Oregon's Medicaid Quality Strategy

2025

I. Introduction

Oregon's Quality Strategy provides a comprehensive framework for monitoring, evaluating, and improving the state's Medicaid managed care program. To support this endeavor, Oregon maintains a performance monitoring system that includes various strategies and mechanisms to monitor and evaluate all managed care arrangements, including Coordinated Care Organizations (CCOs), in accordance with 42 CFR §438.340.

The objective of this Quality Strategy is to assess the effectiveness of Oregon's coordinated care model in achieving key goals related to access, quality improvement, and health system transformation, while also addressing persistent disparities in health outcomes. This includes evaluating whether transformation efforts have led to measurable improvements in access, as required by 42 CFR §438.340.

In alignment with CMS requirements, Oregon conducts ongoing assessments of CCOs through a structured performance measurement process. This process includes regular evaluations of the quality and appropriateness of care and services delivered to Medicaid members, as well as member experience and satisfaction. The performance monitoring system provides comprehensive oversight of all CCO activities, and ensures accountability through targeted quality improvement initiatives and contract compliance.

This Quality Strategy outlines the core components and operational framework of Oregon's performance monitoring system, which supports Oregon's continued effort to strengthen care delivery and improve health outcomes for Oregonians.

II. Oregon Medicaid Overview

Oregon's 1115 Waivers

Oregon uses four 1115 Medicaid Demonstration Waivers to advance its Medicaid program and improve health outcomes for health plan members. These waivers include: the Oregon Health Plan (OHP) 1115 Waiver, Substance Use Disorder (SUD) 1115 Waiver, Contraceptive Care (C Care) 1115 Waiver, and Oregon Project Independence (OPI M) 1115 Waiver. The OHP 1115 Waiver authorizes Oregon to implement delivery system reforms aimed at enhancing access, improving quality, and ensuring sustainability of healthcare services. Key objectives of the OHP waiver include

expanding coverage to all eligible individuals, promoting a member-centered approach through care coordination and integration of physical, behavioral, and oral health services, while supporting value-based purchasing to incentivize efficient, outcome driven care.

Through these reforms, Oregon aims to establish a high-performing Medicaid delivery system that is fair, sustainable, and responsive to the wide-ranging needs of its population. Oregon's 1115 waivers build upon the foundational elements of OHP, with a renewed focus on addressing health disparities and expanding access to health-promoting services. Oregon remains committed to achieving universal coverage and advancing delivery system reforms that promote high-quality care while containing costs.

CCOs: Medicaid Managed Care in Oregon

In 2012, Oregon launched CCOs through the 1115 OHP Medicaid waiver and an accompanying state innovation model grant from the Center for Medicare and Medicaid Innovation (CMMI).

CCOs are community-governed organizations that deliver care to Medicaid members through a coordinated care model of service delivery designed to address problems inherent in a fragmented health system. CCOs are responsible for physical, behavioral, and oral health care services for Medicaid members. They receive a fixed monthly budget to coordinate care, with flexibility to address their members' needs outside traditional medical services, and financial incentives for improving outcomes and quality.

The Oregon Health Authority (OHA) manages the oversight and authority over the CCO program.

Although CCOs operate statewide, no single CCO serves the entire state. Through Oregon's current 1115 OHP waiver, CCOs serve defined regional areas. Each county in Oregon has at least one CCO. In regions with multiple CCOs, members are given the opportunity to select or change their CCO. All CCOs provide integrated benefits for physical, oral, and behavioral health.

Medicaid Plan and Populations

The Medicaid agency elects to enter a risk contract that complies with 42 CFR §438.6 and is procured through an open, competitive process that is consistent with 45 CFR Part 74. The risk contract is with: Managed Care Organizations (MCOs) that meet the definition of 1903(m) of the Act and 42 CFR §438.2.

Except for certain long-term services and supports (LTSS), all plans and populations fall under CCO managed-care authority. OHA CCOs do not provide LTSS benefits. LTSS benefits are managed by Oregon Department of Human Services' (ODHS) Office of Aging and People with Disabilities. Oregon does not have any Prepaid Inpatient Health Plans (PIHPs) or Prepaid Ambulatory Health Plans (PAHPs).

Managed Care Contract Information			
Plan	Plan Type	Managed Care Authority	Population Served
CCO	MCO	1115	Medicaid children without disabilities, parents, and expansion adults ages 20-64
IMCE Indian Managed Care Entity	PCCM Primary Care Case Management	State plan authority	AI/AN individuals attributed by the Tribal or Urban Indian IMCE covering this service area

Oregon's Quality Strategy Goals and Objectives

Aligning with OHA's strategic goal of eliminating health disparities, state quality goals and objectives reflect input from the community, members, health plans, and OHA leadership. Goals and objectives will be reviewed based on the criteria outlined in the "significant change" section on page 60.

Goal 1:	Improve quality and access to care through member-centered and data driven interventions
Objective 1:	Improve healthy birth outcomes, especially of those experiencing disparities such Black and African Americans and American Indian/Alaskan Natives (AI/AN) by increasing utilization of certain maternity services such as treatment of hypertension and diabetes and care for postpartum depression.
Objective 2:	Ensure access to quality for medically necessary and medically and dentally appropriate care to members covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits.
Objective 3:	Stratify performance measures by member enhanced demographic information with a goal that CCOs analyze the data and can identify and address health inequities.
Objective 4:	Improve quality and access to emergency medical transportation.
Objective 5:	Improve quality and access to behavioral health services.
Objective 6:	Improve quality and access to oral health services.
Goal 2:	Incorporate screening and support to address Health-Related Social Needs (HRSN) through quality measurement, coordination with community partners, opportunities for payment, and collection of social needs data in standardized formats.
Objective 1:	Assess access to routine vaccinations, convene partners, and develop a plan to address barriers to access (pharmacists, Local Public Health Authorities (LPHAs), vaccinating providers, and hospitals).
Objective 2:	Evaluate the effectiveness of HRSN service delivery.
Objective 3:	Increase rates of preventive screenings for oral health.
Objective 4:	Ensure School-Based Health Centers (SBHC) have the ability to collect enhanced demographic data for SBHC clients.
Goal 3:	Improve integration and care coordination to ensure underserved and high need members have the appropriate interventions to support their individual needs.
Objective 1:	Integrate maternity care with substance use treatment into CCO Care Coordination activities.

Objective 2:	Reduce payment barriers related to traditional health worker engagement to CCO members.
Objective 3:	Support CCOs in implementing comprehensive risk stratification processes to identify member needs (medical, behavioral, dental, and social) and ensure each member has an appropriate care plan when required, to support individual needs regardless of where the member is receiving care.
Objective 4:	CCOs will engage in care coordination to ensure members receive the appropriate care in the appropriate setting.
Goal 4:	Demonstrate meaningful improvement in access to services and supports that are understandable, respectful, and responsive to individuals' language preferences, communication needs, and varying levels of health literacy.
Objective 1:	Ensure members have access to prevention and health promotion information that is clear, understandable, and aligned with their language and communication needs.
Objective 2:	CCOs will develop a plan to monitor the quality and accessibility of written and electronic member communications, such as member newsletters, in all appropriate languages and accessibility formats.
Objective 3:	Monitor CCOs implementation of the SB 968 SMART Law that seeks to reduce medication errors by requiring pharmacies in Oregon to offer prescription container labels in 14 different languages (other than English).
Objective 4:	Support CCOs in delivering care plans, care coordination, and member-facing materials that are clear, accessible, and responsive to individuals' language preferences, communication needs, and understanding.
Objective 5:	CCOs will expand and maintain a workforce and provider network that can deliver services in ways that are respectful of members' language preferences and communication needs and are aligned with the backgrounds and experiences of the populations they serve.
Goal 5:	Enhance oversight of CCO subcontractors and downstream entities to improve quality of care.
Objective 1:	CCOs will provide oversight to Subcontractors, with a focus on Non-Emergent Medical Transportation (NEMT) and Dental, to ensure timely, appropriate, and fair access to services.

Objective 2:	CCOs will require subcontractors to remedy deficiencies using Corrective Action Plans (CAP) or other alternative methods depending on severity of noncompliance.
Objective 3:	CCOs will identify all Subcontractors and downstream entities and assess their capacity to deliver services that are accessible, respectful, and responsive to members' language preferences and communication needs.

Goal 1: Improve quality and access to care through member-centered and data driven interventions.

OHP members deserve timely, high-quality health care that meets their needs. OHA's overarching goal is to reduce any barriers OHP members may face when accessing health care. OHA is committed to providing the right care, at the right time, and in the right place. As such, OHA is committed to principles of accountability and transparency in how we approach our partnership with CCOs.

One of OHA's top priorities is caring for expectant mothers and the next generation of Oregonians. As such, we strive for healthy birth outcomes that outpace the national average in terms of quality of care. Oregon currently ranks among the top five states for low pre-term birth rate, with 91% of births occurring at or after 37 weeks gestation. Historically underserved populations, such as Black and AI/AN expectant mothers, have delivered infants that are born pre-term or low birth weight nearly 40% more often than White infants.[1] Additionally, pregnancy-related mortality for Black people is 2.5 times the state average;[2] hypertension, diabetes, and untreated postpartum depression are the leading contributors.

As children age, we wish to continue supporting them in their health care needs, which is why Oregon has covered this population since 2023. EPSDT covers the care for children and youth that is needed for health development. This includes screenings, checkups, tests, and follow-up care. These services can find and guide treatment for health concerns early in life which will assist in avoiding illness, disability, or more serious health impacts in the future.

Beyond its focus on children, OHA is committed to stratifying all populations to identify underserved groups, allowing for data driven initiatives that more effectively allocate

[1] Source: March Of Dimes: PeriStats
[2] Oregon Maternal Mortality and Morbidity February 2025

resources and address gaps. CCO measures can be viewed by CCO geographic region, race/ethnicity, and language and disability status on OHA's CCO Performance Metrics Dashboard. Each CCO can analyze its own data and can share the findings with Consumer Advisory Councils (CAC) when appropriate, as well as submit a quality-improvement plan that targets the largest gaps.

OHA is committed to ensuring Oregonians have ease of access to all types of health care services, including physical, behavioral, oral, and specialty care. This goal focuses on two major areas; behavioral and oral health, where gaps have been identified with data driven methods. Together, these identified objectives bring into focus our commitment to providing a wide umbrella to our expanded Medicaid population.

Finally, Oregon recognizes that health care extends beyond what can be planned for. We have identified emergency transportation as a key area we will continue to focus on in the upcoming years. Studies have shown that timely emergency medical care and transportation to nearby medical facilities are critical to positive health outcomes. In addition, through discussions with service users and trusted community partners, we have identified significant barriers for members utilizing these services, as the cost for an ambulance ride can be significant. Beyond that, the training and retention of Emergency Medical Technicians (EMT) is essential for our state health system.

