsibilities with both provider profile and fee schedule activities. The organization is consolidating facilities and moving IT engineers and IT architects into the headquarter building. Staff that typically worked remotely, including project managers, will continue to work remotely.

Primary subcontractors include Amazon for services such as web backup; Payspan Inc., for explanation of benefits, member communication, provider remittance and electronic funds transfer; PHIA Group LLC and HMS for coordination of benefits, accident recovery, third party liability, subrogation and proactive eligibility services.

PH TECH began providing CIM as a SaaS service to customers in 2017. This new business line allows customers more direct control such as paying claims directly from the CIM application.

PH TECH has increased its Oregon customer base to include Umpqua Health Alliance and Primary Health of Jackson County. PH TECH is providing data processing services to these two organizations.

PH TECH holds contracts with the following organizations in Oregon, providing a variety of data processing services:

- Access Dental Care

- AllCare Health Plan
- Capitol Dental Care
- Family Dental Care
- Greater Oregon Behavioral Health Inc. (MHO)
- Health Share of Oregon
- Managed Dental Care of Oregon
- Primary Health of Josephine County
- Umpqua Health Alliance
- Willamette Valley Community Health
- Yamhill CCO
- Advanced Health (formerly Western Oregon Advanced Health)
- Columbia Pacific CCO
- Eastern Oregon CCO
- FamilyCare (2017)
- Intercommunity Health Network
- Jackson Care Connect
- Pacific Source (Central Oregon and Columbia Gorge)
- Trillium Community Health Plan

2018 ISCA Outcomes

Strengths

PH TECH has a comprehensive, detailed business continuity/disaster recovery plan. The plan ensures that organizational assets are protected if a disaster takes place. The plan includes specifically identified personnel, contact information and role, an impact severity analysis and recovery prioritization. The disaster recovery plan includes enough detail to enable an outside IT professional to bring systems up to operational level in a timely manner. PH TECH has completed table-top testing and documented the outcomes.

PH TECH's staff management model includes robust training for new hires and quarterly reviews for all staff that ensure all staff have the required skills.

The organization's information systems model includes a fully separated guest network requiring a login and password. The IT development team works in a mirrored environment, ensuring a team environment and no work silos. A ticketing system is used to capture any new internal or externally originated requests, changes and issues. Tickets are discussed regularly, ensuring issues or requests do not get forgotten.

As a community partner, PH TECH is working closely with OHA and other CCOs to help transition FamilyCare's members (and member data) to other CCOs.

Table E-1 shows PH TECH's results for each of the main ISCA sections.

Table E-1 – ISCA Review Results
Section 1: Staffing – Fully met (4.0)
PH Tech fully met the criteria for this section.
Section 2: Meaningful Use of Electronic Health Records – NA
Not applicable.
Section 3: Configuration Management – Fully met (4.0)
PH Tech fully met the criteria for this section.
Section 4: Member Enrollment Systems – Fully met (4.0)
PH Tech fully met the criteria for this section.
Section 5: Information Systems – Fully met (4.0)
PH Tech fully met the criteria for this section.
Section 6: Security – Fully met (4.0)
PH Tech fully met the criteria for this section.
Section 7: Provider Directory – Fully met (4.0)
PH Tech fully met the criteria for this section.
Section 8: Data Integration – Fully met (4.0)
PH Tech fully met the criteria for this section.
Section 9: Report Production – Fully met (4.0)
PH Tech fully met the criteria for this section.
Section 10: Vendor Management – Fully met (4.0)
PH Tech fully met the criteria for this section.

Table E-1 – ISCA Review Results
Section 11: Administrative Data – Substantially met (3.75)
Finding #1: PH TECH described a process for monitoring trends in reporting of claims/encounters from providers and supplying documentation to the CCOs they contract with, but no documentation was submitted to support this response. PH TECH needs to fully document its process to monitor the volume of claims/encounters submitted by providers to be able to identify when providers are submitting incomplete or reduced levels of claims/encounter data so this can be addressed in a timely manner. *Scoring criteria not met for this section:* • *The CCO has documented policies, procedures or processes relevant to defining how to estimate the completeness of Medicaid claims/encounter data.*

Appendix C. 2017 Dental Plan Network ISCA Findings

Purpose

HSAG is including this 2017 Dental Plan Network (DPN) ISCA Findings report written by HealthInsight Assure as an appendix for EQR reports for the MCEs that contract with the four main DPNs in Oregon.

Overview

With approval by OHA in 2017, HealthInsight Assure performed an ISCA of the four DPNs that contract with the majority of the CCOs. The CCOs that contracted with these DPNs received copies of the DPN ISCA reports, with the understanding that they were responsible for following up with these delegates to ensure they were addressing the issues identified in 2017. See the 2017 OHA EQR Annual Report for full details.

2018 ISCA Outcomes

The 2017 DPN ISCA resulted in findings for the following sections (Figure C-1).

Table C-1 – 2017 ISCA DPN Findings.

2017 ISCA Sections		Advantage Dental	Capitol Dental	ODS	Willamette Dental Group
1	Information Systems (data flow)				√
2	Staffing (claims and encounter, authorization)		√√		√
3	Configuration Management - Hardware Systems				√
4	Security (incident management, risk management)	√	√	√√	
5	Administrative Data (claims and encounter data)		√	√	
6	Enrollment Systems (Medicaid eligibility downloads)				
7	Vendor Data Integration and Ancillary Systems				

Table C-1 – 2017 ISCA DPN Findings.					
2017 ISCA Sections		**Advantage Dental**	**Capitol Dental**	**ODS**	**Willamette Dental Group**
8	Report Production and Integration and Control of Data for Performance Measure Reporting				√
9	Provider Data (compensation and profiles)		√		√
10	Meaningful Use of Electronic Health Records				

Note: These ISCA categories, based on ISCA review tool used in 2017, are somewhat different from the ISCA review tool used for the 2018 ISCA.