Oregon Health Authority

2019 External Quality Review Technical Report

March 2020

HSAG HEALTH SERVICES ADVISORY GROUP

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Abbreviations and Acronyms Used in This Report

ACT.....Acceptance and Commitment Therapy
AHRQ.....Agency for Healthcare Research and Quality
CBT.....Cognitive Behavioral Therapy
CCO.....Coordinated Care Organization
CMHP.....Community Mental Health Program
CMR.....Compliance Monitoring Review
CMS.....Centers for Medicare & Medicaid Services
CY.....Calendar Year
DCO.....Dental Care Organization
DSN.....Delivery System Network
ED.....Emergency Department
EDie.....Emergency Department Information Exchange
EQR.....External Quality Review
EQRO.....External Quality Review Organization
FQHC.....Federally Qualified Health Center
FFS.....Fee-for-Service
GOBHI.....Greater Oregon Behavioral Health, Inc.
HEDIS®*.....Healthcare Effectiveness Data and Information Set
HIA.....HealthInsight Assure
HSAG.....Health Services Advisory Group, Inc.
IP.....Improvement Plan
ISCA.....Information Systems Capabilities Assessment
ISCAT.....Information Systems Capabilities Assessment Tool
LGBTQ.....Lesbian, Gay, Bisexual, Transgender/Sexual, and Queer
MAT.....Medication-Assisted Treatment
MCE.....Managed Care Entity
MCO.....Managed Care Organization

* **HEDIS®** refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

MHO ..... Mental Health Organization
MME ..... Morphine Milligram Equivalent
MMIS ..... Medicaid Management Information System
NCQA ..... National Committee for Quality Assurance
NEMT ..... Non-emergent medical transportation
OHA ..... Oregon Health Authority
OHP ..... Oregon Health Plan
OUD ..... Opioid Use Disorder
PAHP ..... Prepaid Ambulatory Health Plan
PCPCH ..... Patient-Centered Primary Care Home
PDMP ..... Prescription Drug Monitoring Program
PFL ..... Provider File Layout
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
PSV ..... Primary Source Verification
QAPI ..... Quality Assessment and Performance Improvement
QHOC ..... Quality Health and Outcomes Committee
QI ..... Quality Improvement
SAFE ..... Secure Access File Exchange
SDOH ..... Social Determinants of Health
SUD ..... Substance Use Disorder
TA ..... Technical Assistance
TQS ..... Transformation and Quality Strategy

1. Executive Summary

Overview

Coordinated care organizations (CCOs) were formed as part of Oregon's healthcare 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 mental 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)."[1-1]

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. OHA is contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO. EQR activities conducted by HSAG in 2019 include:

- Compliance monitoring reviews (CMRs) to determine DCO compliance with federal (42 CFR §438) and State standards that address requirements related to access, structure and operations, and quality measurement and improvement.[1-2] CMR activities also included follow-up on the status of past CCO/MHO CMR findings and related improvement plans (IPs).
- An evaluation of the CCOs' performance improvement projects (PIPs) and focus studies.
- Performance measure validation (PMV) of five 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 compliance in accordance with the State's standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN.

For 2019, HSAG used review tools, scoring strategies, and other processes that were consistent with CMS Protocols released in 2012. This technical report is a compilation of results from the 2019 EQR-

[1-1] Unless citing Title 42 CFR, this report will refer to OHA's CCOs, MHO, and DCOs collectively as MCEs.

[1-2] The 2018 DCO review standards included: Availability of Services and Grievance and Appeal Systems.

related 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. DCO Profiles* and *Appendix B. CCO/MHO Profiles*.

Compliance Monitoring Review

MCE CMR activities in 2019 consisted of conducting the first CMR of DCOs and, for the CCOs and MHO, following up on findings issued during the 2018 CMR. In addition, previously unresolved findings from the 2017 CMR and unresolved dental plan network Information Systems Capabilities Assessment (ISCA) findings were addressed.

The DCO CMR consisted of a series of technical assistance (TA) webinars for DCO staff members; a pre-onsite desk review of completed evaluation tools and submitted documentation to determine compliance; an onsite review, which included interviews of key MCE staff members and record reviews of administrative files related to grievances and appeals; and a follow-up desk review of any additional documentation provided the day of the onsite visit. DCO performance was evaluated on two compliance standards:

- Standard I—Availability of Services
- Standard X—Grievance and Appeal Systems

The CCO/MHO follow-up review examined corrective actions taken on findings from the 2018 CMR that evaluated one-half of the full set of Medicaid managed care standards to complete the compliance cycle within a three-year period. It also included a review of findings remaining from the 2017 CMR. The CCOs and the MHO were responsible for developing an IP to address the unresolved EQR and ISCA findings. As the EQRO, HSAG was entrusted to assess the action taken by the MCEs and review submitted supporting documentation to determine if the findings had been resolved.

DCO Review Results

DCOs demonstrated compliance with the majority of elements in both standards. Some DCOs performed exceptionally well, with the highest performing DCO achieving 90 percent compliance with Standard I—Availability of Services and 98 percent compliance with Standard X—Grievance and Appeal Systems. Scores were generally lower for Standard I and generally higher for Standard X.

Overall Strengths

A notable strength for all DCOs was their commitment to improving quality of care and access to care, and proactively addressing any grievances and appeals. While some DCOs did not have formal documentation of their policies and procedures, they were able to describe and demonstrate compliant policies, necessary processes, and procedures. HSAG provided this feedback to those DCOs and noted they were receptive to the feedback and promptly made strides to develop such documentation.

Major Areas for Improvement and Recommendations

Many of the DCOs struggled to provide member notifications at an appropriate reading level but acknowledged readability as a priority, with resources being invested to achieve a significant impact on health literacy for their members. In addition, many of the DCOs lacked formal contracts or agreements with out-of-network providers, which could result in liabilities related to service costs and member care.

CCO/MHO Findings Follow-Up Results

Most MCEs provided sufficient documentation to resolve the majority of their findings for each year. Some CCOs were able to resolve all of their findings for some years. Because the number of findings across MCEs varied considerably, resolution percentages cannot be meaningfully compared. This was the final follow-up action for all findings prior to 2019.

Performance Improvement Projects

During 2019, the CCOs 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. For the 2019 activities, as part of the PIP assessment process, HSAG identified areas in need of improvement or TA needed within each CCO's stated progress on the statewide PIP and the CCO-specific PIP topics.

Statewide PIP Results

All 15 CCOs received an overall *Met* PIP validation status after the final submissions. The validation results suggest that the CCOs used methodologically sound and effective strategies for improving the safety of opioid prescribing during the final remeasurement period.

Statewide and CCO-specific study indicator data for the statewide PIP provided by OHA demonstrated that there was a statistically significant statewide improvement (decrease) in the rate of high-dose opioid prescriptions from baseline to the final remeasurement.

The CCO profiles in *Appendix B. CCO/MHO 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 2019.

In addition to submitting the final remeasurement results for the *Improving the Safety of Opioid Management* statewide PIP for validation in 2019, OHA and the CCOs collaborated on developing the design for a new statewide PIP that will focus on improving the safety of acute opioid prescribing among members with little to no knowledge of or prior experience with opioids. The CCOs will submit the new statewide PIP design for validation by HSAG in 2020.

CCO-Specific PIP and Focus Projects Review Results

The CCOs provided quarterly reports on their selected PIPs and focus studies. The OHA contract requires each CCO to conduct three PIPs and one focus study designed to improve care in at least four of the eight quality improvement (QI) focus areas.

HSAG's PIP team reviewed the first, second, and third quarter 2019 progress reports and documented observations and findings for each CCO in the PIP Progress Review Tool. HSAG reviewed progress reports for 46 PIPs each quarter. The CCO-specific PIPs and focus studies addressed a wide range of topics related to the eight focus areas listed in Section 5. Across the CCOs, the number of PIPs addressing each focus area also varied, ranging from one PIP addressing the *reducing preventable rehospitalizations* focus area to 15 PIPs addressing the *ensuring appropriate care is delivered in appropriate settings* focus area.

Performance Measure Validation

HSAG evaluated the accuracy and validity of OHA's calculation of the performance measure rates for the 15 CCOs. These measures represented Healthcare Effectiveness Data and Information Set (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 OHA

Performance Measure
Adolescent Well-Care Visits
Ambulatory Care: Emergency Department (ED) Utilization
Dental Sealants on Permanent Molars for Children
Developmental Screening in the First Three Years of Life
Effective Contraceptive Use

PMV Results

HSAG did not identify any issues or concerns with the accuracy or validity of OHA's calculation of the performance measure rates. It was noted, however, that OHA had no formal process for validation of the encounters used to calculate performance measures.

Delivery System Network Evaluation

Each CCO is required to submit an annual integrated DSN Report and analysis to OHA demonstrating the CCO's capacity to serve enrolled members in its service area in accordance with the State's standards for access to care. OHA requested HSAG provide a comprehensive review of the 2019 CCO DSN reports and document findings regarding compliance in accordance with standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN. HSAG presented these findings in a 2019 DSN Evaluation Report comprised of the evaluation of the two parts of the CCOs' annual integrated DSN Report: the DSN Provider Narrative Report and the DSN Provider Capacity Report.

2019 DSN Evaluation Results

Overall, the CCOs received a score of 24.3 points across aggregated DSN Provider Narrative Report Categories, or approximately 93.5 percent of the maximum points possible (26.0 points). Three of the 15 CCOs met the requirements of all DSN Provider Narrative Report Categories. Most CCOs met the *Coordination of Care* and *Performance on Metrics* categories and six CCOs met the *Description of the Delivery Network and Adequacy* narrative category. As such, while CCO overall aggregate performance was fair, the variation in scores among the CCOs indicated several opportunities for improvement.

The DSN Provider Capacity Report provides an inventory of providers and facilities within the CCOs' provider networks. Similar to the previous year, multiple reporting inconsistencies were identified among the different CCO's DSN Provider Capacity Report submissions. The Provider Capacity Report Template used in 2019 presented several limitations and challenges for submitting provider capacity information, conducting analyses of statewide provider and facility inventories, and conducting comparisons across CCOs. HSAG recommends that OHA consider revisions to the Provider Capacity Report Template to improve the accuracy of network capacity data submitted to the State and that OHA incorporate a more value-added approach to understanding access to care. This could include a provider directory comparative analysis with provider capacity data reported to OHA and secret shopper calls to assess capacity directly with provider offices.

2. Introduction

Overview

As required by 42 CFR §438.364,[2-1] OHA is contracted with HSAG as an EQRO to perform the mandatory EQR 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 2019 by HSAG and provides:

- An overview of Oregon's Medicaid program, referred to as the OHP.
- A description of the scope of EQR activities conducted in 2019.
- 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 2019.
- Recommendations to OHA for each of the EQR activities related to access, timeliness, and quality of care related to the healthcare 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 MCEs responsible for the Medicaid delivery system referred to as the OHP. The now 15 CCOs are responsible for managing physical and mental health services for OHP members (including NEMT), as well as the dental health of members. OHA also contracts with GOBHI, an MHO, and six DCOs to provide behavioral health and dental services, respectively, to OHP members not enrolled with the CCOs. Each MCE is responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory obligations to provide effective care.

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 OHP members (referred to as "members" in this report). As required by 42 CFR §438.364, this independent technical report summarizes conclusions drawn by HSAG related to MCE strengths and areas for improvement with respect to the quality and timeliness of, and access to the healthcare services furnished to members and includes:

- 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.

[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: November 14, 2017.

- 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 healthcare services furnished to Medicaid members.
- Recommendations for improving the quality of healthcare services furnished by MCEs to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid members.
- 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 QI 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. OHA contracted with HSAG to carry out these activities, which included conducting:

- A review to determine DCO compliance with federal (42 CFR §438) and State requirements, which address requirements related to access, structure and operations, and quality measurement and improvement. The review consisted of two specific member-focused standards:
  - Standard I—Availability of Services
  - Standard X—Grievance and Appeal Systems
- Follow up on the status of past CCO/MHO compliance review findings and related IPs.
- A review of CCO 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 members and used to generate feedback to OHA regarding potential areas for improvement.
- PMV to assess the accuracy of a set of five incentive performance measures reported and determine the extent to which the reported rates follow the measure specifications and reporting requirements.
- An evaluation of the 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 members, and strengths and gaps regarding the DSN.

For 2019 compliance review activities, HSAG followed protocols and review tools adapted from CMS guidelines. 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 IPs related to previous compliance review findings.
- Conducted their PIPs properly and achieved improvement in PIP outcomes.
- Had information systems, data processing, and reporting procedures that supported the capacity to manage the healthcare of their members and produced of valid and reliable performance metrics.

Oregon Managed Care

The OHP is the source of health coverage for approximately 988,049 Oregonians[2-2], approximately 890,212 of which are covered by a CCO. Care for OHP members is provided through CCOs, the 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. There were 15 CCOs providing OHP services in Oregon in 2019.

Table 2-1 displays the pre-CCO 2.0 CCOs and their enrollment totals as of October 15, 2019. Numbers do not add up to 988,049 due to some members' lack of enrollment with any CCO and being covered via the State's fee-for-service (FFS) program.