Goal 2: Incorporate screening and support to address Health-Related Social Needs (HRSN) through quality measurement, coordination with community partners, opportunities for payment, and collection of social needs data in standardized formats.

To protect the health and quality of life for OHP members, it is essential for Medicaid programs to effectively assess, evaluate, and reduce barriers to care. Communities across Oregon experience unequal access to the support structures necessary for leading healthier lives. Oregon also recognizes an urban-rural divide that contributes to persistent health disparities in preventive services such as:

- Routine vaccinations
- Oral health screenings
- Access to care that addresses HRSN.

Access to routine immunizations often depends on geographic, socioeconomic, and health care infrastructure factors, with local public health agencies (LPHAs) playing a vital role in reaching individuals who may not have reliable access to primary care. Collaborations between CCOs and LPHA partners help ensure that interventions are accessible, respectful, and responsive to members' language preferences and communication needs. Barriers such as payment limitations, a shrinking network of vaccinating providers, and care gaps within Medicaid-serving practices must be addressed through coordinated local strategies and improved data collection.

Similarly, preventive dental care—despite being covered under OHP—continues to be underutilized. Increasing access to dental screenings and preventive care is critical to early detection of oral health issues, avoiding costly emergency interventions and improving overall health.

Expanding the role of trusted, community-embedded organizations such as Community-Based Organizations (CBOs) and LPHAs also strengthens Oregon's efforts to meet people where they are by offering Medicaid-reimbursed services that align with cultural and linguistic needs. By building robust partnerships and enhancing local capacity, OHA and CCOs can more effectively close gaps in care, support social needs interventions, and promote better outcomes for all populations through data-driven, community-centered strategies.

To support these efforts, CCOs can assist state-certified SBHCs within their service areas in collecting enhanced demographic data from clients. Currently, SBHC providers have varying capacities to collect this information due to differences in Electronic Medical Record (EMR) systems. Some providers need support in developing effective systems for capturing accurate demographic data, including improvements to workflows, paperwork, and EMR functionality. Reliable enhanced demographic data empowers SBHCs and their partners—such as schools, CBOs, LPHAs, Community Mental Health Programs (CMHPs), and CCOs—to better understand the populations they serve and identify gaps in care and access.

The HRSN objective supports CCO efforts to address HRSN through collaboration with community partners, and payment to enrolled HRSN service providers. By building out a network of community-based providers, CCOs and OHA can expand access to essential services, while gaining more direct opportunities to collect standardized social needs data. Recruiting and strengthening the capacity of CBOs, LPHAs, and other trusted partners to serve as HRSN providers, is a critical step toward making these services more accessible. Many of these organizations already support OHP members through care that reflects the diverse needs of the populations they serve. Medicaid reimbursement for HRSN services allows them to expand their impact while enabling other funding sources to extend across non-Medicaid-covered services. This integrated approach helps promote the health of entire communities, recognizing that when Oregon communities are healthier, OHP members are too.

Goal 3: Improve integration and care coordination to ensure underserved and high need members have the appropriate interventions to support their individual needs.

OHA recognizes that care coordination is essential to ensuring members receive the right care, at the right time, in the right setting. It reduces gaps in care and improves health outcomes by aligning providers, services, and supports with an appropriate care plan. In addition to improving health outcomes, effective care coordination promotes more efficient use of resources across the continuum of care, while also improving member experience.

A key part of effective care coordination is the integration of services to address complex and overlapping needs. For example, integrating maternity care with substance use treatment helps meet the full range of health and social needs experienced by pregnant individuals with substance use disorders. This type of integrated approach improves both maternal and infant outcomes by ensuring timely access to prenatal care, substance use treatment, mental health services, and social supports.

Untreated, perinatal depression, anxiety, and substance use disorders increase maternal mortality rates (including suicide and overdose), and are associated with severe maternal morbidity as well as poor neonatal outcomes. Integrating behavioral health in all practice settings allows pregnant and postpartum people to address behavioral health symptoms in a place where they already have relationships and feel comfortable. Integrated behavioral health care improves the reliability of screening, increases the efficiency of referrals, reduces barriers to treatment for mental health and substance use disorders, and improves health outcomes for pregnant and postpartum people.

To further strengthen care coordination, OHA has recently implemented and is currently monitoring risk stratification processes across CCOs. By evaluating and improving how member risk is assessed, OHA can help ensure that members—especially those with the most complex needs—are connected with timely, appropriate interventions and support.

OHA has worked with community-based organizations and CCOs to increase use of a community-informed and holistic integration of Traditional Health Workers (THWs) into the health care system. To support this initiative, OHA has developed multiple funding mechanisms and program pathways for THW services. Based on community engagement sessions conducted in 2024–2025, and findings from the THW Workforce Needs Assessments for Peers (2020), Doulas (2018), and Community Health Workers

(2018), an overarching theme related to the lack of billing education and support, as well as limited use of universal procedure codes, emerged as a potential avenue to reduce THW payment barriers. Reducing payment barriers to THW engagement will help integrate member-centered, community-based support into care teams. Removing these barriers not only improves continuity of care but also builds trust and strengthens support for communities that have historically faced greater challenges in accessing care.[3] [4] [5]

[3]Sanford, B., Wiggins, N., Reyes, M.E., & George, R. (2018). Community Health Workers: Integral Members of Oregon's Health Workforce. Portland, OR: Oregon Community Health Workers Association.
[4] Scavera, A., & O'Neill-Tutor, M. (2020). Flying with Our Own Wings: Oregon's Peer-Delivered Services Workforce Needs Assessment Report. Portland, OR: Mental Health & Addiction Association of Oregon.
[5] Everson, C., Crane, C., & Nolan, R. (2018). Advancing Health Equity for Childbearing Families in Oregon: Results of a Statewide Doula Workforce Needs Assessment. Estacada, OR: Oregon Doula Association.

Goal 4: Demonstrate meaningful improvement in access to services and supports that are understandable, respectful, and responsive to individuals' language preferences, communication needs, and varying levels of health literacy.

Oregon is home to people with a wide range of backgrounds, languages, and experiences. The communication needs of members reflect this range.

Whether it is the ability of each member to read and understand care plans they receive from their health care visits, prescription labels on the medicine they are instructed to take, public health communiques including emergency communications, or members communicating directly with their provider or other health care workers, communication in all forms can be a significant barrier for members seeking health care. Effective communication is necessary throughout the continuum of care and must be—both at the policy and operational levels—inherent to service delivery to be successful.

Nearly one-fifth of OHP members prefer a language other than English, and 11% report limited English proficiency.6 The 2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey shows that only two-thirds of non-English speakers "always" understand their plan materials, compared with 84% of English speakers.7 Member feedback echoes this gap, citing dense wording and poor translations as barriers to care.8 Further, one in every 17 Oregonians cannot read English directions for their prescription medications. Medication errors are costly and dangerous. One out of every five emergency room visits are due to a preventable medication error, resulting in an average cost $10,000 per hospitalization.9

CCOs have an essential role to connect OHP members to information they need to prevent disease, maintain health, and stay safe during events that can harm health, such as an extreme heat event or a foodborne illness outbreak. CCOs have a responsibility to ensure that members receive timely information that meets their language and communication needs, and that there are effective channels in place to reach members directly. CCOs are monitored for network adequacy including culturally

[6] Source: Health Equity Measure: Meaningful Access to Health Care
[7] Oregon Health Plan Report of Results for State Oregon Health Plan
[8] Recommendations of the MAC Consumer Voice Subcommittee
[9] Patel, P. & Zed, P. (2002). Drug-Related Visits to the Emergency Department: How Big is the Problem? Pharmacotherapy, 22(7): 915-923. doi: 10.1592/phco.22.11.915.33630

and linguistically appropriate services through External Quality Review Organization (EQRO) audits and CCO contract deliverables.

Federal rule 42 CFR § 438.10 and Oregon HB 2359 require timely, high-quality language access. Closing this identified gap is a legal requirement as well as being essential to ensuring all members can fully access care. OHA and its EQRO, Health Services Advisory Group (HSAG), currently measure accessibility, the number of providers who speak a prevalent non-English language as per CFR §438.206 (b)(1), which is useful in understanding the ability of the CCOs' provider networks to render linguistically accessible services**.**

By turning readability scores, translation timeliness, and ADA accessibility into performance data, we make "access to information" a measurable quality target and create a feedback loop for continuous, member-centered improvement. Additionally, appropriate use of translated services including care plans, public health announcements, and medication labels can lower medication error rates, prevent unnecessary hospitalizations and mortality, and ultimately be cost saving for the health care system.

Goal 5: Enhance oversight of CCO subcontractors and downstream entities to improve quality of care.

OHA recognizes that consistent oversight of subcontractors and downstream entities is essential to ensuring high-quality performance across CCOs and the services they provide OHP members. However, this level of oversight is not consistently applied across all CCOs. Without a uniform approach, monitoring and compliance efforts remain inconsistent, and adherence to state and federal requirements is not always assured. Implementing a standardized oversight process would help improve care quality, reduce administrative burden, and ensure that subcontractor performance is up to the standards required to maintain member health and safety.

When CCOs delegate services to subcontractors, the subcontractors are held to the same accountability standards as CCOs, as outlined in the CCO contract. There is insufficient monitoring to ensure subcontractors are meeting these contractual requirements. Consequently, when noncompliance is identified, lack of remediation or resolution occurs. CCOs should be issuing Corrective Action Plans (CAPs) to subcontractors within 30 days of identifying deficiencies and updating OHA on remediation progress.

OHA, in collaboration with the CCOs, will develop a standardized performance process to address identified gaps for critical subcontracted services, including NEMT and dental services. The process will improve monitoring and ensure these subcontracted services are meeting contractual requirements.

In addition, OHA will ensure that CCOs consistently verify whether the services their subcontractors provide align with the National CLAS Standards, which promote respectful, effective care that considers members' communication needs and backgrounds. While these standards are a key part of delivering high-quality, person-centered care, current CCO deliverables do not fully address whether subcontractor services are in compliance. This gap limits OHA's ability to confirm that subcontractor services are meeting expectations for accessible and appropriate care for all members. Establishing a consistent subcontractor and CAP process will improve oversight, reduce harm to members, and enhance quality of care.