[2-2] Oregon Health Authority. Oregon Health Plan: Monthly Medicaid Population Report. CCO, Managed Care, and Open Card, October 2019. Available at: https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/October%202019%20Total%20CCO-Managed%20Care%20and%20FFS%20Enrollment.pdf. Accessed on: October 28, 2019.

Table 2-1—OHP Enrollment by CCO[2-3]

CCO	Total Members
Advanced Health (AH)	20,308
AllCare CCO, Inc. (AllCare)	50,335
Cascade Health Alliance, LLC (CHA)	18,600
Columbia Pacific CCO, LLC (CPCCO)	25,390
Eastern Oregon CCO (EOCCO)	51,558
Health Share of Oregon (HSO)	319,190
InterCommunity Health Network (IHN)	55,348
Jackson Care Connect (JCC)	31,755
PacificSource Community Solutions—Central Oregon (PSCS-CO)	49,110
PacificSource Community Solutions—Columbia Gorge (PSCS-CG)	12,041
PrimaryHealth of Josephine County dba Primary Health (PH)	10,399
Trillium Community Health Plan, Inc. (TCHP)	91,711
Umpqua Health Alliance, LLC (UHA)	27,958
Willamette Valley Community Health, LLC (WVCH)	102,058
Yamhill Community Care Organization (YCCO)	24,451
Total	**890,212**

January 1, 2020, marks new contract terms for CCOs referred to as "CCO 2.0."[2-4] The new contract builds on efforts to improve care for OHP members, contain costs, and meet State and federal requirements but also represents a set of new requirements related to better integration, addressing social determinants of health (SDOH), and accountability. Fifteen CCOs were selected to provide OHP services in Oregon. All of the selected CCOs were previously providing OHP services with some of them expanding service areas under CCO 2.0. All counties in Oregon will be served by at least one CCO.

[2-3] Ibid.

[2-4] Oregon Health Authority press release. "OHA signs contracts with 15 coordinated care organizations." Available at: https://www.oregon.gov/oha/ERD/Pages/OHA-Signs-Contracts-15-Coordinated-Care-Organizations.aspx. Accessed on: October 28, 2019.

Mental Health Organization

OHA contracts with GOBHI as an MHO to manage mental health services for FFS Medicaid members. GOBHI has approximately 1,055 FFS members[2-5] throughout the State and has contracts with CCOs to manage mental health benefits for Medicaid managed care members in 15 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 support the triple aim and comply with legal, contractual, and regulatory obligations to provide effective care. Results from EQR activities conducted with GOBHI are included in this report. GOBHI declined to renew their contract to directly serve OHP members and will no longer directly contract with OHA beginning January 2020.

Dental Care Organizations

During 2019, six DCOs were contracted with OHA to provide managed dental care services to approximately 45,338 Medicaid direct contract (referred to in this report as FFS) members.[2-6] They were also contracted with the CCOs to manage dental health benefits for Medicaid managed care members across the State.

Managed Care Quality Strategy

Federal regulations under 42 CFR §438.340 require each state Medicaid agency contracting with MCOs to develop and implement a written quality strategy to assess and improve the quality of managed care services. OHA's current quality strategy was included as part of Oregon's 1115 Medicaid Demonstration Waiver and approved by CMS in June 2018.[2-7] 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 the following eight focus areas:

- Reduce preventable re-hospitalizations

[2-5] Oregon Health Authority Monthly Medicaid Population Report. CCO by Counties for Mental Health Plan – October 2019. Available at: https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/October%202019%20Mental%20Health%20Service%20Delivery%20by%20County.pdf. Accessed on: October 28, 2019.

[2-6] Oregon Health Authority Monthly Medicaid Population Report. CCO by Counties for Dental Health Plan Type—October 2019. Available at: https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/October%202019%20Dental%20Health%20Service%20Delivery%20by%20County.pdf. Accessed on: February 20, 2020.

[2-7] Oregon's 2017 Section 1115(a) Medicaid Demonstration Waiver. Available at: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Oregon%20Health%20Plan%20STCs_2017-2022.pdf. Accessed on: January 13, 2019.

- 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
- SDOH

CCOs are required to submit their own Transformation and Quality Strategy (TQS) incorporating all components of the Quality Assessment and Performance Improvement (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 quality strategy updates. OHA engages several stakeholder groups and provides public comment opportunities in the process.

3. Overall Assessment of Access, Timeliness, and Quality

Overview

From the data collected across EQR activities in accordance with 42 CFR §438.358, HSAG summarized each performance with attention toward each plan's strengths and weaknesses providing an overall assessment and evaluation of the quality and 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, or PAHP increases the likelihood of desired outcomes of its members 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**—The 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 healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members 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 (AHRQ) 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.

Assessment Results

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 8. 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 members.

Quality

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 TQS to ensure robust and streamlined quality programs, and statewide and MCE-specific PIPs and focus studies.

The CCOs all participated in Oregon's statewide PIP on opioid safety and continue to implement their interventions for 46 CCO PIPs and focus study projects ranging from one PIP addressing OHA's focus area on reducing preventable re-hospitalizations, to 15 PIPs addressing the focus area on ensuring appropriate care is delivered in appropriate settings. Validation results for the statewide PIP demonstrated that the CCOs used methodologically sound and effective strategies for improving the safety of opioid prescribing and that there was a statistically significant statewide improvement (decrease) in the rate of high-dose opioid prescriptions from baseline to the final remeasurement. The CCO PIPs and focus study projects include reducing ED utilization, ensuring oral health during pregnancy, screening for specific conditions (e.g., colorectal cancer, Hepatitis C, and SDOH), tobacco cessation, and contraceptive care.

All of the MCEs coordinate 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, but many MCEs continue to lack formal care and treatment plans. The delegation of care coordination also continues to present a challenge for managing care coordination at the CCO level. Full integration continues to be a challenge for the CCOs but could greatly impact care coordination efforts if achieved.

Access

Most of the MCEs continue to provide 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 coordinated and integrated care. To address the inherent challenges associated with the 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 were monitored and used to inform network adequacy. While the majority of the CCOs used single-case agreements to ensure access to out-of-network providers, the DCOs as smaller MCEs with less need for out-of-network providers lacked any formal agreements with such providers. Monitoring access to care continued to be largely reactive, focusing on the review of access-related grievances and complaints, and capacity was less clear in that time and distance were not captured consistently and adequacy of provider to member ratios did not pertain to any specific guidelines across CCOs.

Timeliness

The MCEs have 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. All CCOs have been using the Emergency Department Information Exchange (EDie) system for alerting CCO staff members to member ED visits, enabling them to timely coordinate care and discharge planning. Overall, the MCEs have policies, procedures, and programs that describe their coverage and authorization of service activities and support timely access to care by defining timeliness standards for delegates and providers. However, monitoring efforts for timely access to care continue to be deficient or poorly documented.

4. Compliance Monitoring 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 2019 compliance reviews were compiled and reported to each MCE and the State.

Review Activities

DCO Reviews

MCE CMR activities in 2019 consisted of following up on 2018 CCO/MHO CMR findings and conducting a CMR of DCOs on two compliance standards:

- Standard I: Availability of Services
- Standard X: Grievance and Appeal Systems

Prior to the reviews, DCOs were invited to participate in a series of webinars to adequately prepare them for document submission expectations and the onsite review, which included staff interviews and record reviews of grievance and appeal files. During the 2019 compliance reviews, HSAG used evaluation tools developed by HSAG and followed the CMS Protocol.[4-1]

HSAG reviewers used information obtained from the pre-onsite desk review as well as additional information gathered during the onsite/webinar review and interviews with key MCE staff members to document their observations and findings for each MCE and score them accordingly. HSAG determined whether the element was *Met*, *Partially Met*, or *Not Met* based on the information collected. HSAG assigned a score of *Met (1.0)*, *Partially Met (0.5)*, or *Not Met (0.0)* to each element based on the scoring criteria contained in the respective protocols. Table 4-1 provides the scoring method applied to each standard.

[4-1] The compliance review protocols and review tools were consistent with 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.

Table 4-1—Scoring Scheme for Elements in the 2019 CMR and 2018 CMR Follow-Up

Rating	Standard Score
Met (full compliance)	1.0
Partially Met (partial compliance)	0.5
Not Met (noncompliant)	0.0

After the scoring was completed and tabulated for each CMR standard and record review, HSAG documented the overall strengths and opportunities for performance improvement based on its findings. HSAG then prepared draft reports of its findings and forwarded them to OHA and the respective MCEs for review prior to issuing final reports.

HSAG established a Secure Access File Exchange (SAFE) website to securely share the evaluation tools; instructions for document submission; and an attachment soliciting basic organizational and structural information, including any delegated operations. The evaluation tools consisted of a comprehensive listing of elements to be reviewed and were intended to serve as a guide for the DCOs' submission of compliance documentation and preparation for onsite interviews. The same SAFE website was utilized by the DCOs to submit their completed tools and supporting documentation.

Prior to the onsite review, HSAG conducted a desk review of all completed evaluation tools and submitted documentation in order to prepare a focused and efficient review while onsite. The onsite review served to supplement HSAG's understanding of DCO processes and garner more robust evidentiary support of DCO compliance. During the onsite review, DCOs were able to submit additional or clarifying documentation, navigate reviewers through relevant processes, and allow key staff members to bring processes into greater focus.

For the record review component of the CMR, HSAG requested a comprehensive list of each DCO's grievances and appeals from the first two quarters of 2019 for only those members served through direct contract with the State rather than through CCO contract(s). From the list provided, a random number generator was used to select a sample of 10 grievance records and 10 appeal records to be reviewed onsite. DCOs were made aware of the randomly selected files prior to the onsite review. For those whose lists included less than 10 grievances and appeals, the DCOs were informed that all grievances and appeals would be reviewed. For those that had no grievances or appeals, HSAG requested that the DCO be prepared to share a detailed walk-through of the grievance and appeal process with reviewers.

After the scoring was completed and tabulated for both standards, HSAG documented the overall strengths and opportunities for performance improvement based on its findings. HSAG then prepared an initial draft report of its findings and forwarded it to OHA and the DCO for feedback prior to issuing the final report.

CCO/MHO Findings Follow-Up

The CCO/MHO follow-up review assessed corrective actions taken to resolved findings from the 2018 CMR, which were based on a review of one-half of the full set of Medicaid managed care standards in 2018 to complete the compliance cycle within a three-year period. HSAG also reviewed unresolved findings from a comprehensive ISCA conducted in 2018 and previously unresolved findings from the 2017 EQR and the 2016 ISCA of dental plan networks contracted with the CCOs. Specific compliance standards evaluated in 2018 and followed up on in 2019 included the following:

- 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

To demonstrate the resolution of EQR and ISCA findings, the CCOs and the MHO were responsible for developing an IP with full implementation of the IP by September 3, 2019. As the EQRO, HSAG was entrusted to assess the actions taken and review submitted supporting documentation to determine if the findings had been resolved.

OHA provided HSAG with the IPs submitted by the CCOs and the MHO. Using each organization's IP, HSAG populated an individualized EQR Findings Follow-Up Assessment Tool for each CCO and the MHO, which was then uploaded to its SAFE website for the CCOs and the MHO to access. The tool included the year of the finding and the associated report reference, as well as the findings extracted directly from the associated EQR Report. Each CCO and the MHO were required to complete fields identifying actions taken, current IP status, and documentation being submitted as evidence of IP implementation.

Each CCO and the MHO submitted their respective completed tool via the SAFE website along with supporting documentation to provide evidence of implementation. HSAG conducted a desk review of the tool and the supporting documentation to assess whether the actions taken and documentation provided were adequate to resolve each finding. Once the desk review was complete, HSAG held individual conference calls with each CCO and the MHO to discuss the initial assessment of IP implementation and to allow for further explanation and clarification of actions taken. HSAG then prepared an initial draft summary of its findings and forwarded it to OHA and each CCO for feedback prior to issuing a final summary report.

Review Results

Results for the DCO CMR are presented separately from the CCO/MHO findings follow-up results. Scoring results from the DCO CMRs can be directly compared to one another, while CCO/MHO Findings follow-up results cannot be directly compared to one another, having different elements that were previously found to be noncompliant. The CCO/MHO results are reported as counts of resolved and unresolved findings.

Summary of DCO Review Results

DCOs demonstrated compliance with the majority of elements in both standards reviewed. Some DCOs performed well, with the highest performing DCO achieving 90 percent compliance with Standard I—Availability of Services and 98 percent compliance with Standard X—Grievance and Appeal Systems. Scores were generally lower for Standard I and generally higher for Standard X. The majority of DCOs were able to either demonstrate compliance during the record review portion of the onsite review or did not have any grievances or appeals from the review period. In the case of the latter, HSAG reviewed any grievance and appeal template documentation and processes, as well as the most recent grievance or appeal documentation.

Table 4-2 presents a summary of the performance results for DCOs for each standard and overall. The average scores were rounded to the nearest integer and the average ratings were rounded to the nearest whole number.

Table 4-2—Scores and Ratings by Review Standard for DCOs in Aggregate

Review Standard	Average Score	Average Rating
Standard I—Availability of Services (42 CFR §438.206)	8.3/10	83%
Standard X—Grievance and Appeal Systems (42 CFR §438.228)	28.2/32	88%
Overall	**36.5/42**	**87%**

Standard I: Availability of Services

The Availability of Services standard was evaluated by examining the DCO's compliance with delivery network requirements, its furnishing of services, and provision of culturally competent services. 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 healthcare professional within the network or outside the network, at no cost to the member.
- 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 member is no greater than it would be if the services were furnished within the network.

- Provide timely access to care and services.
- Participate in the State's effort to promote the delivery of culturally competent services.

Table 4-3 shows the individual scores and ratings for each DCO for the Availability of Services standard. The range of compliance ratings was 75 percent to 90 percent, with an average rating of 83 percent. It should be noted that there were only 10 scoring elements within Standard I, and so even slight differences in scores can significantly affect the compliance rating.

Table 4-3—Scores and Ratings for Standard I—Availability of Services

DCO Name	Standard I Score	Standard I Possible	Standard I Rating
Advantage Dental Services (ADS)	7.5	10	75%
Capitol Dental Care (Capitol)	8.5	10	85%
CareOregon Dental (COD)	9	10	90%
Family Dental Care, Inc. (FDCi)	8.5	10	85%
Managed Dental Care of Oregon (MDCO)	8.5	10	85%
ODS Community Dental (ODS)	8	10	80%
Average	**8.3**	**10**	**83%**

Standard X: Grievance and Appeal Systems

The Grievance and Appeal Systems standard was evaluated by examining the DCO's compliance with grievance and appeal processes, provision of information to members and contracted providers, and adherence to time frame and notification requirements. Pursuant to 42 CFR §438.228 and 42 CFR §438.400-424, DCOs are responsible for, but not limited to, the following requirements:

- Implementing a written procedure for accepting, processing, and responding to all grievances and appeals, consistent with CFR requirements.
- Providing information about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.
- Providing members with information on their rights regarding grievances, appeals, and contested case hearings and allowing for members to freely exercise their rights without discouragement or retaliation.
- Adhering to content requirements for notifications sent to members.
- Adhering to all timeline requirements for notifications, resolution of grievances and appeals, expedited requests, extended time frames, and contested case hearings.
- Advising members of the process for continuation of benefits and adhering to delivery of services and payment requirements.
- Complying with record-keeping requirements for grievances and appeals.

Table 4-4 shows the individual scores and ratings for each DCO for the Grievance and Appeal Systems standard. The range of compliance ratings was 81 percent to 98 percent with an average rating of 88

percent. DCOs achieved compliance with the preponderance of elements included in this standard. It should be noted that there were 32 scoring elements within Standard X, and so slight differences in scores had less impact on the overall compliance rating in comparison to Standard I.

Table 4-4—Scores and Ratings for Standard X—Grievance and Appeal Systems

DCO Name	Standard X Score	Standard X Possible	Standard X Rating
ADS	28	32	88%
Capitol	26	32	81%
COD	31.5	32	98%
FDCi	26.5	32	83%
MDCO	26	32	81%
ODS	31	32	97%
Average	**28.2**	32	**88%**

Summary of CCO/MHO Findings Follow-Up Results

Figure 4-1 presents the number of resolved and unresolved 2017 compliance findings, Figure 4-2 presents the number of resolved and unresolved 2018 compliance findings, and Figure 4-3 presents the number of resolved and unresolved 2018 ISCA findings. Since the number of findings across MCEs varied considerably, resolution percentages cannot be meaningfully compared.

Figure 4-1—Results of 2019 Follow-Up Review of 2017 Compliance Findings

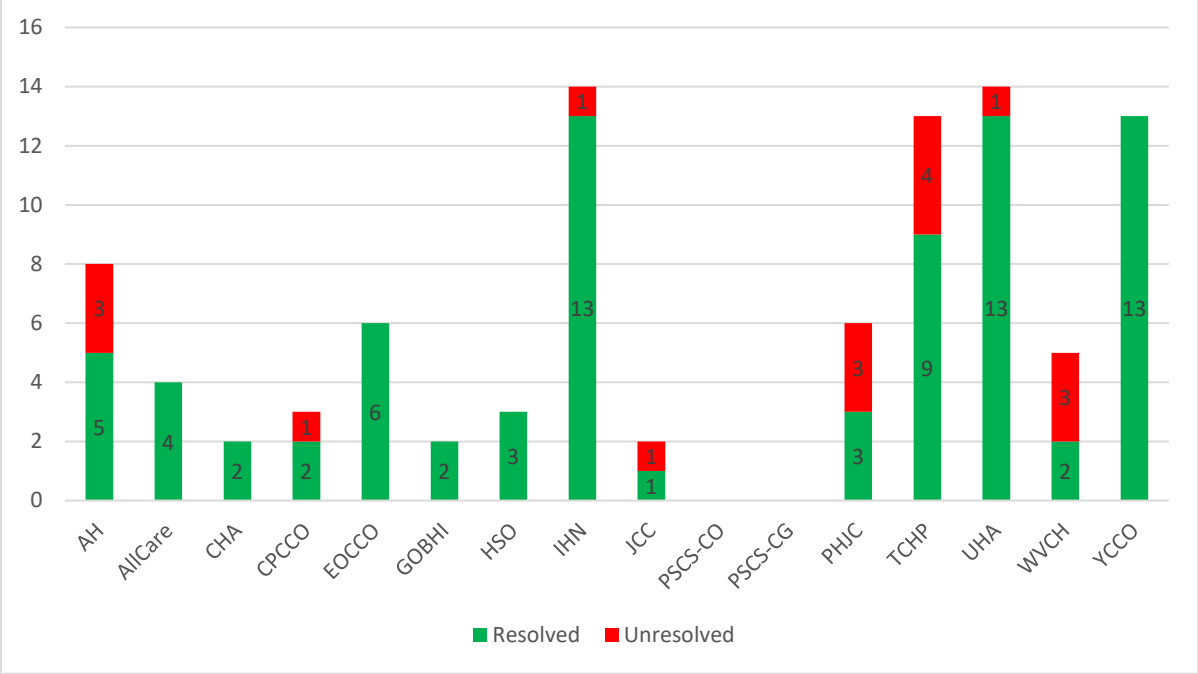


Figure 4-2—Results of 2019 Follow-Up Review of 2018 Compliance Findings

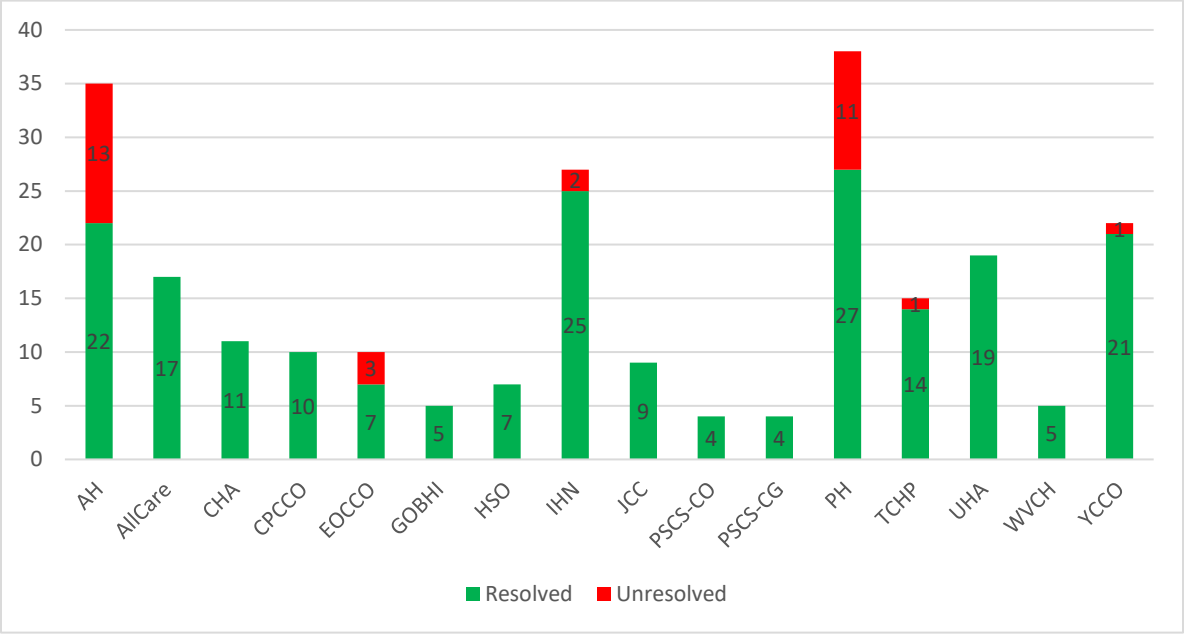
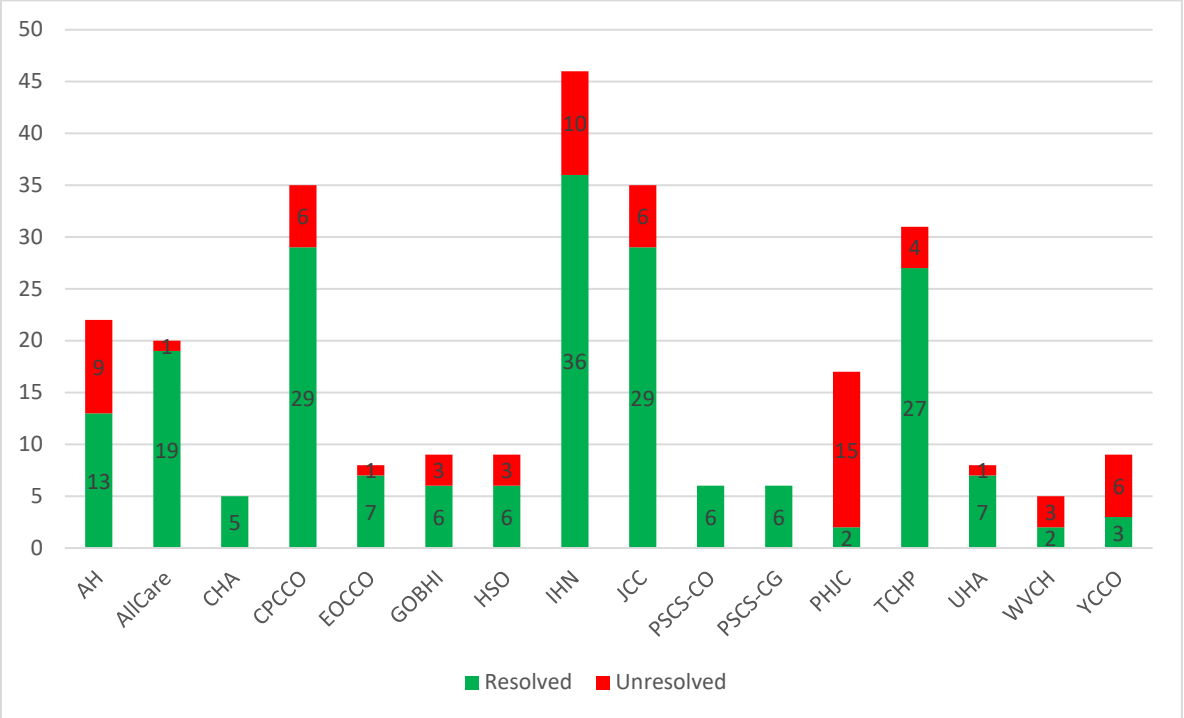


Figure 4-3—Results of 2019 Follow-Up Review of 2018 ISCA Findings



5. Performance Improvement Projects

Overview

PIPs allow MCEs the opportunity to identify areas of concern affecting their membership and strategize ways to improve care. Designed to assess and improve healthcare processes, the purpose of a PIP is to impact healthcare 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 protocols established by CMS to validate the quality and effectiveness of MCE PIPs.[5-1] 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.
- 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 eight QI 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-utilizers
4. Integration of health: physical health, oral health, and/or behavioral health
5. Ensuring 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
8. Addressing SDOH

One of the three PIPs was required to address the statewide PIP topic. Calendar year (CY) 2019 was a transition year for the statewide PIPs. On January 31, 2019, the CCOs submitted results of the third and final remeasurement period for the statewide PIP focused on improving opioid safety by reducing the prescription of high morphine milligram equivalent (MME). HSAG evaluated the CCOs' final

[5-1] 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: June 26, 2018.

remeasurement statewide PIP submissions from February through April for the 2019 annual PIP validation. Throughout 2019, the CCOs also collaborated on the development and design of a new statewide PIP focused on improving the safety of acute opioid prescribing among members with little to no knowledge of or prior experience with opioids. The CCOs will submit the design of the new statewide PIP for validation in 2020.

The goal of HSAG's PIP validation was to ensure that OHA, the CCOs, and other key stakeholders have confidence that any reported improvement is related and can be linked to the QI strategies and activities conducted during the life of the PIP. HSAG's validation of PIPs included the following two key components of the QI process:

- 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.
- Evaluation of the QI 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 CCO executed its QI activities and whether the desired aim was achieved and sustained.

For the remaining PIPs and focus study, the CCOs selected a topic required to target improving care within the eight QI 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 and outcome measure results quarterly.