Accountability Summary

To drive innovation, improve health outcomes and ensure regulatory compliance, OHA collaborates with a range of partners, committees and oversight bodies. These efforts aim to promote CCO accountability and improve the quality of care across the delivery system. The following committees focus primarily on this work:

- Oregon Health Policy Board – develops strategic direction of health system transformation and is member-centered.
- Metrics and Scoring Committee – selects quality measures and benchmarks for Oregon's Quality Incentive Program (QIP), which rewards CCOs when they provide exceptional care for OHP members.
- Medicaid Advisory Committee – advises OHA on the policies, procedures, and operations of the Oregon Health Plan.
- Medicaid Leadership Committee for Quality and Evaluation– provides overall structure for the OHP quality governance to monitor and improve quality initiatives.
- Quality and Health Outcomes Committee – monitors clinical quality performance with improvement strategy development and implementation.
- Health Evidence Review Committee – reviews and develops evidence-based practices for all managed care entities.
- CCO Operations Collaborative – shares important communication to CCOs regarding contract changes and OHA program updates.
- Contracts and Compliance Workgroup – monitors compliance with CCO contract requirements and provides guidance on operational implementation of requirements.
- All Plan System Technical Workgroup (APST) – systems technical and quality metrics workgroup.
- Behavioral Health Directors – focuses on guidance for behavioral health policy.
- Care Coordination Workgroup – focuses on improving care coordination.
- Oral Health Forum – focuses on guidance for oral health policy.

Oregon's Medicaid Data-Driven Path to Eliminating Health Disparities

Oregon's Medicaid program covers 1.4 million people—one in four Oregonians—including children, pregnant individuals, low-income adults, older adults, and individuals with disabilities. These groups often bear a disproportionate burden of disease. Our quality strategy places data—both quantitative and qualitative—at the center of efforts to identify and address differences in health access, experiences, and outcomes across

populations. We collect enhanced demographic information, engage with communities and Medicaid members, report disparities transparently, and act on our findings.

Oregon Medicaid is building a strong infrastructure to help identify and analyze gaps in health coverage and collaborate with CCOs to address these issues.

Using data driven analysis, OHA evaluates health gaps and shares the findings publicly. Annually, OHA updates a Stratified Metrics Dashboard that displays several core measures—such as well-child visits, diabetes control, prenatal care, and behavioral health follow-up—broken down by demographic categories.

Every six months, OHA's Ombuds program produces a report containing crucial member-centered data and stories aimed at strengthening our systems and better serving OHP members. This information is publicly presented to the Oregon Health Policy Board (OHPB) and its committees. For instance, the complaints data and member stories in the latest report from late 2024 indicate that OHA should prioritize resources and improve processes, systems, and oversight around HRSN, provider and network adequacy, dual eligible members, and language access. In response to these recommendations, the Medicaid Division has created periodic updates outlining its progress on each recommendation, along with a publicly available progress log.

Current contract language allows OHA to place a CCO on a Corrective Action Plan (CAP) when ongoing noncompliance exists. Prior to initiating a corrective action, OHA divisions responsible for requirements in the CCO contract provide periodic technical assistance to CCOs to facilitate data analysis and program improvement.

Each year, OHA provides the CCO Quality Incentive Program CCO Metrics Final Report[10] to assess quality and access to care, holding CCOs accountable to key metrics as a cornerstone of Oregon's health system transformation. The CCO Performance Metrics Dashboard expands on this final report, offering a detailed overview of Oregon's CCOs' progress on quality measures. Users can easily find metrics of interest and

[10] Oregon Health Authority. Oregon CCO Quality Incentive Program: CCO Metrics 2023 Final Report. Portland, Oregon. August 2024. https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2023-CCO-Metrics-Annual-Report.pdf

observe individual CCO trends over time, with an option to explore breakdowns of many measures by enhanced demographics. In addition, OHA uses these measures to produce an annual Completeness Report to the Oregon Legislature[11] ensuring visibility and accountability regarding collections of demographic data.

This update to the Oregon Medicaid Quality Strategy includes revised goals and objectives and additional narratives responding to CMS' request for details on our efforts to identify, measure, and address health gaps. This submission includes plans to identify each disparity factor, methods for evaluating gaps, and clear targets.

For reports outlining OHA's current progress toward reducing disparities, please see the OHA Ombuds reports here.

Methods and Resources for Monitoring

Across OHA's quality programs, the agency utilizes a variety of quality strategies as tools for improvement. Continuous quality improvement, Plan-Do-Study-Act models, and Lean principles are examples of proven methods of improvement. Ongoing use of these methods across the agency supports transformation of the health care delivery system through train-the-trainer models in partnership with CCOs. An additional resource for monitoring is the use of robust data systems that support a data-driven data-decision making culture. Key agency data sources include, but are not limited to, the All Payer All Claims database, performance monitoring through measures reporting, Delivery System Network (DSN) reports, appeal and grievance data, and CCO data dashboards generated from claims reporting and deliverable tracking.

Standards For Managed Care Contracts

As required by CFR §438.340, Oregon must establish standards for all CCO contracts that address access to care, structure and operations, and quality measurement and improvement. These federal requirements are embedded within the CCO contracts, along with corresponding deliverables that support quality monitoring and ensure contract compliance.

[11] https://www.oregon.gov/oha/EI/Reports/REALDSOGILegislativeReport_2024.pdf

Compliance and Expectations for CCOs

Achieving the policy objectives outlined in the previous contract renewal requires a strong operational foundation with clearly defined performance expectations and a system for monitoring compliance with all contract provisions. While CCOs are given some flexibility to address the unique needs of their communities, OHA also has a responsibility to conduct effective oversight of the program to ensure members receive the care they are entitled to.

OHA established the internal structures needed to set a standard of accountability across the health care delivery system and to apply that standard consistently to all providers. To enhance oversight and support CCOs, OHA created a comprehensive, standardized process enabling all divisions to proactively evaluate, monitor and manage individual CCO remediation to contract requirements. Aligning contract deliverables with a streamlined, transparent compliance review process will:

- Create a sustainable process that is standardized and driven by deliverable requirements, not variable and people driven.
- Ensure CCOs have clear information and guidance about deliverables for which they are accountable, OHA's review process, and corresponding timelines.
- Strengthen partnership and coordination between CCOs and OHA.
- Enable remediation of process gaps and focus on prevention of future findings.

The standard evaluation process enables OHA to monitor and track CCO performance across all federal and state requirements. Contract deliverables are updated annually to improve clarity around requirements, reporting, due dates, and the accountability process. Through this effort, OHA is developing more prescriptive guidance in areas where community partners have expressed concern about access barriers or inconsistencies; providing technical assistance, if needed; and utilizing enforcement mechanisms as necessary to achieve desired outcomes.

Through enhancements to our monitoring and compliance infrastructure, increased enforcement of new and existing requirements, and clearer performance expectations for CCOs, OHA is creating the conditions necessary for CCO success and advancing Oregon's broader health system transformation efforts.

Health Priority Alignment

CCO contract priorities

The current phase of Oregon's health care transformation is focused on four key areas identified by the Governor:

1. Improve the behavioral health system and address barriers to access to and integration of care.
   Integrate behavioral, physical and oral health to allow patients to receive the right care at the right time and in the right place. Focus on behavioral health (mental health and substance use disorder) services. Assure that children with serious behavioral health care needs are addressed as a priority.
2. Increase value and pay for performance.
   Reward providers' delivery of patient-centered and high-quality care. Reward health plan and system performance. Ensure consideration of health disparities and members with complex needs. Align payment reforms with other state and federal efforts.
3. Focus on elimination of health disparities.
   Build stronger relationships between CCOs and other sectors. In addition, align outcomes between health care and other social systems to improve health disparities. Encourage a greater investment in prevention and the factors that affect our health outside the doctor's office
4. Maintain sustainable cost growth and ensure financial transparency.
   Continue to operate within a sustainable budget and address the major cost drivers in the system. Ensure ongoing financial transparency and accountability.

These focus areas and the associated policies are the foundation of the CCO contracts awarded for 2020–2024. Legislative activity created an extension of the current CCO contracts through 2026.

State Health Improvement Plan

OHA provides foundational support for the implementation of the State Health Improvement Plan, Healthier Together Oregon (HTO). Oregon's 2020–2024 HTO outlines the actions needed to improve health outcomes for people and communities with complex or unmet health needs through collective efforts in five key areas: structural barriers within systems; the cumulative effects of trauma and long-term stress; access to preventive health care; behavioral health; and the economic factors that influence health, such as housing, food security, and living-wage jobs. HTO is intended to be an alignment tool for anyone working to improve health, including other state agencies and partners who develop and implement Community Health Improvement Plans (CHPs). CCO CHPs are required to align with at least two HTO priorities and strategies.

Finally, OHA convenes the PartnerSHIP, a community-based steering committee that provides oversight and governance of the State Health Improvement Plan. The PartnerSHIP includes representatives from populations experiencing disparities and key implementers of the State Health Improvement Plan, including CCOs and their community advisory councils.

III. Methods

Accountability Methods

Oregon has developed a comprehensive program to assess all components of the health care delivery system. This program involves routine analysis and monitoring of delivery system performance and consumer satisfaction data, comprehensive on-site operational reviews, and other focused reviews and surveys designed to monitor areas of particular concern (such as provider availability, marketing activities, and other issues identified through routine monitoring). In addition to these activities, OHA conducts ongoing accountability and compliance reviews (described below).

Ongoing Focused Reviews

Focused reviews, which may or may not be on-site, are conducted in response to suspected deficiencies that are identified through routine monitoring processes and reporting. These reviews also provide more detailed information on areas of particular interest to OHA such as emergency department visits, availability and access of services, behavioral health, utilization management, and data collection problems. One example of a focused review is the ongoing evaluation of plans' provider networks to ensure physicians are not listed as practicing if their medical license has been suspended or revoked.

Appointment and Availability Studies

The purpose of these studies is to review managed care provider availability/ accessibility and to determine compliance with contractually defined performance standards. OHA and its External Quality Review Organization (EQRO) conduct a secret shopper telephone survey among Primary Care Providers (PCPs) contracted with one or more CCO. The primary purpose of this secret shopper survey is to collect appointment availability for OHP members who are new to the provider location and requesting routine well-checks or non-urgent problem-focused ("symptomatic") visits. Specific survey objectives included the following:

- Determine whether PCP service locations accepted OHP members enrolled with the requested CCO and the degree to which CCO and OHP acceptance aligned with the CCOs' DSN provider capacity report data
- Determine whether PCP service locations accepting OHP for the requested CCO accepted new patients and the degree to which new patient acceptance aligned with the CCOs' DSN provider capacity report data
- Determine appointment availability with the sampled PCP service locations for routine well-checks and non-urgent symptomatic visits

Marketing and Member Materials Review

CCOs are contractually required to submit all marketing materials or advertising, and written member notices to OHA for approval prior to use. This process ensures the information presented to members and potential members is compliant with state and federal requirements. Examples would include readability by the Flesch Kincaid Model and use of plain language.

Performance Monitoring

Through the standardized deliverable evaluation process, OHA has the ability to compare and measure performance across all CCOs on a variety of deliverables. To support this effort, OHA is improving reporting tools and systems to better assess performance in key priority areas: timely and appropriate denials, appeals and grievances; access to language translation services; quality of non-emergent medical transportation services; adequacy of provider network; access to care coordination services; and integration of behavioral health services.