HSAG conducted the quarterly PIP reviews of the CCO-selected PIPs throughout 2019. To conduct quarterly reviews and evaluations, HSAG employed a PIP Progress Review Tool that was used to review elements derived from the existing PIP Progress Report Template, developed by HealthInsight Assure for OHA, and adapted from CMS' protocols and HSAG's PIP Progress Review Tool. Beginning for the 2019 third quarter reviews, HSAG piloted a new review tool, approved by OHA, to streamline the review process and provide more actionable information on high-priority TA needs.

Statewide PIPs: Improving the Safety of Opioid Management

In alignment with Medicaid CFR §438.330(d), Oregon's 1115 Medicaid Demonstration Waiver, and Oregon CCO contracts, the CCOs were required to conduct a statewide PIP focused on opioid management in 2018, in addition to three other PIPS. The statewide PIP, initiated in 2015, focused on improving opioid safety by reducing the prescription of high MME. In early 2017, CCO medical directors and QI staff members elected to continue the PIP for a third remeasurement period (2018). For the third remeasurement period, PIP stakeholders chose to focus on four study indicators, two of which measured the rate of ≥ 50 MME opioid prescriptions and two of which measured the rate of ≥ 90 MME opioid prescriptions. The dosage limits of ≥ 50 MME and ≥ 90 MME align with current

recommendations from the Centers for Disease Control and Prevention[5-2] and the Oregon Opioid Prescribing Guidelines Task Force.[5-3] The four study indicators selected for the third remeasurement period were:

- **Study Indicator 1:** The percentage of members who filled opioid prescriptions totaling ≥ 90 mg MME on at least one day within the measurement year.
- **Study Indicator 2:** The percentage of members who filled opioid prescriptions totaling ≥ 90 mg MME for 30 consecutive days or more within the measurement year.
- **Study Indicator 3:** The percentage of members who filled opioid prescriptions totaling ≥ 50 mg MME on at least one day within the measurement year.
- **Study Indicator 4:** The percentage of members who filled opioid prescriptions totaling ≥ 50 mg MME for 30 consecutive days or more within the measurement year.

Study Indicators 1 and 2 were part of the statewide PIP during all four measurement periods; however, Study Indicators 3 and 4 were added for the third remeasurement period, in place of two study indicators focused on prescriptions totaling ≥ 120 mg MME, which were eliminated from the PIP for the third remeasurement period.

Statewide PIP Validation

Prior to July 2018, OHA contracted with HealthInsight Assure to conduct a review of the statewide PIP topic, including progress from inception through the first quarter of 2018. On July 1, 2018, OHA contracted with HSAG to perform EQR activities, including PIP validation. In 2019, HSAG validated the CCOs' PIP submissions for the third and final remeasurement period of the statewide *Opioid Safety: Reducing Prescribing of Hight Morphine Equivalent Doses* PIP. The third remeasurement period was CY 2018. The CCOs' PIP submissions for the third remeasurement period were submitted to OHA on January 31, 2019, and HSAG received the submissions from OHA in early February 2019. HSAG conducted PIP validation activities, which included reviewing CCOs' initial PIP submissions, providing initial feedback and TA to CCOs, and reviewing CCOs' PIP resubmissions prior to completing the annual PIP validation in April 2019.

Technical Assistance

In October 2018, HSAG provided training to CCOs on HSAG's PIP validation process. The training provided a detailed overview of documentation requirements for the PIP submission and the evaluation elements in the validation tool that would be used for scoring each PIP and assigning an overall validation status. At that time, HSAG reminded the CCOs that TA on the statewide PIP validation was available upon request.

5-2 Oregon Opioid Prescribing Guidelines: Recommendations for the Safe Use of Opioid Medications. https://www.oregon.gov/oha/HPA/dsi-pmc/Pages/medications-prescribing.aspx. Accessed on February 28, 2018.

5-3 Ibid.

HSAG also offered each CCO the opportunity for a one-on-one TA call in early January 2019, prior to the initial PIP submission due date of January 31, 2019. Nine of the 15 CCOs participated in a TA call. The CCOs were invited to submit specific questions prior to the TA calls. During the TA calls, HSAG answered any specific questions, summarized HSAG's review findings from the CCO's third quarter statewide PIP progress report, and reviewed the documentation requirements for the January 31 PIP submission for validation.

HSAG offered another opportunity for one-on-one TA after reviewing and providing initial feedback to the CCOs on the PIP submission in March 2019.

Validation and Scoring

The 2019 PIP validation evaluated the implementation of the PIP during the third remeasurement period (CY 2018). Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of barriers, and subsequent development of relevant interventions. HSAG evaluated how well the CCOs implemented QI processes (i.e., barrier analyses, intervention, and evaluation of results) and the effectiveness of interventions. HSAG then presented detailed feedback to each CCO based on the findings of the critical analysis. This provided the CCOs with guidance on how to refine their approach in identifying specific barriers that impede improvement and identified more appropriate interventions that could overcome these barriers and result in meaningful improvement in targeted areas. The process helps to ensure that the PIP is not simply an exercise in documentation, but rather that the process can positively affect healthcare delivery and outcomes of care.

As previously mentioned, the goal of HSAG's PIP validation was to ensure that OHA and other key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP. HSAG's methodology for assessing and documenting PIP findings provides a consistent, structured process and a mechanism for providing the CCOs with specific feedback and recommendations. Using its PIP Validation Tool and standardized scoring, HSAG reported the overall validity and reliability of the findings as one of the following:

- *Met* = high confidence/confidence in the reported findings
- *Partially Met* = low confidence in the reported findings
- *Not Met* = reported findings are not credible

HSAG has designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all the critical elements must receive a *Met* score. Given the importance of critical elements to the scoring methodology, any critical evaluation element that receives a score of *Not Met* would result in an overall PIP validation rating of *Not Met*.

A PIP that accurately documents CMS protocol requirements would have high validity and reliability. Validity is the extent to which the data collected for a PIP measure its intent. Reliability is the extent to which an individual can reproduce the study results. For each completed PIP, HSAG assesses threats to the validity and reliability of PIP findings and determines when a PIP is no longer credible.

HSAG assigns each PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*. The outcome of these calculations determines the validation status of *Met*, *Partially Met*, or *Not Met*.

Interventions

As part of the validation process, HSAG evaluated each CCO's PIP on the appropriateness and timeliness of selected interventions. Each CCO was responsible for developing improvement strategies to address the PIP topic in its community responsive to the unique population characteristics, geography, health system infrastructure, and existing improvement efforts impacting its members. For the third remeasurement period in 2018, the CCOs continued, revised, and/or initiated new improvement strategies for the PIP. While the CCOs tailored improvement strategies toward their communities and member populations, many CCOs identified similar types of barriers and developed interventions with common themes. Common barriers identified by the CCOs included:

- Lack of member and community awareness of the risks of opioid medications.
- Lack of coordinated efforts beyond individual CCOs in reducing high-dose prescriptions.
- Provider confusion about prescription opioid guidelines.
- Lack of access to alternative pain management options.
- Lack of provider and member awareness of alternative pain management options and coverage.
- Opioid use disorder (OUD) among members and lack of access to OUD treatment options.
- Difficulty tracking and managing opioid prescriptions from multiple providers or pharmacies.

Common interventions used by the CCOs during the third remeasurement period to address barriers to reducing high-dose opioid prescriptions can be grouped into several themes, as described below.

- **Education and training to increase opioid awareness and skills for pain management**
  - *At the community level*, CCOs launched a media campaign with the purpose of creating a "climate of understanding" regarding the true effectiveness and risks of opioid use. The media campaign utilized radio, television, and internet to provide information on risks of opioid medications, alternative pain treatment options, and resources for OUD treatment.
  - *At the member level*, CCOs offered in-person and online chronic pain management classes to provide members with skills and resources to safely and effectively manage persistent pain.
  - *At the provider level*, CCOs informed providers on the latest recommendations and guidelines related to safe opioid prescribing. CCOs used provider dashboards and report cards to provide individualized feedback and guidance on improving opioid management for members. For those members on long-term opioid prescriptions, CCOs worked with providers to develop tapering plans to gradually and safely reduce prescription dosages. Some CCOs also offered training courses on related topics such as having difficult conversations with patients about opioid use.

- **Regional and statewide collaborations on prescription opioid monitoring and management**
  - CCOs collaborated at statewide Quality Health and Outcomes Committee (QHOC) meetings to discuss and share improvement strategies and address barriers. Additionally, some CCOs established regional workgroups to promote consistent opioid coverage and guidance at a regional level, preventing "CCO shopping" by members seeking out high-dose opioid prescriptions.
  - CCOs also collaborated with pharmacies to monitor and share opioid prescription data to identify high-risk prescribers and at-risk members. CCOs played an integral part in promoting pharmacy and provider participation in the Oregon statewide Prescription Drug Monitoring Program (PDMP) to allow providers and pharmacies better care for patients and appropriate management of prescription medications.[5-4] Additionally, CCOs worked directly with pharmacies to institute point-of-sale checks and restrictions on high-dose opioid prescription fills, leveraging pharmacy data to prevent high-risk opioid prescriptions at the point of sale.
- **Increased access to alternative pain management services**
  - CCOs increased and expanded coverage for alternative pain therapies including cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), and movement therapy. CCOs offered access to fitness classes and aquatic centers and offered services, such as transportation, to remove barriers to access. Some CCOs also collaborated with health systems to create and pilot specialty pain clinics to provide comprehensive pain management services.
- **Increased access to medication-assisted treatment (MAT) for OUD**
  - To assist members diagnosed with OUD, CCOs increased the number of providers, including primary care providers, offering MAT services. CCOs also worked to address geographic barriers to MAT providers. Finally, CCOs ensured that medications, such as buprenorphine and naltrexone, were included in the covered formulary.

Statewide PIP Results

HSAG validated the CCOs' statewide PIP submissions for the third remeasurement period (CY 2018) from February through April 2019. This was the first year HSAG validated the CCOs' statewide PIPs. The HSAG PIP Review Team scored each evaluation element as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed (NA)*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements had to be *Met*.

[5-4] Oregon allows voluntary registration to the PDMP for those who do not meet mandatory registration requirements. More information can be found at: https://www.oregon.gov/omb/Topics-of-Interest/Pages/Prescription-Drug-Monitoring-Program.aspx

Table 5-1 displays the validation scores and overall validation status HSAG assigned to each CCO's PIP submission. This table illustrates the CCOs' performance on applying QI processes and strategies during the third remeasurement period for the statewide PIP. The validation results include the percentage of applicable evaluation elements that received a *Met* score and the overall validation status HSAG assigned to each CCO's PIP submission.

Table 5-1—2018 Statewide PIP Validation Results for Remeasurement Three by CCO

CCO Name	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Overall Validation Status
AH	100% (6/6)	100% (3/3)	*Met*
AllCare	83% (5/6)	100% (3/3)	*Met*
CHA	100% (6/6)	100% (3/3)	*Met*
CPCCO	100% (6/6)	100% (3/3)	*Met*
EOCCO	100% (6/6)	100% (3/3)	*Met*
HSO	100% (6/6)	100% (3/3)	*Met*
IHN	100% (6/6)	100% (3/3)	*Met*
JCC	83% (5/6)	100% (3/3)	*Met*
PSCS-CO	100% (6/6)	100% (3/3)	*Met*
PSCS-CG	100% (6/6)	100% (3/3)	*Met*
PH	83% (5/6)	100% (3/3)	*Met*
TCHP	100% (6/6)	100% (3/3)	*Met*
UHA	100% (6/6)	100% (3/3)	*Met*
WVCH	100% (6/6)	100% (3/3)	*Met*
YCCO	100% (6/6)	100% (3/3)	*Met*

The validation results suggest that the CCOs used sound QI processes and strategies during the third remeasurement period of the PIP. All 15 CCOs received a *Met* score for all critical evaluation elements and a *Met* overall validation status for their PIP submissions. The percentage of all applicable evaluation elements that received a *Met* score ranged from 83 percent (five of six elements) to 100 percent (six of six elements) among the 15 CCO PIP submissions.

OHA collected and tabulated CCO-specific and statewide data on the PIP study indicators from the baseline measurement period (CY 2014) through the third remeasurement period (CY 2018). OHA allowed at least 90 days after the end of the measurement period before pulling the data for tabulation and reporting. HSAG received the study indicator data from OHA in May 2019. For the two study indicators with remeasurement data, measuring the percentage of members who filled opioid prescriptions totaling ≥ 90 mg MME on at least one day and for 30 consecutive days or more, significant improvement was achieved statewide. Furthermore, statewide study indicator results demonstrated that statistically significant improvement over baseline in study indicator rates was achieved and maintained for one or more subsequent measurement periods. This suggested that the PIP was successful in bringing about sustained improvement in reducing high-dose opioid prescriptions over time. Subsequent annual measurement data are required to evaluate improvement for the two study indicators that were added to the PIP in 2018 to measure ≥ 50 mg MME opioid prescriptions.

The tables below display statewide study indicator results. Table 5-2 displays the numerators and denominators used to calculate the statewide results of Study Indicator 1, the percentage of members who filled opioid prescriptions totaling ≥ 90 mg MME on at least one day within the measurement year. Table 5-2 shows that the study indicator rate improved (decreased) for each age group across the four measurement periods.

Table 5-2—Aggregated Statewide PIP Results—Study Indicator 1: Percentage of Members by Age Group Who Filled ≥ 90 mg MME Opioid Prescriptions on at Least One Day by Age Group in 2014, 2016, 2017, and 2018

Age Group		Baseline 2014	Remeasurement 1 2016	Remeasurement 2 2017	Remeasurement 3 2018
12–17 years	Numerator	354	230	179	95
	Denominator	6,453	4,623	4,194	3,693
	Rate	**5.5%**	**5.0%**	**4.3%** ♦	**2.6%** ♦ ♦
18 years and older	Numerator	19,881	16,548	12,877	9,171
	Denominator	106,315	95,963	84,443	83,178
	Rate	**18.7%**	**17.2%** ♦	**15.2%** ♦ ♦	**11.0%** ♦ ♦
12 years and older	Numerator	20,235	16,778	13,056	9,266
	Denominator	112,768	100,586	88,637	86,871
	Rate	**17.9%**	**16.7%** ♦	**14.7%** ♦ ♦	**10.7%** ♦ ♦

♦ Designates statistically significant improvement over the baseline measurement period (*p* value < 0.05).

♦ ♦ The remeasurement rate demonstrated sustained improvement over the baseline rate.

Table 5-3 displays results of Study Indicator 2, the percentage of members who filled opioid prescriptions totaling ≥ 90 mg MME for 30 consecutive days or more within the measurement year. The tables also identify remeasurement rates that demonstrated statistically significant improvement and sustained improvement over baseline.

Table 5-3—Aggregated Statewide PIP Results—Study Indicator 2: Percentage of Members by Age Group Who Filled ≥ 90 mg MME Opioid Prescriptions for 30 Consecutive Days or More by Age Group in 2014, 2016, 2017, and 2018

Age Group		Baseline CY 2014	Remeasurement 1 CY 2016	Remeasurement 2 CY 2017	Remeasurement 3 CY 2018
12–17 years	Numerator	1	0	1	1
	Denominator	6,453	4,623	4,194	3,693
	Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**
18 years and older	Numerator	4,447	3,201	2,353	1,540
	Denominator	106,315	95,963	84,443	83,178
	Rate	**4.2%**	**3.3%** ♦	**2.8%** ♦♦	**1.9%** ♦♦
12 years and older	Numerator	4,448	3,201	2,354	1,541
	Denominator	11,2768	100,586	88,637	86,871
	Rate	**3.9%**	**3.2%** ♦	**2.7%** ♦♦	**1.8%** ♦♦

♦ Designates statistically significant improvement over the baseline measurement period (*p* value < 0.05).

♦♦ The remeasurement rate demonstrated sustained improvement over the baseline rate.

Future Steps

Throughout 2019, the CCOs collaborated on the development of a new statewide PIP focused on improving the safety of acute opioid prescribing among opioid-naïve members. The new statewide PIP topic was selected with input from CCOs and various community stakeholders to build upon the improvement efforts, lessons learned, and relationships established from the first opioid-focused statewide PIP. The topic furthers the work of the Oregon Acute Opioid Prescribing Guidelines[5-5] and the Opioid Prescribing Guidelines for Dentists,[5-6] and continues the integration coordination amongst the plans and health system delivery across Oregon. Additionally, the expansion of this coordination will begin to include hospitals (post-surgical prescribing) and oral health providers across Oregon.

[5-5] Oregon Health Authority. Oregon Acute Opioid Prescribing Guidelines: Recommendations for patients with acute pain not currently on opioids, October 2018. Available at: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/Acute-Prescribing-Guidelines.pdf. Accessed on: October 28, 2019.

[5-6] Oregon Health Authority. Opioid Prescribing Guidelines for Dentists, August 2017. Available at: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/oregon-recommended-opioid-guidelines-dentists.pdf. Accessed on: October 28, 2019.

Recommendations

HSAG's validation results suggest that the CCOs used robust and innovative QI strategies during 2018, the third and final remeasurement period for the statewide PIP. The PIP's study indicator results suggested that statewide collaboration and effective QI strategies deployed by the CCOs supported significant improvement in outcomes from baseline through the third remeasurement period. The CCOs can build upon the success achieved as they begin improvement work in the area of acute opioid prescribing for opioid-naïve members.

Recommendations:

- OHA should continue to foster a collaborative environment for CCOs and continue providing regular opportunities for CCOs to exchange ideas and work together to address opioid prescription management and pain management safety for members.
- OHA and the CCOs should continue to monitor outcomes to support sustained improvement in study indicator outcomes over time. For the two study indicators added to the PIP in 2018, measuring rates of ≥ 50 mg MME opioid prescriptions, data from 2019 could be compared to the 2018 results to evaluate whether improvement is achieved for the lower dosage threshold.
- CCOs should review intervention evaluation results and identify improvement strategies believed to have had the greatest impact on study indicator outcomes. CCOs should direct resources toward continuing those interventions that demonstrated the greatest impact on study indicator outcomes.
- CCOs should leverage collaborative relationships to sustain improvement achieved and to support improvement efforts for the next statewide PIP.
- CCOs should review successes and lessons learned from the statewide PIP and consider how these experiences can be applied to drive improvement in the new PIP.

2019 Statewide PIP Development Activities

In 2019, the CCOs collaborated with OHA on design development for a new statewide PIP to improve the safety of acute opioid prescribing for opioid-naïve members. As noted above, the new statewide PIP will build on the efforts and achievements of the previous statewide opioid PIP but will shift the focus to members receiving a first opioid prescription. OHA selected the new acute opioid prescribing topic to further the Oregon Opioid Initiative, a statewide approach to reduce the risk and harm of the opioid crisis. The improvement efforts for the acute prescribing statewide PIP are expected to move the opioid work toward prevention (reducing long-term opioid use) and support the continued efforts across the state of health systems, practices, policy, community groups, and MCEs.

The new statewide PIP topic was selected through collaborative discussions between the CCOs and OHA beginning in early 2018. Discussions occurred primarily through the QHOC monthly meetings, which are public meetings with input from CCOs and various community stakeholders. During 2019 QHOC meetings, the CCOs explored and discussed State and national opioid prescribing guidelines and existing opioid-focused metrics used nationally and in other states to identify a metric that could be used as the new statewide PIP study indicator. The PIP is expected to focus on improving the safety of opioid

prescribing among opioid-naïve OHP members, 12 years of age and older. For the purpose of the PIP, members with no history of filling an opioid prescription in the preceding six months will be defined as opioid-naïve.

As with the previous statewide PIP, OHA will be responsible for collecting study indicator data for the new statewide PIP and providing the data to CCOs. The CCOs will be responsible for analyzing the specific needs of their member populations to identify and address barriers to improving the safety of acute opioid prescribing at the community level. Monthly QHOC meetings will continue to provide opportunities to discuss barriers and improvement strategies for the PIP.

The CCOs will submit the new statewide PIP design for validation in 2020. The PIP design will define and document the topic, study question, eligible population, study indicator(s), and data collection methods for the project. HSAG will provide feedback and TA on the design submission to the CCOs as part of the 2020 PIP validation.

CCO-Specific PIPs and Focus Project Topics

Each CCO was required to provide quarterly reports on three additional projects targeting focus areas defined by OHA. HSAG's PIP team reviewed and documented its observations and findings for each CCO in the PIP Progress Review Tool. HSAG then analyzed the information to prepare a listing of TA needs associated with each PIP element and CCO, including the identification of high-priority CCOs and PIPs in need of TA.

Figure 5-1 summarizes the CCO-specific PIP topics conducted in the third quarter of 2019, which addressed various issues of healthcare access, timeliness, and quality. The color-coded column headers at the top of the table identify seven of the eight focus areas defined by OHA. The eighth focus area, *integration of health: physical health, oral health, and/or behavioral health*, was addressed by the statewide PIP, which was in the design phase in 2019. The CCOs were exempted from the statewide PIP progress report requirement in 2019 because CCO activities focused on developing the PIP design; outcomes measurement and interventions had not yet begun. The CCOs are expected to submit progress reports on the statewide PIP in 2020. The CCO-specific project titles falling under each focus title are grouped under the corresponding focus area addressed. PIP topics addressed by each CCO are also included in the individual CCO profiles in *Appendix B. CCO/MHO Profiles*. The identification of "P" (PIP) vs. "F" (Focus Study) in Figure 5-1 is based on the CCOs' documentation provided in quarterly progress reports. Very few CCOs identified one of their projects as a focus study. If "focus study" was not specified in the progress report, the project was labelled "P" by default.

Figure 5-1—CCO-Specific PIP Topics

	Reducing Preventable Re-Hospitalizations	Population Health				Reduce Utilization by "Super-Utilizers"					Appropriate Care/ Appropriate Setting								Perinatal/ Maternity Care					Improving Primary Care			Addressing SDOH			CCO Subtotal
	Reduce Re-hospitalization	Hepatitis C Screening and Treatment	Colorectal Cancer Screening	Oral Health Care for Patients with Diabetes	Tobacco Cessation	Expanding Access to MAT for Opioid Use Disorder	Reducing ED utilization among high-frequency Users	CHW/Case Management	Syringe Exchange Program	Reducing ED utilization among members with SPMI	Oral Health Care Access across All Ages	Contraceptive Care	Reducing Preventable ED Utilization	Adolescent Well Child Visits	Reducing ED and Inpatient Hospitalization among High Complexity Members	SUD Treatment for Older Adults	Reducing gender disparity in HPV vaccine coverage	Childhood Immunization Status	Maternity Case Management	Pregnancy / Oral Health Visit	Prenatal/Postnatal Care Incentive	Post partum visit	Maternal Medical Home	Improving Foster Care RAPID Assessment Process	PCPCH Engagement	Oral Health Screening in Primary Care	SDOH Screening and Follow-Up	Health Complexity	Behavioral Support Services and Care Coordination for Children 0-5 years with high social complexity	
AH				P									P								P									3
AllCare			P									F		P																3
CHA							P				P																	P		3
CPCCP					P		P				P																			3
EOCCO			P											P		P														3
HSO						P						F												P						3
IHN							P							P						P										3
JCC															P				P								P			3
PSCS-CO												P								P							P			3
PSCS-CG												P								P							P			3
PH								P															P			P				3
TCHP			P															P				P								3
UHA	P									P									P									P		4
WVCH					P				P								P													3
YCCO		P											P												P					3
Subtotal	1	1	3	1	2	1	3	1	1	1	2	4	2	3	1	1	1	1	2	3	1	1	1	1	1	1	3	1	1	46
Focus Area Total	**1**	**7**				**7**					**15**								**8**					**3**			**5**			**46**

*The CCOs did not submit quarterly progress reports for the Statewide PIP for the Quarter 3-2019 PIP progress review because the PIP was still in the design development phase

The CCOs reported progress on a total of 46 CCO-selected PIPs for the third quarter of 2019. The number of PIPs addressing each focus area varied, ranging from one PIP addressing the focus area on reducing preventable re-hospitalizations, to 15 PIPs addressing the focus area on ensuring appropriate care is delivered in appropriate settings. Each PIP was categorized in Figure 5-1 under the focus area that best represented the topic, improvement strategies, and study indicators reported by the CCO; however, in some cases, a PIP topic may impact other focus areas in addition to the one area listed in the table.

Dental Care Organization PIP Activities

OHA contractually requires each DCO to conduct a system-level PIP specific to the DCO direct contracted members from OHA. The DCOs must obtain approval of the selected PIP topic from OHA and the topic must align with OHA-defined oral health improvement focus areas. The DCOs are required to submit a PIP once a year for the annual validation and once for a semiannual progress review.

During a PIP update at the March 2019 All Plan Dental Workgroup, OHA reviewed the PIP implementation and validation requirements with the DCOs. In April 2019, HSAG delivered an introductory PIP training webinar to the DCOs, which included a description of HSAG's PIP validation process and reviewed the PIP validation forms and documentation requirements. After the April training, HSAG worked with OHA to develop an updated New PIP Notification form that the DCOs would use to submit the PIP topic to OHA for approval. OHA presented the updated New PIP Notification form to the DCOs during a PIP update at the September 2019 All Plan Dental Workgroup. The notification form included the four OHA-defined oral health focus areas for the DCO PIPs:

1. Prevention (clinical)
2. Addressing special populations' health issues
3. Access and utilization (nonclinical)
4. Community (clinical or nonclinical)

OHA expects the DCOs to submit a proposed PIP topic, addressing one of the four focus areas, by the end of 2019. The DCOs will submit the PIP design for validation in 2020. The PIP design will define the topic, study question, eligible population, study indicator(s), and data collection methods for the project. HSAG will provide training and TA to OHA and the DCOs, as needed, to support development of the PIP design.

6. Performance Measure Validation

Overview

In accordance with 42 CFR §438.330(c), states must require that MCOs submit performance measurement data as part of their QAPI programs. The validation of performance measures is one of the mandatory 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 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,[6-1] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not an MCO, or an EQRO.