On-Site Operational Reviews

On-site reviews will be conducted periodically in response to various triggers, including identified performance gaps, requests from the CCO, or recommendations from the EQRO. Reviews may include, but are not limited to, validating reports and data previously submitted by the CCO, an assessment of supporting documentation, and/or conducting a more in-depth review of the CCO's quality assurance and compliance activities. Reviews will also serve as an opportunity for in-person, one-on-one technical assistance in identified gap areas.

Furthermore, on-site review(s) supplement OHA's CCO monitoring program by providing direct and focused areas of improvement.

Quality and Evaluation Committee reviews

The OHA Medicaid Leadership Committee for Quality and Evaluation ensures that Medicaid quality expectations are clearly defined, and that performance is consistently assessed against those standards. The committee evaluates key data sources, audits, and compliance activities to support continuous improvement and strategic decision-making.

Key Goals**:**

- Foster a culture of accountability, fairness, and quality in Medicaid programs.
- Use data-driven evaluation methods to improve health outcomes.
- Ensure policies align with federal and state quality assurance standards.

Inputs**:**

- Audits & Compliance Reviews – Assess what Medicaid is tracking, identify gaps, and address unmonitored areas.
- Reporting Requirements – Review reports developed for the Governor, legislature, and OHA leadership to ensure consistency and accuracy.
- Oversight & Monitoring – Analyze work conducted by the Quality Assurance team, HSAG, and compliance logs. Evaluate opportunities for alignment between CCO and FFS quality measures.
- Medicaid Strategy – Consider broader Medicaid goals and ensure that quality-related efforts align with long-term priorities.

Outputs**:**

- Recommendations for clarifying or establishing Medicaid quality standards.
- Identification of key performance measures for tracking progress and outcomes.
- Reports on trends, performance, and quality improvement initiatives.
- [Long-term] Development of a two-year Medicaid planning cycle, with the committee serving as a steering group to navigate key requirements (e.g., legislative session milestones, budget thresholds, annual CCO contract updates).

Performance Improvement

Advancing PIPs

As referenced in 42 CFR §438.340(b)(3)(ii), OHA requires CCOs to conduct performance improvement projects (PIP). Moving forward, OHA and CCOs are working to align PIP strategies with OHA's strategic goal, the quality strategy, and individual CCO priorities. This alignment considers member needs, workforce capacity, the use of technology in care coordination, and expanding into integrated practice. By managing these relationships, CCOs that have developed data monitoring systems, case management programs, and aligned measurement strategies, are better positioned to address social determinants of health. Lessons learned from the previous demonstration for PIP implementation have led to the development of SMART (Specific, Measurable, Attainable, Relevant, and Timely) objectives, each with corresponding metrics to track progress. Future technical assistance and monitoring efforts will continue to focus on these quality improvement foundations.

PIP Focus Areas

To move forward in testing and implementing improvement strategies, the CCOs will be required to conduct four performance improvement projects. Two of the four will be selected from the focus area list by the CCO, the third will be a statewide PIP under the "integration of health" focus area, and the fourth will be a statewide substance use disorder PIP.

As per STC 24b.ii within Oregon's Medicaid 1115 waiver, OHA contractually requires each CCO to address four of the eight quality improvement focus areas including:

- Reducing preventable re-hospitalizations;
- Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs;
- Deploying 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;
- Ensuring appropriate care is delivered in appropriate settings;
- Improving perinatal and maternity care;
- Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home (PCPCH) model of care, and

- Social determinants of health

In addition, CCOs are contractually required to demonstrate improvement in care coordination for members with serious and persistent mental illness. PIP focus areas are subject to change as CCOs mature or as directed by CMS and/or OHA.

External Quality Review Organization (EQRO) activities

States with Medicaid managed care delivery systems are required to annually provide an assessment of Managed Care Entities' (MCEs') performance related to the quality of, timeliness of, and access to care and services provided by each entity, as mandated by 42 Code of Federal Regulations (CFR) §438.364. In Oregon, a CCO is a specific type of MCE. To meet this requirement, OHA contracted with HSAG, an EQRO, to perform the assessment. The EQRO performs the following mandatory and optional External Quality Review (EQR) activities, as described in 42 CFR Part 438 and 42 CFR §438.358.

- Compliance monitoring reviews to determine MCE compliance with federal (42 CFR §438) and state standards that address requirements related to access, structure and operations, and quality measurement and improvement. CMR activities also included follow-up on the status of past CMR findings.
- Validation of performance improvement projects and focus studies.
- Performance measure validation of seven specific measures to evaluate the accuracy and validity of OHA's calculation of the performance measure rates for CCOs.
- Validation of network adequacy involving the comprehensive review of MCE Delivery Service Network (DSN) provider capacity reports and DSN provider narrative reports regarding compliance in accordance with Oregon's standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN.
- An encounter data validation study to evaluate CCO processes for collecting, maintaining, and submitting encounter data to OHA.
- A mental health parity analysis to ensure that coverage and access to mental health/substance use disorder benefits were provided in parity with medical/surgical benefits.

OHA has no applicable arrangements to report regarding non-duplication of mandatory EQR activities (according to 42 CFR §438.360 (c)).

IV. Quality Components

Quality Management Plans

CCOs are contractually required to maintain internal quality management plans. Plans must document structures and processes in place to assure quality performance.

Transformation and Quality Strategy

The Transformation and Quality Strategy (TQS), developed in 2017, specifically focuses on CCO documentation of key efforts across the following components, as well as documentation of the CCO's overall quality program within the CCO's larger strategic plan:

- Behavioral health integration
- CLAS standards
- Enhanced demographic data
- Reducing disparities through tailored services
- Oral health integration
- Patient-centered primary care home: member enrollment
- Patient-centered primary care home: tier advancement
- Serious and persistent mental illness
- Social determinants of health
- Special health care needs

CCO TQS documentation will be monitored to ensure a robust CCO quality and transformation program, in accordance with best practices. This includes a formal OHA assessment and scoring of each CCO TQS submission with actionable feedback to support continuous quality improvement. The TQS will also be used as a basis for peer sharing of evidence-based and emerging best practices to further health transformation across CCOs. See "Expectations of CCOs" section above for further details.

Performance Improvement Projects

Overview of CCO PIPs

Under Oregon's 1115 demonstration waiver, CCOs developed Performance Improvement Projects (PIPs) in oral health, maternal health, and chronic disease using measures like social determinant of health screening and meaningful language access. See table below for example of current CCO specific PIPs.

As of December 2024, the statewide integration PIP focuses on Mental Health Access Monitoring, while the Substance Use Disorder (SUD) PIP addresses Initiation and Engagement of Alcohol and Other Drug Abuse or Dependance Treatment (IET). The Mental Health Access PIP will be retired at the end of calendar year 2024. In preparation, OHA and CCOs are undertaking a collaborative design process to develop a new statewide PIP.

CCO Name	PIP Title/Topic Area
Advanced Health	Meaningful Language Access
AllCare	Increasing PCP visit rates for Black/African American members
Cascade Health Alliance	SDOH Screening and Referral Process
Columbia Pacific	Meaningful Language Access
Eastern Oregon	Person Centered Services by Community Health Workers
Health Share	Increasing Access to Traditional Health Worker (THW) Services
Intercommunity Health	Reducing Disparities in Diabetes Care
Jackson Care Connect	Social Determinants of Health
Pacific Source – Columbia Gorge	Oral Health Integration through PCPCH Value-Based Payment
Pacific Source – Central Oregon	Oral Health Integration through PCPCH Value-Based Payment
Pacific Source – Lane	Oral Health Integration through PCPCH Value-Based Payment
Pacific Source – Marion/Polk	Oral Health Integration through PCPCH Value-Based Payment
Trillium – Lane	Maternal Health Case Management
Trillium – Tri County	Maternal Health Case Management
Umpqua	Care Coordination Engagement for LTSS Members

CCO Name	PIP Title/Topic Area
Yamhill Community Care	Reducing Housing Instability

Information regarding performance improvement projects, inclusive of CCO selected PIPs and the statewide PIPs can be found on the OHA Quality Improvement website[12]:

Performance Measurement

Access

Network Adequacy

Federal and State regulations require each Medicaid managed care contractor to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. Each contractor must submit documentation to the State Medicaid authority[13] demonstrating the contractor's capacity to serve enrolled members in its service area in accordance with Oregon's standards for access to care.[14]

OHA performs an analysis twice annually to document the accessibility of CCO provider networks and to assess compliance with existing network standards and requirements. OHA is looking at three key dimensions to explore and understand beneficiary access to care (network capacity, geographic distribution, and availability of service). Network capacity addresses the underlying foundation of the provider network and refers to the supply of provider services available to beneficiaries. Using a variety of measures (for example, provider-to-beneficiary ratios and provider counts), an assessment of the underlying capacity of a provider network can be obtained. If services are available and an adequate supply of providers and services are present, the opportunity to obtain health care exists, suggesting that beneficiaries may have access to services.

Once capacity and infrastructure are established, it is important to understand the extent to which beneficiaries can gain access to reported services. However, gaining access to and utilization of services are dependent upon physical accessibility and

[12] OHA Quality Improvement website
[13] 42 CFR §438.358(b)(1)(iv) and 42 CFR §438.604(a)(5).
[14] See 42 Code of Federal Regulations (CFR) §438.206 and §438.207; Oregon Administrative Rules (OAR)410-141-3515.

acceptability of services, not simply on adequacy of supply. Geographic distribution addresses whether the distribution of available services is adequate to facilitate access to all beneficiaries. Key measures for assessing the geographic distribution of providers include time/distance analyses and compliance with network adequacy requirements. When combined with beneficiary and provider characteristics, these analyses will determine the extent to which the supply of providers is distributed appropriately relative to the beneficiary population. However, even with adequate capacity and appropriate distribution of services, assessing the availability of relevant services is critical in making sure beneficiaries have access.

The third dimension of access, availability of services, is important for understanding the extent to which network services are relevant and effective in producing positive health outcomes. The availability of services is assessed in terms of appointment availability, utilization and/or outcomes of services. Taken together, the three dimensions offer a broad understanding of the factors impacting beneficiaries' access to care. The framework addresses the intersection of a network's underlying infrastructure (making services available), distribution (getting the services to beneficiaries) and availability (having the right kind of services available when needed). The analysis will help OHA identify network adequacy gaps and improve the network adequacy requirements at the state level.

Network Adequacy Monitoring

Pursuant to 42 CFR §438.206 and 42 CFR §438.207, the CCOs are required to demonstrate to OHA, with supporting documentation, that all covered services are available and accessible to members and that they have adequate provider capacity. To support federal and state network adequacy requirements, the CCOs are contractually required to develop and submit DSN reports that consist of two components, an annual DSN provider narrative report and quarterly DSN provider capacity reports, that crosswalk to the network standards in the CCOs' contracts with Oregon.