OHA selected HSAG to evaluate the accuracy and validity of OHA's calculation of the performance measure rates for the 15 CCOs. A set of five incentive performance measures were selected by OHA for validation by HSAG during CY 2019. OHA's rate calculations for measures in the scope of HSAG's validation were based on administrative data only (i.e., enrollment and claims/encounters) for the CY 2018 measurement period. A summary 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 selected by OHA for validation. These measures represented HEDIS-like measures and measures developed by OHA. Table 6-1 lists the performance measure indicators that HSAG validated in 2019.

Table 6-1—List of Performance Measure Indicators for OHA

Performance Measure
Adolescent Well-Care Visits
Ambulatory Care: ED Utilization
Dental Sealants on Permanent Molars for Children
Developmental Screening in the First Three Years of Life
Effective Contraceptive Use

[6-1] 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: August 30, 2018.

Review Activities

Pre-Audit Strategy

Validation activities were conducted as outlined in the CMS PMV Protocol. 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. Additionally, HSAG worked closely with OHA to help guide responses to the ISCAT and ensure the right staff members were involved in PMV activities.

HSAG conducted a pre-onsite conference call with OHA to discuss onsite logistics and expectations, important deadlines, outstanding documentation, and questions from OHA. At least two weeks prior, 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.

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:

- **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 source code provided 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).
- **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 collected information using several methods including interviews, system demonstration, review of data output files, observation of data processing, and review of data reports. An onsite visit was conducted with OHA in November 2019 that included the following activities:

- **Opening session:** The opening session included introductions of HSAG's PMV 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 system compliance:** 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, a review of how all data sources were combined, and how the analytic file used for reporting the performance measures was generated. HSAG performed primary source verification to further validate the output files and reviewed supporting documentation provided for data integration. This session addressed data control and security procedures as well. Since OHA contracted essential functions and reporting requirements to another entity, Providence Health & Services Center for Outcomes Research and Education (CORE), OHA maintained detailed files documenting work performed by the contractor. HSAG queried OHA staff members to confirm that appropriate documentation and processes.
- **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 data in OHA's systems during the onsite review for verification. This method provided OHA an opportunity to explain its processes as needed for any unique, case-specific nuances that may have impacted final measure reporting.
- **Closing conference:** The closing conference included a summation of preliminary findings based on the pre-onsite and onsite review of the ISCAT and additional onsite activities. In addition, documentation requirements for post-onsite activities were summarized.

Post-On-Site Activities

Following the onsite visit, 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 has 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 PMV Protocol identifies two possible validation finding designations for performance indicators, which are defined in Table 6-2.

Table 6-2—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 measures for which (1) the rate was materially biased or (2) OHA chose not to require reporting of 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 6-3 lists the validation result for each performance measure indicator for OHA.

Table 6-3—PMV Ratings

Performance Measure	Validation Result
Adolescent Well-Care Visits	**R**
Ambulatory Care: ED Utilization	**R**
Dental Sealants on Permanent Molars for Children	**R**
Developmental Screening in the First Three Years of Life	**R**
Effective Contraceptive Use	**R**

Recommendations

All five performance measure indicators in the scope of HSAG's PMV activities for measure year 2018 were given a validation result of "R," indicating that the measures were compliant with the measure specifications and that 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. However, HSAG recognized that performance measures were calculated based on data from CCOs that was checked for errors, but not validated. HSAG recommends OHA implement a more formal process for validation of encounters, especially for those used to calculate performance measures.

7. Delivery System Network Evaluation

Overview

Federal and State regulations require each MCE to maintain a network of appropriate healthcare providers to ensure adequate access to all services covered under the Medicaid contract. CCOs are required to submit an annual integrated DSN Report to OHA by July 1 each year comprised of two parts: the DSN Provider Capacity Report and the DSN Provider Narrative Report. The annual integrated DSN Report should demonstrate the CCO's capacity to serve enrolled members in its service area in accordance with the State's standards for access to care.

In 2018, HSAG began a comprehensive review of the CCO's DSN reports to evaluate provider capacity compliance in accordance with standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN. HSAG presented these findings in a 2018 DSN Evaluation Report submitted to CMS in July 2019. For the 2019 DSN evaluation, HSAG adjusted the protocol and guidance documents to incorporate lessons learned and feedback from the 2018 DSN evaluation.

2019 DSN Evaluation Objectives and Methodology

Based on the requirements outlined in the OHA 2019 Health Plan Services CCO Contract, Exhibit G (1)(a)(b), HSAG developed the DSN Evaluation Report to provide OHA with an evaluation of CCO network compliance with established network standards and timely access to care and services requirements. To conduct the evaluation, HSAG reviewed:

- Each CCO's DSN Provider Narrative Report and supplemental documentation.
- The distribution and documentation of each CCO's inventory of providers and facilities.

HSAG reviewed each CCO's DSN Provider Narrative Report, assessed each category, and evaluated the elements of each category. Elements evaluated in 2019 received a score ranging from 0.0 (*Not Met*) to 1.0 (*Met*) based on the scoring criteria defined in Table 7-1 below. Element scores were then aggregated into category scores and an overall summary score.

Table 7-1—2019 DSN Provider Narrative Report Scoring Criteria

Score	Rating	Rating Description
0.0	Not Met	Discussion does not address the element.
0.5	Partially Met	Discussion addresses some, but not all of the element.
1.0	Met	Discussion comprehensively addresses the element.

The points possible for each DSN Provider Narrative Report category are outlined in Table 7-2 below. A maximum of 26.0 total points was possible across all five categories.

Table 7-2—DSN Provider Narrative Report Categories

Category Number	Category	Number of Elements	Maximum Points
1	Description of the Delivery Network and Adequacy	12	12.0
2	Description of Members	3	3.0
3	Additional Analysis of the CCO's Provider Network to Meet Member Needs	4	4.0
4	Coordination of Care	5	5.0
5	Performance on Metrics	2	2.0
	Totals	**26**	**26.0**

Based on the submitted 2019 DSN Provider Capacity Reports, HSAG assessed the quality and completeness of each CCO's provider network. Due to the extent of CCO data and reporting inconsistencies, the 2019 DSN Provider Capacity Reports were not directly scored or aggregated; however, HSAG conducted comparative evaluations across CCOs and highlighted variations in the quality and completeness of data.

2019 DSN Evaluation Results

2019 DSN Provider Narrative Report Results

Overall, the CCOs received a score of 24.3 points across aggregated DSN Provider Narrative Report Categories, or approximately 93.5 percent of the maximum points possible (26.0 points), as shown in Table 7-3 below. Three of the 15 CCOs met the requirements of all DSN Provider Narrative Report Categories. Most CCOs met the *Coordination of Care* and *Performance on Metrics* categories and six CCOs met the *Description of the Delivery Network and Adequacy* narrative category. As such, while CCOs' overall aggregate performance was fair, the variation in scores among the CCOs indicated several opportunities for improvement.

Table 7-3—DSN Provider Narrative Report Review Results

CCO Name	DSN Provider Narrative Report Categories					Total CCO Score
	Description of the Delivery Network and Adequacy	Description of Members	Additional Analysis of the CCO's Provider Network to Meet Member Needs	Coordination of Care	Performance on Metrics	
AH	12.0	3.0	4.0	5.0	2.0	26.0
AllCare	8.0	1.5	3.0	5.0	2.0	19.5
CHA	12.0	3.0	4.0	5.0	2.0	26.0
CPCCO	11.5	3.0	4.0	5.0	2.0	25.5
EOCCO	11.0	3.0	4.0	5.0	2.0	25.0
HSO	12.0	3.0	4.0	5.0	2.0	26.0
IHN	8.0	2.5	3.5	3.0	2.0	19.0
JCC	11.5	3.0	3.5	5.0	2.0	25.0
PSCS-CO	11.0	2.5	3.0	5.0	2.0	23.5
PSCS-CG	11.0	2.5	3.0	5.0	2.0	23.5
PH	12.0	3.0	4.0	4.0	2.0	25.0
TCHP	11.5	3.0	4.0	5.0	2.0	25.5
UHA	12.0	2.5	4.0	5.0	2.0	25.5
WVCH	12.0	2.5	4.0	5.0	2.0	25.5
YCCO	10.0	3.0	4.0	5.0	2.0	24.0
Statewide Average Scores	**11.0**	**2.7**	**3.7**	**4.8**	**2.0**	**24.3**
Points Possible	**12.0**	**3.0**	**4.0**	**5.0**	**2.0**	**26.0**

2019 DSN Provider Capacity Report Results

In 2019, multiple reporting inconsistencies were identified among the different CCO Provider Capacity Report submissions. The Provider Capacity Report Template used in 2018 and 2019 presents several limitations and challenges for submitting provider capacity information, conducting analyses of statewide provider and facility inventories, and conducting comparisons across CCOs. HSAG recommends that OHA consider revisions to the Provider Capacity Report Template 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.

2019 DSN Provider Narrative Report Recommendations

HSAG recommends that OHA revise the required DSN Provider Narrative Report Template to minimize inconsistent interpretations of the elements and ambiguity around the appropriate type of supplemental documentation. The specific DSN Provider Narrative Report recommendations are as follows:

1. **Align Category Elements with Requirements:** OHA should re-evaluate the elements within the categories outlined in the DSN Provider Narrative Report Template to ensure alignment with both the network adequacy standards established in accordance with paragraphs (b)(1) and (2) of 42 CFR §438.206 and the OHA 2018 CCO Health Plan Services Contract Exhibit G (1)(a)(b), creating clear and concise elements that describe what is required of the CCO.
2. **Identify Elements that Require Specific Responses:** OHA should re-design the DSN Provider Narrative Report Template to clearly define the template elements that require a CCO's responses to specify outcomes by physical health, dental health, and mental health services.
3. **Include Proper Citations:** OHA should review and cite the correct contract language and/or federal regulations for each element instead of generic language.
4. **Indicate when Supporting Documentation is Necessary:** OHA should identify elements within each category in which supporting documentation is required to demonstrate compliance with reporting template elements. Instructions should include information such as what type of evidence is acceptable—e.g., report, policy and procedure, desktop process, illustration, graph, etc.
5. **Establish Standardize Time and Distance Standards:** OHA should re-evaluate the time and distance standard elements outlined in the DSN Provider Narrative Report Template to ensure alignment with both the routine travel time and distance standards established in accordance with paragraphs (b)(1) and (2) of 42 CFR §438.206 and the OHA 2018 CCO Health Plan Services Contract Exhibit G (1)(a)(b), creating clear and concise elements that describe what is required of the CCO.
6. **Include Proper Instructions:** OHA should develop and implement standardized and clear instructions with detailed guidance on the appropriate method for submitting time and distance standard reporting. Instructions should also define time and distance standard measurement (e.g., minutes, miles, or percentages), geographic classification (urban, rural, etc.), and member population (adult, pediatric, etc.).

2019 DSN Provider Capacity Report Recommendations

HSAG recommends that OHA consider further revisions to the DSN Provider Capacity Report Template 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. The specific DSN Provider Capacity Report recommendations are as follows:

1. **Expand the Service Category List:** OHA should re-evaluate the list of service categories included in the Provider Capacity Report and include specific primary care and specialty care providers types

to better assess whether adult, geriatric, and pediatric members have access to all covered services throughout the continuum of care.

2. **Utilize the Standardized Healthcare Provider Taxonomy Code Set:** OHA should implement a time-limited work group to facilitate the adoption of the Standardized Healthcare Provider Taxonomy Code Set and eliminate the use of historical OHA Medicaid Management Information System (MMIS) Provider Type and Specialty Type Codes. The Taxonomy Code Sets are a Health Insurance Portability and Accountability (HIPAA) standard code set designed to categorize the type, classification, and/or specialization of healthcare providers and facilities. All physicians and facilities are required to select the taxonomy code(s) that most closely describes the healthcare provider's type/classification/specialization when applying for a National Provider Identifier.
3. **Establish a Standardized Provider File Layout (PFL) With Instruction Manual:** OHA should develop and implement a standardized PFL that, accompanied by a Provider Network Data Submission Instruction Manual, would establish a more standardized data reporting structure for the CCOs' submission of provider network data. The manual should include detailed guidance on proper completion of the PFL, standard naming conventions, a data dictionary that categorizes provider types (i.e., primary care, physician specialty, mental health, and dental healthcare providers), program specific definitions, standardized provider and facility type specifications, and a sample PFL template.
4. **Conduct CCO Training on Proper Provider Capacity Reporting:** OHA should conduct training for all CCOs and provide detailed guidance on appropriate methods for submitting provider capacity information and review the requirements for submitting provider capacity network data.
5. **Establish Compliance Expectations:** OHA should hold the CCOs accountable for timely, accurate, and complete data submissions. A CCO that submits documentation that does not conform to the new templates and submission requirements within an established time frame would be rejected until the CCO's data submission adheres to the template requirements.
6. **Eliminate "Mental Health Crisis Services" From the Provider Capacity Report:** OHA should re-evaluate the inclusion of Mental Health Crisis Services as one of the service categories due to the inability of this service to be measured by capacity. Instead, adequate access to these services should be evaluated, analyzed, and described within the DSN Provider Narrative Report.
7. **Expand the Provider Capacity Report for Broader Use:** OHA should revise the standardized Provider Capacity Report Template to be used by OHA for other provider related reporting and ad hoc analysis (e.g., cross referencing provider types across CCOs).

8. Recommendations

Overview

HSAG used its analyses and evaluations of 2019 EQR activity findings and conclusions to develop overarching recommendations for OHA. For a more detailed discussion of the strengths, weaknesses, conclusions, and recommendations for OHA and its MCEs, please refer to Sections 4 through 7 of this report. There are additional findings detailed by MCE in *Appendix A. DCO Profiles* and *Appendix B. CCO/MHO Profiles*. Below are the overarching recommendations.

Overarching Recommendations

EQR Process

For 2019 EQR activities, HSAG conducted a QI evaluation that incorporated general feedback and survey results from those involved in the activities. While HSAG worked to streamline review tools and reporting and received positive feedback, additional work should be done to:

- Ensure appropriate timing of activities so that activities involving the same CCO staff members do not unnecessarily overlap.
- Coordinate OHA and HSAG communications with MCEs regarding EQR activities, ensuring the right MCE staff members are involved in such communications.
- Clarify regulatory references to eliminate ambiguity in areas where a high degree of interpretation is required.
- Continue QI efforts to ensure streamlined and value-added EQR activities.

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, time frames, and roles and responsible parties were lacking. In some cases, the applicability of policies was also unclear due to policies not including the MCE's name or being 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.
- **Interpretation:** EQR activities over the last year identified inconsistencies with how MCEs are interpreting specific regulatory and contractual requirements. HSAG recommends that OHA ensure contractual and other guidance documentation include consistent interpretations of regulatory

requirements. OHA can also assess which regulatory areas experience the most inconsistent interpretations (e.g., care coordination) and target opportunities for TA across the MCEs.

- **Follow-Up on Findings:** HSAG recommends that follow-up on findings from EQR activities be addressed soon after the findings are reported, rather than during the next year's EQR activities. This would ensure the same MCE staff members and reviewers are available to recall the issues and context of the findings in order to appropriately address them and would also help ensure that compliance issues are mitigated immediately.
- **Care Coordination and Treatment Plans:** CCOs continue to struggle with care coordination and appropriately developing and maintaining treatment plans. Delegation also continues to make care coordination challenging, especially when there are no formalized systems or processes in which to capture and maintain care plans and treatment plans. Specifically, the systems most MCEs are continuing to use 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 should continue to work with MCEs to provide guidance on care coordination, treatment planning, and effective care coordination system functionality, especially when these functions are delegated to other entities. It is additionally necessary for MCEs to be able to properly identify and track individuals with special healthcare needs to proactively ensure they are receiving the services they need.
- **Contracting with Out-of-Network Providers:** DCO compliance reviews identified the need to ensure that DCOs properly contract with out-of-network providers to provide oral healthcare services to members. Many of the DCOs lacked formal contracts or agreements with out-of-network providers, which could result in liabilities related to service costs and member care. OHA should ensure the DCOs utilize formal agreements when providing out-of-network care that requires such providers to adhere to any pertinent DCO policies and secure pricing for services.
- **Readability:** While this area continues to be a challenge across all MCEs, there is a clear acknowledgement that readability is a priority to achieve a significant impact on health literacy for their members. Part of the challenge is related to the inconsistency of readability tools. OHA should identify a consistently accurate readability tool for MCEs to use when assessing member materials.
- **Delegation Accountability:** OHA should continue working with MCEs on identifying clear expectations for oversight activities. The concept of 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 regularly, and not at all in some cases. MCEs are ultimately accountable for all activity subcontracted or delegated to other organizations or providers.

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,[8-1] support clearer documentation of PIP activities by the CCOs, and facilitate more effective TA.
- **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 TA opportunities.
- **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.
- **Promoting Efficient CCO Engagement in Statewide PIP Activities:** HSAG recommends that OHA examine processes that may promote a balance of CCO engagement with efficient progress in PIP activities. OHA may want to consider staffing, planning, and scheduling needs that may support the timely progression of PIP activities.

Performance Measure Validation

All five performance measure indicators in the scope of HSAG's PMV activities for CY 2019 were compliant with the measure specifications and the rates can be reported. HSAG did not identify any issues or concerns with the accuracy or validity of OHA's calculation of the performance measure rates. However, given OHA's reliance on CCO-submitted encounters for calculating performance measures, HSAG recommends OHA implement a more formal process for evaluating the completeness and accuracy of encounter data used in calculating incentive measures.

DSN 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 of supplemental documentation. This should include moving away from assessing providers using the categories of service list and instead using the Standardized Healthcare Provider Taxonomy Code Set and clearly defining specific provider types (e.g., primary care providers).

[8-1] 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: November 6, 2018.

- **Addressing Provider Capacity:** HSAG recommends OHA adjust the self-reported mechanism currently used to evaluate capacity to ensure a value-added approach to understanding access to care. This could include a provider directory comparative analysis with provider capacity data reported to OHA, and include secret shopper calls to assess capacity directly with provider offices.
- **TA to CCOs:** Due to inconsistencies in CCO reporting of DSN data elements, OHA should provide additional DSN reporting guidance in the form of TA on compliance expectations and proper reporting.

Advantage Dental Services (ADS)

ADS EQR Results
Founded in 1994 by a group of dentists, ADS is one of the largest DCOs in Oregon. ADS began partnering with CCOs in 2013 and, in 2016, joined DentaQuest Care Management Group (DentaQuest), a national dental benefits administrator that the DCO has been able to leverage for operational and network needs. In 2017, Access Dental Plan, LLC merged with ADS, providing greater network capacity. Based in Redmond, ADS is contracted with OHA as a DCO to provide dental services to OHP members throughout the State. ADS serves approximately 17,923 members through its direct contract with OHA. ADS employs a delivery system of more than 40 of its own dental practices, as well as contracted providers and "community care" hygienists to serve its members.

Compliance with Regulatory and Contractual Standards

Compliance Standard	Score
Standard I—Availability of Services	7.5/10 (75%)
Standard X—Grievance and Appeal Systems	28/32 (88%)

Overall Strengths and Areas for Improvement

Strengths:

- Robust network of general dentistry and specialty providers throughout the State
- Leverages teledentistry and health information technology
- Operates a walk-in "emergency only" clinic in Lane County
- Partners with two ambulatory surgery centers and the Oregon Anesthesiology Group
- Monitors network capacity and access
- Participates in multiple SDOH and community-wide care initiatives

Areas for Improvement:

- Member-facing documents lack clarity on some points of accessibility
- Lacks documented processes for out-of-network care specific to routine, non-emergency care
- Has not consistently held network providers accountable when deficits in compliance were identified and not remediated
- Assessment of accessibility for disabled members relies on the self-reporting of network providers

Capitol Dental Care (Capitol)

Capitol EQR Results	
Capitol serves approximately 11,498 members through its direct contract with OHA. Based in Salem, Capitol was founded in 1991 to serve Oregon's Medicaid population with efforts concentrated on underserved children. The DCO was acquired by InterDent in 1997. Capitol's information technology needs are delegated to InterDent.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard I—Availability of Services	8.5/10 (85%)
Standard X—Grievance and Appeal Systems	26/32 (81%)
Overall Strengths and Areas for Improvement	

Strengths:

- Strong member engagement and outreach program
- Present in multiple community settings
- Coordinates mobile dental vans to provide dental care services to rural regions of the State
- Uses information technology to engage members
- Uses PreManage health information technology platform to retrieve and use real-time data on ED visits to guide outreach priorities
- Large, regularly monitored network

Areas for Improvement:

- Lacks documented processes for out-of-network care specific to routine, non-emergency care
- No mechanism in place to ensure members have access to covered services that are delivered in a culturally and linguistically competent way or setting

CareOregon Dental (COD)

COD EQR Results	
COD is contracted with OHA as a DCO to provide direct dental services to approximately 2,147 members in Multnomah, Washington, and Clackamas counties. COD works with Multnomah County dental clinics and Federally Qualified Health Centers (FQHCs) in the Tri-County area. COD is a part of the larger CareOregon, Inc. MCE and is based in Portland.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard I—Availability of Services	9/10 (90%)
Standard X—Grievance and Appeal Systems	31.5/32 (98%)
Overall Strengths and Areas for Improvement	

Strengths:

- Strong commitment and systematic approach to monitoring and improving accessibility of care for members
- Routine review of data for access and utilization of care
- Easily understandable member materials and notices
- Strong provider adherence to policies and priorities
- Deep relationships with 20 area FQHCs and co-location with community resources
- Employs dental innovation specialists to facilitate knowledge transfer between clinics

Areas for Improvement:

- Nondiscrimination and culturally competent care policies and trainings did not include gender identification as a basis for protection from discrimination, and culturally competent care training for providers and staff members did not include any component specifically addressing lesbian, gay, bisexual, transgender/sexual, and queer (LGBTQ) members. COD stated that LGBTQ-specific training is in development.
- Operational procedures stated that a member should not be billed for any second medical opinion, but written policy contradicted this. COD was unaware of the contradiction and immediately corrected the policy to adhere to the compliance requirement.

Family Dental Care, Inc. (FDCi)

FDCi EQR Results	
FDCi is contracted with OHA as a DCO to provide direct dental services to members residing in the Portland Tri-County area. Based in Beaverton, FDCi serves approximately 2,103 members residing in Clackamas, Multnomah, and Washington counties.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard I—Availability of Services	8.5/10 (85%)
Standard X—Grievance and Appeal Systems	26.5/32 (83%)
Overall Strengths and Areas for Improvement	

Strengths:

- Prompt decision-making by executive leadership; grievances and appeals acknowledged and resolved quickly
- Leverages providers from other DCOs in the region
- Prioritizes customer service
- Deploying new mobile dental van in October 2019
- Monthly monitoring of data trends to strategize improvements and identify missed utilization opportunities

Areas for Improvement:

- Documentation was neither consistent nor effectively transposed across policies and procedures, provider handbook, provider enrollment agreements, and member handbook
- No written agreements for coordination of payment with out-of-network providers for non-emergent care
- Documentation around grievances and appeals needs improvement, particularly with regard to processes and State requirements

Managed Dental Care of Oregon (MDCO)

MDCO EQR Results	
MDCO is contracted with OHA as a DCO to provide direct dental services to approximately 1,942 members in the Portland metropolitan area. Based in Salem, MDCO was founded in 1991 to serve Oregon's Medicaid population with efforts concentrated on underserved children. The DCO was acquired by InterDent in 1997.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard I—Availability of Services	8.5/10 (85%)
Standard X—Grievance and Appeal Systems	26/32 (81%)
Overall Strengths and Areas for Improvement	

Strengths:

- Focus on improving access for members
- Uses information technology in outreach efforts to members
- Uses PreManage health information technology platform to capture real-time data on member ED visits to ensure appropriate member follow-up care
- Large, regularly monitored network

Areas for Improvement:

- Lacks documented processes for out-of-network care specific to routine, non-emergency care
- No mechanism in place to ensure members have access to covered services that are delivered in a culturally and linguistically competent way or setting

ODS Community Dental (ODS)

ODS EQR Results	
ODS is contracted with OHA as a DCO to provide direct dental services to approximately 9,725 members. Based in Portland, ODS began operations in Oregon in 1955 and was one of three founders of Delta Dental, the largest dental plan system in the United States.	
Compliance with Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard I—Availability of Services	8/10 (80%)
Standard X—Grievance and Appeal Systems	31/32 (97%)
Overall Strengths and Areas for Improvement	

Strengths:

- Demonstrated commitment to bolstering access, eliminating barriers to care, and bringing services to members
- Operates mobile dental van, which is dual-equipped for medical treatment
- Monthly monitoring of provider network
- Launching monthly monitoring of contracted providers
- Comprehensive and robust grievance and appeal system

Areas for Improvement:

- Single-case agreements with out-of-network providers do not include a statement that the provider may not balance bill the member
- Cultural competency training and priority does not specifically extend to non-Latino cultures or ethnicities, including the LGBTQ community
- Did not supply evidence of promoting cultural competency or encouraging training among its contracted providers during the review period
- Some member communications do not meet the State requirement of sixth-grade reading level or lower

Advanced Health (AH)

AH EQR Results
AH is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Coos and Curry counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 20,308 members. With administrative offices in Coos Bay, AH delegates several functions including mental health, substance use disorder (SUD) treatment, dental services, pharmacy benefits, and NEMT.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• AH provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed three unresolved compliance findings from the 2017 EQR, 13 unresolved compliance findings from the 2018 EQR, and nine unresolved ISCA findings from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP
Interventions: • Regional collaborative media campaign • Provider education on safe opioid prescribing • Provider education on alternative pain treatments • MAT program for OUD
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification and prioritization • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes • Interventions were evaluated for effectiveness and next steps were determined by evaluation results **Areas for Improvement:** • *None identified.* The CCO received a *Met* score for 100 percent of evaluation elements in the 2019 Statewide PIP Validation.
CCO-Specific PIP/Focus Study
• Reducing preventable ED utilization • Improving oral healthcare for patients with diabetes • Supporting the health aspects of kindergarten readiness

AllCare CCO, Inc. (AllCare)