DSN Provider Narrative

The DSN provider narrative report requirement defines five categories based on OHA's CCO contract requirements. Each category includes corresponding elements that require the CCOs to describe and submit comprehensive narrative responses and analysis demonstrating how the CCOs ensure, monitor and evaluate adequate provider capacity, including geographic location of network providers and members, considering distance, travel time, member needs, coordination of care and performance metrics. CCOs must, at a minimum, incorporate the provided specifications into their

comprehensive written responses and supplemental documentation (for example, policies, procedures, manuals, analytics) and demonstrate how the DSN is monitored to ensure adequate provider capacity and member access.

If any component of a CCO's DSN is subcontracted or delegated, the CCO must also include a narrative response and supplemental documentation (for example, policies, procedures, manuals, analytics). This includes three OHA-defined time and distance standards for each geographic classification in its service area, describing how delegated services are integrated with the CCO's overall DSN, and how the CCO monitors its delegated providers, ensuring compliance with federal and State provider network requirements.

DSN Provider Capacity Report

CCOs submit a DSN provider capacity report, which is an inventory of the CCOs' providers and facilities, using a template provided by OHA. All participating providers, either employed directly or through subcontract with an CCO and providing services to Medicaid members, were included. Required data elements of the report are outlined in the OHA 2020 Health CCO Contracts (Exhibit G(2)(a)). Each provider capacity report is evaluated on four domains:

- Quality of DSN provider capacity reporting
- Provider network count
- Provider accessibility
- Geographic distribution

Using member data, a time and distance analysis is performed looking at the following key measures:

- Percentage of members living within the time/distance standards.
- Average time (in minutes) and distance (in miles) to the nearest three providers. for each provider type evaluated (for example, primary care providers and hospitals).

Provider Directory Validation

OHA is also carrying out a variety of supplemental activities to assess access to providers and provider information. For example, OHA contracted with its EQRO to perform a provider directory validation activity to ensure members have appropriate access to provider information. For the provider directory validation, key elements published in the online provider directories were compared with the data in the provider

capacity reports and will confirm each CCO's website meets the federal requirements in 42 CFR §438.10(h), OAR 410-141-3585, and relevant State contractual requirements.

Access & Availability Survey

OHA contracts its EQRO to conduct annual telephone surveys among PCPs contracted with one or more CCOs as well as a secondary provider type. Other provider types surveyed in addition to PCPs have included oral health providers and outpatient mental health providers. The primary purpose of this survey is to collect appointment availability for OHP members new to the provider location and requesting routine well-checks or non-urgent problem-focused ("symptomatic") visits. Specific survey objectives include the following:

- Determine whether service locations accept OHP members enrolled with the requested CCO and the degree to which CCO and OHP acceptance aligns with the CCOs' DSN provider capacity report data.
- Determine whether service location has providers. OHP for the requested CCO accepted new patients and the degree to which new patient acceptance aligned with the CCOs' DSN provider capacity report data.
- Determine appointment availability with the sampled service locations for routine well-checks and non-urgent symptomatic visits.

Network Adequacy Standards

OHA creates standards for CCOs related to network adequacy and availability of services to align with federal requirements and further state priorities related to access to care. Those requirements are included in the CCO Contract as well as Oregon Administrative Rule.[15] OHA currently has two quantitative standards against which the CCOs are monitored – time and distance and time to appointment. Those standards are included below. OHA also sets and maintains a host of other non-quantitative standards related to the requirements set in § 438.206. 95% of CCO members must be able to access providers within the time and distance standards by provider type. Compliance

[15] CCO Contract related information can be found at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx. Oregon Administrative Rules applicable to CCOs (Chapter 410, Division 141) can be accessed via the Oregon Secretary of State website https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87

rates are calculated at the provider level under which includes a roll-up of the geographic designations.

- Large Urban is defined as conjoined urban areas with a total population of at least 1 million people or with a population density greater than 1,000 people per square mile.
- Urban is defined as an area with greater than 40,000 people within a 10-mile radius of a city center.
- Rural is defined as an area greater than 10 miles from the center of an urban area.
- County with Extreme Access Considerations is defined as county with a population density of 10 or fewer people per square mile.
- Evaluated by age groups served (i.e. providers serving adult members and providers serving pediatric members).

CCO Time and Distance Standards

Provider Type	Large Urban	Urban	Rural	County with Extreme Access Considerations
Primary Care Providers	10 minutes or 5 miles	25 minutes or 15 miles	30 minutes or 20 miles	40 minutes or 30 miles
Primary Care Dentists[7]	10 minutes or 5 miles	25 minutes or 15 miles	30 minutes or 20 miles	40 minutes or 30 miles
Mental Health Providers[7]	10 minutes or 5 miles	25 minutes or 15 miles	30 minutes or 20 miles	40 minutes or 30 miles
Substance Use Disorder Treatment Providers[7]	10 minutes or 5 miles	25 minutes or 15 miles	30 minutes or 20 miles	40 minutes or 30 miles
Pharmacy	10 minutes or 5 miles	25 minutes or 15 miles	30 minutes or 20 miles	40 minutes or 30 miles
Obstetric & Gynecological service providers	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Cardiology[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles

Provider Type	Large Urban	Urban	Rural	County with Extreme Access Considerations
Neurology[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Occupational Therapy[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Medical Oncology[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Radiation Oncology[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Ophthalmology[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Optometry[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Physical Therapy[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Podiatry[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Psychiatry[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Speech Language Pathology[7]	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Hospital	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Durable Medical Equipment	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Methadone Clinic	20 minutes or 10 miles	30 minutes or 20 miles	75 minutes or 60 miles	95 minutes or 85 miles
Allergy & Immunology[7]	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles

Provider Type	Large Urban	Urban	Rural	County with Extreme Access Considerations
Dermatology[7]	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles
Endocrinology[7]	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles
Gastroenterology[7]	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles
Hematology[7]	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles
Nephrology[7]	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles
Otolaryngology[7]	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles
Pulmonology[7]	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles
Rheumatology[7]	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles
Urology[7]	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles
Post-hospital Skilled Nursing Facilities	30 minutes or 15 miles	45 minutes or 30 miles	110 minutes or 90 miles	140 minutes or 125 miles
Exceptions	CCOs may request exceptions to any of the time and distance standards described above. CCOs may request multiple exceptions. It is at the discretion of the state agency as to whether those exceptions will be approved or denied.			

Appointment Wait Time Standards

Physical Care	
Appointment Type	**Population**

	All Populations			
Emergency care[16]	Immediately or referred to an emergency department depending on the member's condition			
Urgent care[8]	Within 72 hours or as indicated in initial screening			
Well care	Within four (4) weeks			
Oral and Dental Care				
Appointment Type	**Population**			
	Children & Non-pregnant Individuals	Pregnant Individuals		
Emergency services	Seen or treated within 24 hours	Seen or treated within 24 hours		
Urgent care	Within two (2) weeks	Within one (1) week		
Routine care	Within eight (8) weeks, unless there is a documented special clinical reason that makes a period of longer than eight (8) weeks appropriate	Within four (4) weeks, unless there is a documented special clinical reason that must make access longer than four (4) weeks appropriate		
Behavioral Health Care				
Appointment Type	**Population**			
	All Populations			
Urgent care	Within 24 hours			
Routine care for non-prioritized populations	Assessment within seven days of the request, with a second appointment occurring as clinically appropriate			
	Population Specialty Behavioral Health Care for Prioritized Populations			
	Pregnant women, veterans and their families,	IV drug users including heroin	Members with opioid use disorder	Members seeking medication

[16] Urgent and emergency

	women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population			assisted treatment
	Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist	Immediate assessment and entry. Admission for treatment in a residential level of care is required within fourteen (14) days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist.	Assessment and entry within 72 hours	As quickly as possible, not to exceed 72 hours for assessment and entry
	If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist.			

Availability of Services Standards (applicable to Medicaid and CHIP contracts)	
Code of Federal Regulations Reference	**Description of Requirements**
42 CFR §438.206(a)	OHA requires CCOs to meet the quantitative standards established in accordance with § 438.68 (see tables above for specific information related to those quantitative standards) and conducts regular monitoring through the collection and analysis of CCO provider network data of the availability and accessibility of covered services. This includes the use of time and distance analyses using geo-mapping software and telephonic surveys of health care providers participating in CCO networks to monitor compliance with wait time to appointment standards.
42 CFR §438.206(b)(1)	OHA requires through its contracts with CCOs that CCOs maintain and monitor a participating provider network that is supported with written agreements and has sufficient capacity and expertise to provide adequate, timely, and medically appropriate access to covered services to members across the age span from child to older adult, including full-benefit dual eligible members. CCOs are also required to ensure that its participating providers contract with facilities that meet the diverse needs of its members, including, without limitation, adolescents, parents with dependent children, pregnant individuals, IV drug users, and those with medication assisted treatment needs.
42 CFR §438.206(b)(2)	OHA requires through its contracts that CCOs provide female members with direct access to women's health specialists within the provider network for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated primary care provider (PCP) if the designated PCP is not a women's health specialist.
42 CFR §438.206(b)(3)	OHA requires through its contracts that CCOs provide for a second opinion from a participating provider, which may include, if appropriate, a participating behavioral health provider to determine medically appropriate services. If a participating provider cannot be arranged then the CCO must arrange for the

	member to get a second opinion from a non-participating provider, at no cost to the member.
42 CFR §438.206(b)(4)	OHA requires through its contracts and administrative rules that if the CCO is unable to provide members with services through the use of participating providers qualified and specialized to treat a member's condition, it must arrange for the member to access care from non-participating providers as geographically close to the member as possible, including providers outside the service area.
42 CFR §438.206(b)(5)	OHA requires through its contracts and administrative rules that CCOs must coordinate payment with out-of-network providers and ensure that the cost to members is no greater than it would be if the services were furnished within the network.
42 CFR §438.206(b)(6)	OHA requires through its contracts and administrative rule that CCOs ensure that all participating providers in their network providing coordinated care services to members are credentialed upon initial contract with the CCO and re-credentialed no less frequently than every three (3) years.
42 CFR §438.206(b)(7)	OHA requires through its contracts and administrative rules that CCOs provide family planning services in a manner that protects and enables the member's freedom to choose the method of family planning to be used and the member's free choice of provider. Regardless of CCO enrollment, members can choose to received family planning services with any provider enrolled with OHA as an OHP provider.
42 CFR §438.206(c)(1)(i)	OHA requires through its contracts and administrative rules that CCOs meet, and require all providers to meet, OHP standards for timely access to care and services, taking into the account the urgency of need for services. Timely access to care (i.e. appointment wait time) standards are described in the chart above.
42 CFR §438.206(c)(1)(ii)	OHA requires through its contracts that CCOs ensure that providers do not discriminate between members and non-OHP persons with respect to benefits and services to which they are both entitled and shall ensure that providers offer hours of

	operation to members that are no less than those offered to non-members.
42 CFR §438.206(c)(1)(iii)	OHA requires through its contracts that CCOs make covered services available twenty-four (24) hours a day, seven (7) days a week, when medically appropriate.
42 CFR §438.206(c)(1)(iv)	OHA requires through its contracts and administrative rules that CCOs establish mechanisms to ensure compliance by network providers. CCOs must develop a system and methodology for monitoring and evaluating member access including, but not limited to, the availability of network providers within time and distance standards, adherence to standards for wait time to appointment for primary care, specialty care, and behavioral health services, and sufficiency of language services and physical accessibility.
42 CFR §438.206(c)(1)(v)	OHA requires through its contracts and administrative rules that CCOs monitor their provider networks regularly to ensure compliance with standards. CCOs are required to monitor its provider network with respect to all of the following criteria: (1) Travel time and distance to providers; (2) Wait time to appointment availability for primary care, specialty care, oral health, and behavioral health services; (3) Provider to member ratios; (4) Percentage of contracted providers accepting new OHP members; (5) Hours of operation; (6) Call center performance and accessibility; (7) Availability of providers who speak a prevalent non-English language as per CFR §438.206 (b)(1) ;(8) Availability of oral and sign language interpreter, including Qualified and Certified Health Care Interpretation Services, and written translation services; (9) Use of telehealth modalities; (10) Availability to make accommodations for physical accessibility;

	(11) Provider data management, including provider category, provider specialty category, and taxonomy code. CCOs are also required to have an access plan that establishes a protocol for monitoring and ensuring access, outlines how provider capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity. The access plan and associated monitoring protocol must address the following: (a) Expected utilization of services based on anticipated member enrollment and health care needs of the member population; (b) The number and types of providers required to furnish the contracted services based on the expected utilization of services referenced above and the number and types of providers actively providing services within the CCO's current provider network; (c)How the CCO shall meet the accommodation and language needs of individuals with limited English proficiency and people with disabilities in their service area in compliance with state and federal rules; (d) The availability of telemedicine within the CCO's contracted provider network.
42 CFR §438.206(c)(1)(vi)	OHA requires through its contracts that CCOs promptly and fully remedy any provider network deficiencies identified through the course of self-assessment, in the event of a material change, or as a result of OHA monitoring, or EQRO review. Material change to the network is defined as: (a) Any change to the CCO's DSN that may result in more than five (5) percent of either its total Members or its Members in a county changing the physical location(s) of where services are received; or (b) Any change to CCO's DSN that may likely affect less than five (5) percent of its Members but involves a Provider or Provider group that is the sole provider specialty type within the overall Provider Network or is the sole provider specialty type with a practice within a county in the CCO's service area; or

	(c) Any change in CCO's overall operations that affects its ability to meet a required DSN standard including, but not limited to: termination or loss of a Provider or Provider group, or any change likely to affect more than five (5) percent of CCO's total Members or Provider Network or both; or (d) Any combination of the above changes.
42 CFR §438.206(c)(2)	OHA requires through its contracts and administrative rules that CCOs participate in efforts to promote the delivery of services with the number of providers who speak a prevalent non-English language as per CFR §438.206 (b)(1).When assessing its network capacity, the CCO identifies and incorporates the needs of linguistically and culturally diverse populations in the following ways: (a) Monitors the sufficiency of language services. (b) Develops an action plan to ensure its workforce is prepared to provide the physical, behavioral, and dental health services to members in its service area in a manner that is culturally and linguistically appropriate and trauma informed. (c) Ensures its network providers and subcontractors deliver culturally and linguistically appropriate services as described in Culturally and Linguistically Appropriate Service (CLAS) Standards, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care.
42 CFR §438.206(c)(3)	OHA requires through its contracts and administrative rules that CCOs ensure that its employees, subcontractors, and facilities are prepared to meet the special needs of members who require accommodations because of a disability or limited English proficiency.

Provider Oversight

Clinical Practice Guidelines

In accordance with 42 CFR §438.340(b)(1), CCOs are contractually required to adopt

clinical practice guidelines. To support a health system delivery with evidence-based care, quality and access, CCOs also use the OHA clinical coverage policies adopted by the OHA Health Evidence Review Commission in the Prioritized List of Health Services. OHA directs CCOs to use the OHA clinical coverage policies reflected in the Prioritized List as well as other national clinical practice guidelines. With this approach, CCOs and providers have the tools to guide 1) decisions for utilization management 2) enrollee education 3) coverage of services 4) and other areas to which the guidelines apply. This approach is consistent with the guidelines as described in 42 CFR §438.236. Please refer to the links below to see two of our clinical practice guidelines for Acute Lymphoblastic Leukemia and Teratogenesis, Perinatal and Neurodevelopmental outcomes after in utero exposure to antiseizure medication.

Acute Lymphoblastic Leukemia

Teratogenesis, perinatal and neurodevelopmental outcomes after in utero exposure to antiseizure medication

Credentialing

CCOs are required to implement a provider credentialing process that includes, at a minimum, verifying valid licenses; reviewing any history of professional misconduct or malpractice actions; confirming that providers have not been sanctioned by Medicaid, Medicare or other state agencies; and the provider's National Practitioner Data Bank profile. Additionally, all credentialed providers must verify regularly through the Office of Inspector General (OIG) and Substance Abuse and Mental Health Services Administration (SAMHSA) for compliance with conflict-of-interest standards.

Policy requirements include standards for credentialing, privileging, conflict of interest compliance, including time and interval of credentialing activities. CCOs must also collaborate with OHA to ensure proper credentialing of mental health programs, associated providers, and traditional health care workers.

Licensing

CCOs must ensure all licensed or certified providers maintain active licenses or certifications. The CCOs must monitor provider licenses and certifications for any adverse action from a licensing or certifying entity and develop a process for reviewing a provider's contractual status due to any adverse action. All actions against a provider's license, certification or contractual status with a CCO must be immediately reported to the Provider Enrollment Unit through the OHA.Provider.Review@dhsoha.state.or.us email address. Adverse action reports must

include the provider information, the action taken by the CCO or MCO and all supporting documents.

Member Satisfaction

Ombuds team

Pursuant to Oregon Revised Statute (ORS) 414.712, OHA provides Ombuds services to individuals who receive medical assistance through Oregon's Medicaid program. The Ombuds person serves as the advocate for OHP members in these areas:

- Access to care;
- Quality of care; and
- Channeling member experience into recommendations for system improvement.

The OHA Ombuds position serves as a formal, internal advocate for process and system improvements, addressing identified trends that impact services OHP members. This work is essential for health care transformation that is grounded in the needs of Oregonians and informs the Ombuds Program recommendations for client-focused process and system improvements within OHA and ODHS. As required by ORS 182.500, the OHA Ombuds Program provides a quarterly report to both the Governor and OHPB. Each person who makes it to the Ombuds Program deserves nurturing and support. The stories they share often illustrate challenges many others experience. Each story brings lessons for ways to improve Oregon's Medicaid delivery system.

Medicaid Advisory Committee

The Medicaid Advisory Committee (MAC) is a federally mandated body consisting of not more than 15 members appointed by the governor that advises OHA and DHS leadership, OHPB, the Legislature and the Governor's office about the operation and administration of the Oregon Health Plan from a consumer and community perspective. The MAC's role includes reviewing Oregon's Medicaid Quality Strategy, changes to OHA's quality rating strategy for CCOs, CCO marketing materials, and the access monitoring plan for OHP members enrolled in the Open Card plan (FFS Medicaid). Additionally, the MAC receives information about CAHPS survey findings, Ombuds Program updates, grievance and appeal data trends, and CCO deliverables that provide visibility into Oregon's health transformation from a consumer experience lens.

Grievance and Appeal System

Oregon's contracted EQRO evaluates CCO's compliance with Grievance and Appeal System requirements including grievance and appeal processes, provision of information to members and contracted providers, and adherence to time frame and

notification requirements, pursuant to 42 CFR §438.400-424, applicable Oregon Administrative Rules (OARs), and contractual requirements. The CCO's are evaluated against the following requirements:

- Implementing written procedures for accepting, processing and responding to all grievances and appeals, consistent with 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 required time frames 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.

In addition, OHA requires CCOs submit a quarterly report including a log of prior authorizations, grievances, appeals, and all Notices of Adverse Benefit Determination (NOABDs) issued for denied services. OHA selects a random sample of denials from the log and each CCO must submit the selected sample of NOABDs and associated Prior Authorization (PA) and/or claim documentation. The NOABD sample submitted by each CCO is evaluated against criteria outlined in the CCO Contract, including Exhibit I, as well as any other applicable provisions of the implemented contract. NOABD samples are evaluated for compliance to state and federal requirements.

A summary of all grievances registered during that quarter is compiled, along with a more detailed record of all grievances that have been unresolved for more than 30 days. A uniform report format has been developed to ensure that grievance data is consistent and comparable. OHA uses grievance data to identify developing trends that may indicate a problem in access, quality of care, and/or education.

The next step is to improve the processes for the quarterly Grievance and Appeal Logs report (including Appeal, NOABD, Prior Authorizations and Grievance Logs) which will enable deeper analysis for trend reporting. Analysis through the updated automated report will provide greater detail for health system (oral health, behavioral health,

physical health) delineation of complaints origin, and tracking of topic issues (e.g. non-emergency medical transportation) across the CCOs.

On an annual basis, OHA reviews CCO Grievance and Appeal System Policies and Procedures (P&Ps) to ensure they meet the requirements of OARs, 42 CFR §438.406, and address how the CCO will accept, process, and respond to Grievances, Notices of Adverse Benefit Determinations, Appeals, and Hearings.

OHA has allowed attestation of Grievance and Appeals System Policies and Procedures, as well as Member Notice Templates (MNT) over the past three years. This year, OHA is conducting a review of all CCO's MNTs to ensure compliance. These reviews are also conducted ad hoc if there is a need to perform an audit.

Fiscal monitoring

Fraud, Waste and Abuse

The CCOs must submit complaints of or allegations of suspected fraud or abuse, within 7 days, that are made to or identified by the CCO and warrant preliminary investigation. The CCO must also submit the following information on an ongoing basis for each case of fraud and abuse it identifies through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees or any other source:

- The name, NPI and tax ID (or member ID number) of the individual or entity that is suspected of committing the fraud or abuse;
- The source that identified the fraud or abuse;
- The type of provider, entity, or organization that is suspected of committing the fraud or abuse;
- A description of the fraud or abuse;
- The approximate dollar amount of the fraud or abuse;
- The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred; and
- Other data or information as requested.

The CCOs also conduct audits of providers, subcontractors and other third parties to identify overpayments and uncover suspected fraud and abuse. CCOs provide quarterly and annual audit reports to OHA and report any recouped overpayments from their audit activities on the quarterly and annual Exhibit L financial reports.