AllCare EQR Results
AllCare is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Curry, Jackson, and Josephine counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 50,335 members. With administrative offices in Grants Pass, AllCare delegates several functions including behavioral health, dental health, pharmacy benefit management, and NEMT.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• AllCare provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed six unresolved ISCA findings from the 2017 EQR and one unresolved ISCA finding from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Regional collaborative media campaign • Provider education on appropriate opioid prescribing • Provider education on alternative pain treatments
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes **Areas for Improvement:** • The CCO should clearly report the QI tools or processes used to prioritize barriers to be addressed by interventions. A methodologically sound QI tool or process should be used to identify high-priority barriers that can be impacted by interventions. • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Study
• Colorectal cancer screening • Adolescent well visits • Effective contraceptive care

Cascade Health Alliance, LLC (CHA)

CHA EQR Results
CHA is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Clackamas, Jackson, Klamath, and Lane counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 18,600 members. Based in Klamath Falls, CHA contracts with four behavioral health organizations, and includes other relationships among its delegated and community providers.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• CHA provided sufficient evidence to resolve all of its prior findings.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Regional collaborative media campaign • Alternative pain therapy clinic pilot program • Pharmacy point-of-sale checks on opioid prescriptions for greater than seven days
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification and prioritization • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes **Areas for Improvement:** • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Studies
• Preventive oral healthcare at all ages • Health complexity • ED utilization improvement

Columbia Pacific CCO, LLC (CPCCO)

CPCCO EQR Results
CPCCO is contracted with OHA as a CCO subsidiary of CareOregon to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Columbia, Clatsop, and Tillamook counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO served 25,390 members. With Portland-based CareOregon providing administrative and risk-associative services, CPCCO delegates several functions including behavioral and dental health services.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• CPCCO provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed one unresolved compliance finding from the 2017 EQR, six unresolved ISCA findings from the 2017 EQR, and six unresolved ISCA findings from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Funding and support of MAT programs for OUD • Provider education on opioid prescribing guidelines and opioid tapering strategies • Data sharing with providers and community to support data-driven improvement strategies
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes **Areas for Improvement:** • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Study
• Oral health integration • ED utilization • Tobacco cessation

Eastern Oregon CCO (EOCCO)

EOCCO EQR Results
EOCCO is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in 12 of Oregon's eastern counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 51,558 members. EOCCO is comprised of two entities: GOBHI and ODS. EOCCO delegates several functions including NEMT, medical and pharmacy services, and dental services.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• EOCCO provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed three unresolved ISCA findings from the 2017 EQR, three unresolved compliance findings from the 2018 EQR, and one unresolved ISCA finding from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Provider-specific data sharing to offer provider-level feedback on high-dose opioid prescription rates • Online chronic pain management training for members on alternative pain management strategies • Pharmacy point-of-sale "soft and hard edits" for high-dose opioid prescriptions
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification and prioritization • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes • Interventions were evaluated for effectiveness and next steps were determined by evaluation results **Areas for Improvement:** • *None identified.* The CCO received a *Met* score for 100 percent of evaluation elements in the 2019 Statewide PIP Validation.
CCO-Specific PIP/Focus Study
PIPs/Focus Study: • Improving adolescent well-care visit access and services • Colorectal cancer screening • Addressing SUDs in older adults

Greater Oregon Behavioral Health, Inc. (GOBHI)

GOBHI EQR Results
GOBHI is contracted with OHA as an MHO to provide direct behavioral health services to approximately 1,055 members in 15 Oregon counties. Based in The Dalles, GOBHI contracts with CMHPs, other private nonprofit agencies, individual providers, and hospitals to deliver treatment services. GOBHI's members 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
Findings Follow-Up Results
• GOBHI provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed three unresolved ISCA findings from the 2018 EQR.

Health Share of Oregon (HSO)

HSO EQR Results
HSO is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in the Clackamas, Multnomah, and Washington Tri-County area. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 319,190 members. With administrative offices in Portland, HSO contracts with multiple business partners to provide direct services.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• HSO provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed seven unresolved ISCA findings from the 2017 EQR and three unresolved ISCA findings from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Provider-specific data sharing to offer provider-level feedback on high-dose opioid prescription rates • Expanded access to alternative pain treatments such as acupuncture • Increased MAT services for OUD in primary care and behavioral healthcare settings • Behavioral health integration training for pain treatment by primary care providers • Virtual pain management class for members with chronic pain
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification and prioritization • Carried out timely interventions that were logically linked to identified barriers • Interventions were evaluated for effectiveness and next steps were determined by evaluation results **Areas for Improvement:** • The CCO should ensure that all interventions selected and reported for the PIP are likely to impact the study indicators defined for the project.
CCO-Specific PIP/Focus Study
PIPs/Focus Study: • Improve effective contraception rates • Expanding access to MAT services for people with OUD • Improving the foster care relational health, academic, psychological, intellectual, developmental (RAPID) assessment process

InterCommunity Health Network (IHN)

IHN EQR Results
IHN is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Benton, Lincoln, and Linn counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO served 55,348 members. IHN is a wholly owned subsidiary of Samaritan Health Services and is managed by Samaritan Health Plan Operations. IHN delegates several functions including dental care, behavioral health services, and NEMT.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• IHN provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed one unresolved compliance finding from the 2017 EQR, six unresolved ISCA findings from the 2017 EQR, two unresolved compliance findings from the 2018 EQR, and 10 unresolved ISCA findings from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Pharmacy point-of-sale limits on high-dose opioid prescriptions • Provider education on opioid tapering strategies, pain management options, and appropriate opioid prescribing practices • Member education on pain management options • Increased access to alternative pain treatment such as physical and occupational therapy
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification • Carried out timely interventions that were logically linked to identified barriers **Areas for Improvement:** • The CCO should ensure that all interventions selected and reported for the PIP are likely to impact the study indicators defined for the project and can be measured for effectiveness. • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Study
• Adolescent annual well-care visits • Pregnancy and oral health • Reduce costly and frequent ED usage

Jackson Care Connect (JCC)

JCC EQR Results
JCC is contracted with OHA as a CCO subsidiary of CareOregon to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Jackson County. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 31,755 members. With Portland-based CareOregon providing administrative and risk-associative services, JCC delegates dental services.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• JCC provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed one unresolved compliance finding from the 2017 EQR, six unresolved ISCA findings from the 2017 EQR, and six unresolved ISCA findings from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Implementation of regional opioid coverage and opioid tapering protocols • Regional collaborative media campaign • Hosted chronic pain training for mental healthcare providers • Creation of a comprehensive pain clinic
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification • Carried out timely interventions that were logically linked to identified barriers **Areas for Improvement:** • The CCO should ensure that all interventions selected and reported for the PIP are likely to impact the study indicators defined for the project and can be measured for effectiveness. • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Study
• Improving maternal and perinatal care • High utilizer focus area • SDOH screening and follow-up

PacificSource Community Solutions—Central Oregon (PSCS-CO)

PSCS-CO EQR Results
PSCS, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-CO and PSCS-CG. PSCS-CO provides physical, behavioral, and dental health services to OHP members in Deschutes, Jefferson, Crook, and Klamath counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 49,110 members.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• PSCS-CO provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed six unresolved ISCA findings from the 2017 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Provider education on safe opioid prescribing practices and guidelines • Increased access to MAT for OUD • Pharmacy point-of-sale limits on high-dose opioid prescriptions • Regional collaborative media campaign
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification and prioritization • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes **Areas for Improvement:** • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Study
• Assessing and addressing SDOH • Oral healthcare during pregnancy • Effective contraceptive use

PacificSource Community Solutions—Columbia Gorge (PSCS-CG)

PSCS-CG EQR Results
PSCS, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-CO and PSCS-CG. PSCS-CG provides physical, behavioral, and dental health services to OHP members in Hood River and Wasco counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 12,041 members.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• PSCS-CG provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed three unresolved ISCA findings from the 2017 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Provider education on safe opioid prescribing practices and guidelines • Increased access to MAT for OUD • Pharmacy point-of-sale limits on high-dose opioid prescriptions • Regional collaborative media campaign
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification and prioritization • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes **Areas for Improvement:** • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Study
• Assessing and addressing SDOH • Oral healthcare during pregnancy • Effective contraceptive use

Primary Health of Josephine County dba Primary Health (PH)

PH EQR Results
PH is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Josephine County and in select surrounding cities in Douglas and Jackson counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 10,399 members. With administrative offices in Grants Pass, PH contracts with Oregon Health Management Systems, Inc. (OHMS) to provide many MCE operations including managing benefits for physical health and substance abuse treatment and pharmacy benefits management.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• PH provided sufficient evidence to resolve approximately half of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed three unresolved compliance findings from the 2017 EQR, nine unresolved ISCA findings from the 2017 EQR, 11 unresolved compliance findings from the 2018 EQR, and 15 unresolved ISCA findings from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Provider training on alternative pain management methods, CBT, and ACT • Increased access to MAT for OUD • Regional collaborative media campaign
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification • Carried out timely interventions that were logically linked to identified barriers **Areas for Improvement:** • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Study
• Improving perinatal screening and outcomes: maternal medical home • Oral health screening in primary care • Community health workers

Trillium Community Health Plan, Inc. (TCHP)

TCHP EQR Results
TCHP is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Lane and Douglas counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 91,711 members. TCHP is owned by Centene Corporation, a national MCO. TCHP delegates several functions including dental services, NEMT, pharmacy benefits, and vision care services.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• TCHP provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed four unresolved compliance findings from the 2017 EQR, four unresolved ISCA findings from the 2017 EQR, one unresolved compliance finding from the 2018 EQR, and four unresolved ISCA findings from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Member education classes on alternative pain management strategies • Opioid tapering plans for members with long-term opioid prescriptions • Prior authorization requirement for coverage of long-term opioid prescriptions
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification and prioritization • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes **Areas for Improvement:** • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Study
• Childhood immunizations status • Colorectal cancer screening • Postpartum care

Umpqua Health Alliance, LLC (UHA)

UHA EQR Results
UHA is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Douglas County. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 27,958 members. With administrative offices in Roseburg, UHA delegates several functions including service authorizations, network development, care coordination, and the processing of grievances.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• UHA provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed one unresolved compliance finding from the 2017 EQR and one unresolved ISCA finding from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Prior authorization requirement and coverage restrictions for high-dose, long-term opioid prescriptions • Increased access to MAT for SUDs • Regional collaborative media campaign
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification and prioritization • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes • Interventions were evaluated for effectiveness and next steps were determined by evaluation results **Areas for Improvement:** • *None identified.* The CCO received a *Met* score for 100 percent of evaluation elements in the 2019 Statewide PIP Validation.
CCO-Specific PIP/Focus Study
PIPs/Focus Study: • New Day Program 2: prenatal to postpartum care for pregnant women • ED diversion program for members with serious and persistent mental illness • Readmission reduction • New Beginnings: coordination of care for members prenatal to five years

Willamette Valley Community Health, LLC (WVCH)

WVCH EQR Results
WVCH is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Marion and Polk counties. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 102,058 members. With administrative offices in Salem, WVCH delegates several functions including dental care and information technology services.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• WVCH provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed three unresolved compliance findings from the 2017 EQR, four unresolved ISCA findings from the 2017 EQR, and three unresolved ISCA findings from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Provider training on MAT services for SUD • Expanded access to MAT services • Prior authorization requirement and coverage restriction for high-dose opioid prescriptions • Opioid prescription monitoring and feedback for dental providers
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification and prioritization • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes **Areas for Improvement:** • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Study
• Reducing gender disparities for human papillomavirus vaccines • Tobacco cessation • Syringe exchange program

Yamhill Community Care Organization (YCCO)

YCCO EQR Results
YCCO is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to Medicaid members residing primarily in Yamhill County. According to OHA's October 2019 Total CCO Managed Care and FFS Enrollment Report, the CCO serves 24,451 members. With administrative offices in McMinnville, YCCO delegates several functions including management services, behavioral health services, IT services, and dental care.
Compliance with Regulatory and Contractual Standards
Findings Follow-Up Results
• YCCO provided sufficient evidence to resolve the majority of its prior findings. The results of the 2019 Findings Follow-Up Assessment revealed one unresolved ISCA finding from the 2017 EQR, one unresolved compliance finding from the 2018 EQR, and six unresolved ISCA findings from the 2018 EQR.
Performance Improvement Projects (PIPs)
Statewide PIP on Opioid Safety
Interventions: • Alternative payment methodology providing an incentive to providers who do not prescribe high-dose opioids • Provider-specific feedback and education on opioid prescribing performance • Collaboration with Yamhill County Public Health to increase provider registration for the PDMP • Community-based pain management program for members experiencing persistent pain
Overall Strengths and Areas for Improvement
Strengths: • Methodologically sound QI processes for barrier identification and prioritization • Carried out timely interventions that were logically linked to identified barriers and study indicator outcomes **Areas for Improvement:** • Intervention-specific evaluation results should be reported for the PIP. The CCO should ensure that each intervention is evaluated for effectiveness and evaluation results are used to guide next steps of each intervention.
CCO-Specific PIP/Focus Study
• Reduce ED utilization • Hepatitis C screening and treatment improvement project • PCPCH engagement—improving primary care through increased adoption of the PCPCH model