The OHA Office of Program Integrity conducts ongoing audits of participating providers, CCO subcontractors, and third party or downstream entities receiving Medicaid funds through a CCO.

Surveys

CAHPS

OHA conducts an annual CAHPS survey of approximately 90,000 members, asking them to report on and evaluate their experiences with health care. The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. Surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

MHSIP

The Mental Health Statistics Improvement Program (MHSIP) are a set of validated surveys to measure clients' perceptions of the quality and efficiency of the mental health services they receive. The program consists of four surveys fielded annually, which vary based on the client's age and the type of services they received. These surveys are: 1) adults who have received outpatient services; 2) adults who have received residential treatment services; 3) parents or guardians of youth 0-17 years of age who have received mental health services; and 4) youth 14-17 years of age who have received mental health services. The four surveys assess perception of mental health services across several domains, such as access to services, quality of services, satisfaction with surveys, and treatment outcomes and participation.

V. Quality measurement

Oregon's Medicaid measurement information is fully integrated into the Medicaid Quality Strategy. Details of the measurement strategy can be found here. Oregon's Medicaid measurement strategy includes a mix of performance measures that are incentivized and select CMS Adult and Child Core Set measures that are not incentivized. These metrics and measures are used across OHA Medicaid programs for the Oregon Health Plan populations described earlier. All measures represent an effort to improve quality of and access to care and support the goals and objectives of this Quality Strategy. All of Oregon's performance measures are displayed in the 2023 Performance Metrics Dashboard.

Additional Oregon Medicaid measurement information can be found here.

Performance Measures

Established in the 1115 waiver and corresponding state legislation, the CCO Quality Incentive Program (QIP) is a mechanism for focusing CCO efforts and driving continuous quality improvement. Financial incentives are a key strategy for driving quality of services and supporting the transition from capitated payments to value-based purchasing.

The funds in the CCO QIP are bonus dollars based on a percentage of CCO capitation payments as defined in 42 CFR §438.6(b)(2) and are meant to reward exceptional care. To date, the CCO QIP has been a success, and CCOs show improvements in a number of incentivized areas as documented in the 2023 CCO Metrics Performance Report.

Measures in the CCO QIP are selected annually by the Metrics and Scoring Committee. Measures chosen by the committee must be downstream or upstream, as defined by Oregon legislation (Senate Bill 966, 2023). Downstream measures focus on traditional health care and medical services and are chosen from the CMS Child and Adult Core Sets, while upstream measures focus on social determinants of health and are typically unique to Oregon. Per SB 966, the Metrics and Scoring Committee must include at least four upstream measures in the program each year.

The Metrics and Scoring Committee also sets the benchmark and improvement targets for each measure. A CCO can meet a measure by meeting either the benchmark or the improvement target. Benchmarks are aspirational goals often equal to top performance in the country (such as 75th or 90th percentiles for national Medicaid). Improvement targets are individually calculated for each CCO based on performance in the prior year using the Minnesota method (MM), and must exceed designated 'floors,' which are detailed in the table below. Minnesota method performance target formula: (National 75th percentile – Oregon baseline)/10 + Oregon baseline

The goal is to reward CCOs for continuous improvement towards the benchmark, which can take several years. Detailed measure specifications, technical documentation and additional guidance are all published online.

2025 Incentive Measures and Benchmarks

Measure	NQF Number	Statewide Baseline	Statewide Performance Target (benchmark)
Adults with Diabetes - Oral Evaluation	n/a	24.8%	35.0% CCO Improvement Target: MM with a 2 percentage point floor
Assessments for Children in ODHS Custody*	n/a	87.8%	MY 2022 CCO 75th percentile, 93.2% CCO Improvement Target: MM with a 3 percentage point floor
Child and Adolescent Well-Care Visits (Ages 3-6)	1516	65.4%	MY 2023 CCO 90th percentile, 72.0% CCO Improvement Target: MM with a 2 percentage point floor
Childhood Immunization Status (Combo 3)	38	59.0%	MY 2022 National Medicaid 75th percentile, 69.0% CCO Improvement Target: MM with a 1.5 percentage point floor

Measure	NQF Number	Statewide Baseline	Statewide Performance Target (benchmark)
Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control	59	24.6%	MY 2022 National Commercial 90th percentile, 20.0% (lower is better) CCO Improvement Target: MM with a 2 percentage point floor
Immunizations for Adolescents (Combo 2)	1407	32.7%	MY 2022 National Medicaid 75th percentile, 40.9% CCO Improvement Target: MM with a 1.5 percentage point floor
Initiation and Engagement of Substance Use Disorder Treatment	4	Initiation: 42.3% Engagement: 16.6%	*Must meet both components to achieve measure*. MY 2022 National Medicaid 75th percentile: • Initiation: 49.0% • Engagement: 18.8% CCO Improvement Target: MM with a 2 percentage point floor

Measure	NQF Number	Statewide Baseline	Statewide Performance Target (benchmark)
Meaningful Language Access*	n/a	10.7%	*Must meet both components to achieve measure*. Component 1: Minimum 97 points as outlined in measure specifications. Component 2: 50.0% CCO Improvement Target: MM with a 3 percentage point floor
Prenatal & Postpartum Care - Postpartum Care Rate	1517	83.6%	MY 2023 CCO 90th percentile, 87.0% CCO Improvement Target: MM with a 2 percentage point floor

Measure	NQF Number	Statewide Baseline	Statewide Performance Target (benchmark)
Preventive Dental or Oral Health Services (ages 1-5 and 6-14)*	n/a	Ages 1-5: 56.0% Ages 6-14: 61.8%	*Must meet both components to achieve measure*. MY 2023 CCO 90th percentile: • Ages 1-5: 60.6% • Ages 6-14: 67.3% CCO Improvement Target: MM with a 2 percentage point floor
Screening for Depression and Follow-Up Plan	418	64.9%	MY 2023 CCO 90th percentile, 73.8% CCO Improvement Target: MM with a 2-percentage point floor

Measure	NQF Number	Statewide Baseline	Statewide Performance Target (benchmark)
Social Determinants of Health: Social Needs Screening & Referral*	n/a	n/a	*Must meet both components to achieve measure*. Component 1: CCO must attest to completion of all must-pass elements as outlined in measure specifications. Component 2: Reporting only. 90% completeness threshold for sample.
Young Children Receiving Social-Emotional Issue-Focused Intervention/Treatment Services*	n/a		11.0% CCO Improvement Target: MM with a 0.5 percentage point floor

*Upstream measures as defined in 2023 SB 966

In addition to the Quality Incentive Program metrics, Oregon has selected other non-incentivized measures to track and improve upon among the CCOs. These measures align with OHA's Strategic Plan pillars, which include transforming behavioral health, strengthening access to affordable care for all and fostering healthy families and environments, as well as Oregon's Quality Strategy goals and objectives.

Statewide performance targets were calculated by assessing the 2023 national 75th percentile using the CMS Core Set Data Dashboard. Oregon's 2023 performance was compared with the 75th percentile, and where performance was already above the 75th percentile, the target was set to hold at current performance. Where Oregon's

performance was below the 75th percentile, we used the Minnesota method (MM) to calculate a performance target.

MM performance target formula: (National 75th percentile – Oregon baseline)/10 + Oregon baseline

Adult and Child Core Measures	Measure Abbreviation	2023 OR Baseline	2023 National Median	Statewide Performance Target (CMS 75th percentile or Minnesota method)
Domain: Behavioral Health Care				
Adherence to antipsychotic medications for individuals with schizophrenia	SAA-AD	**66.7%**	62.3%	66.7% (75th)
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	SSD-AD	**71.0%**	77.1%	71.9% (MM)
Follow-up after emergency department visit for mental illness ages 6 to 17: 7 day*	FUM-CH	60.6%	51.5%	60.6% (MM)
Follow-up after emergency department visit for mental illness age 18 and older: 7 day*	FUM-AD	50.6%	35.4%	50.6% (75th)
Follow-up after emergency department visit for mental illness ages 6 to 17: 30 day*	FUM-CH	77.0%	69.6%	77.0% (75th)
Follow-up after emergency department visit for mental illness age 18 and older: 30 day*	FUM-AD	64.3%	51.3%	64.3% (75th)
Follow-up after hospitalization for mental illness ages 6 to 17: 7 day*	FUH-CH	41.2%	47.3%	42.8% (MM)

Adult and Child Core Measures	Measure Abbreviation	2023 OR Baseline	2023 National Median	Statewide Performance Target (CMS 75th percentile or Minnesota method)
Follow-up after hospitalization for mental illness age 18 and older: 7 day*	FUH-AD	38.5%	32.3%	38.8% (MM)
Follow-up after hospitalization for mental illness ages 6 to 17: 30 day*	FUH-CH	65.1%	72.1%	66.4% (MM)
Follow-up after hospitalization for mental illness age 18 and older: 30 day*	FUH-AD	58.9%	53.9%	59.3% (MM)
Follow-up care for children prescribed attention deficit/hyperactivity disorder (ADHD) medication – Initiation	ADD-CH	**55.7%**	46.0%	55.7% (75th)
Follow-up care for children prescribed attention deficit/hyperactivity disorder (ADHD) medication – Continuation	ADD-CH	**70.1%**	60.4%	70.1% (75th)
Metabolic monitoring for children and adolescents on antipsychotics	APM-CH	**33.6%**	32.3%	34.4% (MM)
Use of first-line psychosocial care for children and adolescents on antipsychotics	APP-CH	**68.6%**	60.5%	68.6% (75th)
Use of pharmacotherapy for opioid use disorder	OUD-AD	**70.6%**	60.2%	70.7% (MM)
Domain: Care of Acute and Chronic Conditions				

Adult and Child Core Measures	Measure Abbreviation	2023 OR Baseline	2023 National Median	Statewide Performance Target (CMS 75th percentile or Minnesota method)
Ambulatory care: emergency department utilization, ages 0-19* (rate per 1,000 member months)	AMB-CH	28.4	36.5	28.4 (75th) *Lower is better*
Controlling high blood pressure (EHR)	CBP-AD	**67.0%**	61.2%	67.0% (75th)
Ratio of expected to observed plan all-cause readmissions	PCR-AD	0.7926	1.0139	.7926 (75th) Lower is better
Domain: Dental and Oral Health Services				
Oral evaluation, dental services (ages 0-20)	OEV-CH	**39.8%**	42.8%	40.6% (MM)
Sealant receipt on all permanent first molars	SFM-CH	**45.0%**	35.4%	45.0% (75th)
Topical fluoride for children (ages 1-20)	TFL-CH	**19.6%**	19.0%	19.9% (MM)
Domain: Maternal and Perinatal Health				
Prenatal and postpartum care: Timeliness of prenatal care	PPC-CH	**80.5%**	80.0%	80.9% (MM)
Domain: Primary Care Access and Preventive Care				
Cervical cancer screening	CCS-AD	**44.3%**	52.3%	45.7% (MM)
Chlamydia screening in women ages 16 to 20	CHL-CH	40.2%	46.8%	41.9% (MM)
Chlamydia screening in women ages 21 to 24	CHL-AD	51.2%	56.2%	52.5% (MM)
Colorectal cancer screening, ages 46-49	COL-AD	18.9%	19.1%	19.1% (MM)
Colorectal cancer screening, ages 50-64	COL-AD	40.4%	36.4%	40.6% (MM)
Developmental screening in the first three years of life	DEV-CH	**66.6%**	35.7%	66.6% (75th)
Lead screening in children	LSC-CH	**30.3%**	57.0%	34.1% (MM)

Adult and Child Core Measures	Measure Abbreviation	2023 OR Baseline	2023 National Median	Statewide Performance Target (CMS 75th percentile or Minnesota method)
Well-child visits between 15 and 30 months	W30-CH	**66.6%**	64.8%	67.0% (MM)
Domain: Experience of Care				
CAHPS: customer service	CPA-AD	66.4%	69.8%	67.0% (MM)
CAHPS: getting care quickly	CPA-AD	47.9%	56.2%	49.1% (MM)
CAHPS: getting needed care	CPA-AD	44.6%	53.9%	45.8% (MM)

Notes: 2023 OR baseline numbers that are bolded represent CCOs only and were retrieved from the 2023 CCO Performance Metric Dashboard. Measures denoted with an asterisk are in the 2023 CCO Performance Metrics Dashboard, but do not use the same age breakdowns as core set measures.

VI. Quality Strategy governance

Quality Structure

OHA is comprised of subject matter experts in evidence-based care, contract compliance, quality assurance, population health management, performance management, and quality improvement across the agency to support the monitoring and improvement of the health delivery system. Quality and health transformation elements are monitored at the programmatic level with key agency-wide committees responsible for oversight and planning.

OHA structure to support quality and access monitoring:

- Oregon Health Policy Board
- Medicaid Advisory Committee
- Metrics and Scoring Committee
- Quality Management Program and contract compliance
- All Plan System Technical Workgroup
- Behavioral Health Directors
- Care Coordination Workgroup
- Oral Health Forum
- Medicaid Leadership Committee-Quality and Evaluation Committee

- Quality and Health Outcomes Committee
- Health Evidence Review Committee
- CCO Operations Collaborative and Contracts and Compliance Workgroup
- CCO Rates Workgroup
- Member Engagement & Outreach Committee (MEOC)
- OHA-CCO Leadership Meeting
- Pharmacy Directors Meeting

Review of Quality Strategy

The OHA Quality Strategy shall be reviewed annually and upon significant changes. Upon completion of each review the evaluation will be submitted to CMS. OHA Quality and Evaluation Committee shall have overall responsibility to guide the annual review and update the Quality Strategy. The review and update shall include an opportunity for both internal and external partners and interested parties to provide input and comment on the Quality Strategy and will be publicly posted on the OHA CCO Operations Quality Assurance webpage.

Tribal Consultation

Tribal consultation is a vital component of the Quality Strategy approval process which lasts 60 days and offers consultation to the Nine Federally Recognized Tribes of Oregon and Urban Indian Health Program. The solicited feedback is integrated into this plan.

Tribal consultation is a formal process agreed to by the Tribes, Oregon Department of Human Services (ODHS) and OHA for regular and meaningful collaboration in the initiation of program development, program implementation and policy changes impacting Tribes. It upholds and honors Tribal sovereignty, strengthens agency government-to-government relations with Tribal governments and establishes minimum standard procedures.[17]

[17] ODHS/OHA Tribal Consultation Policy

Public Comment

OHA provided a 45-day public comment period, including three separate public listening sessions, which occurred prior to the submission of this plan. OHA has also taken that feedback into consideration and revised the strategy accordingly. Notes and other communications received through these processes are available at the on Oregon's Quality Strategy webpage. Key partners and interested parties shall include, but are not limited to:

- Medicaid Advisory Committee*
- Medicaid Division Executive Team
- Health Policy and Analytics Management Team
- OHA Executive Team
- CCO medical directors
- CCO quality management coordinators
- Local Community Advisory Council*
- DHS internal partners
- OHA internal partners
- Oregon Health Policy Board and subcommittees

*Committees including consumer representatives.

Final versions of the Quality Strategy will be posted on the OHA website. To see HSAG's evaluation of Oregon's Quality Strategy in full, please find the report here.

In accordance with 42 CFR §438.340(c)(3)(ii), the state's definition of "significant change" for the purpose of revision to Oregon's Medicaid Quality Strategy will be when:

- Medicaid Quality Strategy Goals and Objectives updates as result of;
  - Significant trend in deficiencies identified through analysis of the annual data,
  - OHA strategic plan release and/or updated,
- A significant change[18] in membership demographics or the provider network of 50% or greater within one year.

[18] 42 CFR §438.340(c)(3)(ii)

- Changes to quality standards resulting from regulatory authorities or legislation at the state or federal level; and
- Input received from partners and interested parties (e.g., EQRO) and senior leadership

Enforcement

The OHA managed care program has an enforcement policy for data reporting, which also applies to reporting for quality and appropriateness of care, contract compliance and reports for monitoring. If a plan cannot meet a reporting deadline due to extenuating circumstances, a request for an extension must be submitted in writing to the CCO Quality Assurance unit in the Medicaid Division. Plans that are unable to submit mandated data or reporting participate in an improvement plan process.

Enforcement options for plans that are out of compliance are progressive in nature, beginning with collaborative efforts between OHA and the plans to provide technical assistance and to increase shared accountability through informal reviews and visits to plans, or increased frequency of monitoring efforts. Depending on the severity of the noncompliance, or if these efforts are not producing results, other remedial actions may be jointly developed such as:

- Improvement Plan
- Corrective Action Plan
- Sanctions
- Civil penalties
- Restricting enrollment
- Financial penalties
- Potential non-renewal of contracts

Conditions that may result in sanctions:

1. Fails to authorize or otherwise substantially provide Medically Appropriate services that Contractor is required to authorize and provide to a member in accordance with applicable State or federal law or as required under this Contract;
2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under this Contract or applicable State or federal law; Contractor shall not charge Members any Premiums for any services provided pursuant to this Contract;

3. Per OAR 410-141-3530, Acts to discriminate among Members on the basis of, health status, or need for health care services. Acts that may be evidence of discrimination include, but are not limited to: (i) Disenrollment of, or refusal to reenroll, a Member, except as permitted under this Contract, (ii) any practice that would reasonably be expected to discourage Enrollment, or (iii) any practice that seeks or encourages the Disenrollment of individuals whose medical condition or history indicates probable need for substantial future Medical Services;
4. Misrepresents or falsifies any information that is required to be submitted to CMS, the State, or their designees under this Contract, including but not limited to any such information submitted in: (i) or in connection with Contractor's Application, or enrollment with CMS, (ii) any certification made in connection with this Contract, (iii) any report required to be submitted under this Contract, or (iv) any other documentation or other communication provided to the State, CMS, or their designees relating to the care or services provided to a Member or as otherwise required to be made under this Contract;
5. Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care provider;
6. Fails to comply with the requirements for Physician Incentive Plans, as the requirements are set forth in 42 CFR §422.208 and §422.210 and this Contract;
7. Fails to comply with the operational and financial accounting and reporting requirements required under Ex. L of this Contract;
8. Fails to maintain a Participating Provider Network sufficient to ensure adequate capacity to provide Covered Services to its Members under this Contract;
9. Fails to implement and maintain an internal Quality Improvement program, a Fraud, Waste and Abuse prevention program, a Quality Assurance and Performance Improvement Program, or to provide timely reports and data in connection with such programs as required under this Contract;
10. Fails to comply with Grievance and Appeal System requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, or record keeping and reporting requirements;
11. Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services as required under this contract;
12. Fails to make timely claims payments to Providers or fails to provide timely approval of authorization requests;

13. Fails to disclose required ownership information or fails to supply requested information to OHA relating to Contractor's Subcontractors or suppliers of goods and services;
14. Fails to submit accurate, complete, and truthful Pharmacy or Non-Pharmacy Encounter Data in the time and manner required by Ex. B, Part 8;
15. Distributes directly or indirectly through any Agent or independent contractor, Marketing Materials that have not been approved by the State or that contain false or materially misleading information;
16. Violates of any of the other applicable requirements of sections 1903(m), 1932 or 1905(t) of the Social Security Act and any implementing regulations; or
17. Violates any of the other applicable requirements of 42 USC §1396b(m) or §1396u-2 and any implementing regulations.

Technical report

The technical report provides a feedback loop for ongoing quality strategy direction and development of any technical assistance training plans. In addition to the statement of deficiencies and resulting plans of correction, findings from the operational reviews may be used in future qualification processes as indicators of the capacity to provide high-quality and cost-effective services, and to identify priority areas for program improvement and refinement.

Appendix A:

CCO Contract

The CCO managed care contract template can be found on the OHA website for CCO Contract Forms.

Appendix B:

CCO Care Coordination and Transition of Care

In accordance with the requirement from CMS for the transition of care policy requirement under 42 CFR §438.62(b)(3), OHA has multiple Oregon Administrative Rules to support care coordination and transitions of care.

Current OARs

OAR 410-141-3850	Transition of Care
OAR 410-141-3860	Care Coordination: Administration, Systems and Infrastructure

OAR 410-141-3865 Care Coordination: Identification of Member Needs

OAR 410-141-3870 Care Coordination: Service Coordination

Continually reviewing and updating policies and rules to support care coordination and quality, for implementation and compliance with federal requirements, updates were held through a transparent Rules Advisory Committee (RAC) for the respective policies with and effective date of policy updates January 1, 2025.

Notice of Proposed Rule Making to OARs

OAR 410-141-3500 Coordination policy under state for CCOs

OAR 410-120-0000 Definitions for FFS: includes acronyms to support systems of care and the special health care needs population definition

Medicaid Managed Care OARs for Oregon can be found here.

Disability in Adults

The law defines disability as the inability to engage in any Substantial Gainful Activity (SGA) by reason of any medically determinable physical or mental impairment(s) that can be expected to result in death or that have lasted or can be expected to last for a continuous period of not less than 12 months.

Disability in children

Under title XVI, a child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.[19]

Summary

In conclusion, Oregon's Quality Strategy serves as a foundational tool for ensuring that CCOs operate in alignment with state goals and federal requirements under 42 CFR §438.340. By maintaining a robust performance monitoring system, Oregon is able to track progress, identify areas for improvement, and support accountability across all

[19] Source: Disability Evaluation Under Social Security

CCOs. This framework reinforces the state's commitment to improving access, addressing health disparities, and driving system wide quality improvement. As Oregon continues to utilize the CCO model, the Quality Strategy will remain central to evaluating performance and advancing meaningful, measurable, outcomes for Medicaid members.